Counsellors and Outcome Measures: Usage Trends, Familiarity and Attitudes – A NSW Pilot Study

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August 2021

This thesis was submitted in partial fulfilment of the requirements for the degree of Master of Research, Western Sydney University, 2021.

Abstract

Outcome measures play a crucial role in the evaluation of counselling and psychotherapy. Perspectives on what contributes to and brings about therapeutic change vary widely, with outcome measures having also been a source of disagreement with regards to what they measure – as well as when, and how often they should be used. Since the early 1980's, the endorsement of Routine Outcome Monitoring by regulatory and funding bodies has intensified this dialogue. It has been argued that commonly used outcome measures are over-simplistic, irrelevant, therapy interfering and primarily aligned to behavioural approaches to treatment. Consequently, alternative measures that attempt to capture relational aspects and more nuanced therapeutic change processes have been developed. Little research has been conducted on the current usage trends and attitudes towards outcome measures amongst Australian counsellors. A cross disciplinary online survey, employing a mixed methods design was conducted to develop an understanding of Australian counsellors' usage patterns and attitudes towards using outcome measures. One hundred and six clinicians were asked about their experiences with using outcome measures. Outcome measure usage was found to be widespread at 80% and voluntary usage was determined to be 47%. Few process-oriented measures were used or known about. Attitudes towards measures were found to be mixed, with clinicians articulating perceived benefits, limitations and potential harms associated with measuring. This pilot study contributes to the understanding of outcome measure usage patterns and their effects from the perspective of clinicians in Australia. It casts a "wide net" in investigating the utilisation of outcome measures and connects to a wider range of issues within the field. The results, therefore, lead to a range of recommendations for research, clinical training, and practice which aim to enhance awareness and application of outcome measures and more broadly, optimize clients' experiences of counselling and psychotherapy.

DEDICATION

I wish to dedicate this work to all the clients I have had the honour of working with, who have taught me so much.

ACKNOWLEDGEMENTS

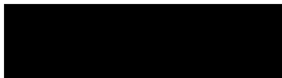
To begin, I acknowledge the traditional custodians of the Gadigal and Darkinjung lands, upon which this research was conducted. Thanks to my husband David, who wholeheartedly supported me in this venture by giving me space to research and write. Likewise, thanks to Caitlin and Tom for your acceptance and encouragement - and to Caitlin especially, for the statistical and style tuition. To my principal supervisor, Penny Gardner, thank you for believing in me and setting me upon this course and your guidance, and to co- supervisor Amanda Webb for your consistent, wise and generous help and advice. Thanks to the Graduate Research School for providing practical support and financial assistance. To my colleagues who gave so kindly of their time and assistance, your interest is much appreciated. It seems only fair to acknowledge to the three dogs (Peter, Tara, and Maisie) who helped ease the isolation of research with their companionship - and for reminding me to take breaks to walk them and feed them treats. Finally, I am indebted to my mother and father, although passed, their proud spirits were with me and encouraged me to carry on when things felt bleak.

Míle Buíochas go Léir

(A thousand thanks to you all)

STATEMENT OF AUTHENTIFICATION

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, at this or any other institution.



Carmel Hamilton

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Counsellors and Outcome Measures: Usage Trends, Familiarity and Attitudes – A NSW Pilot Study

1.Chapter 1 Introduction

This thesis was inspired by a peer supervision session I attended two years ago with five counsellor work colleagues. The topic of discussion was outcome measures. Although our organization did not specify that we use any particular measures, there was an expectation (for ongoing funding purposes) that we would use at least one with every client. Management also stipulated that most of our clients should demonstrate improvement on the chosen measure as a result of counselling. The discussion was a lively one, the clinical merits and drawbacks of using outcome measures with our clients were explored. Although a small team, we were a cross disciplinary one, comprising three psychologists, one social worker, one counsellor and one psychotherapist and it was evident that some differences of opinion existed on the basis of professional background. We all agreed that implementing and scoring outcome measures added to our workload and we discussed which of the measures utilised might better reflect the work we do (working with adult survivors of childhood trauma), and whether there may be more suitable measures available for this clientele. As a group, we felt safe enough to openly discuss how we determined whether we were actually helping our clients (or not) recover. This led to musings about developing the "ideal outcome measure" which would adequately represent the indications of therapeutic change we had articulated. Unsurprisingly, perhaps, this "ideal measure" did not eventuate, however the conversation in that supervision session was rich, informed and honest - and illustrates the complex aspects pertaining to outcome measure usage in clinical practice.

1.1 Background

In the field of Counselling and Psychotherapy, there exists an ongoing and increasing emphasis on evaluation of counselling interventions supported via the use of outcome measures. The introduction of Routine Outcome Monitoring (ROM) in the early 1990's resulted in an exponential increase in outcome measure usage rates (Miller et al., 2015), which led Wampold, (2015) to describe measures as being "pervasive" in the field. ROM involves the utilization of at least one outcome measure with clients in every session. Given the professional and ethical obligation to prioritize the wellbeing of clients, it seems fitting that such a prevalent practice warrants ongoing, thorough, and unbiased appraisal. However, this seems to be only partially the case as significant gaps in our knowledge around outcome measures exist. These gaps relate to usage patterns, types of measures utilized and first- hand reports from counsellors who are using measures with clients in clinical practice. The current study aims to help fill these gaps.

In Australia, ROM became mandatory in Public Mental Health in 2003 (Australian Health Ministers' Advisory Council, 2003). Outside of the Public Health System, it is not known to what extent outcome measures are being used by counsellors or to what extent usage is mandated by funding bodies. Similarly, whilst it is known what types of measures are utilized in the Government funded Health System, there is less clarity surrounding the nature of the outcome measures being used in Non-Government Organizations (NGOs), private corporations and in private practice. Additionally, rates of voluntary outcome measure usage by counsellors are undetermined. This knowledge deficit potentially impedes our understanding of counsellors' attitudes towards using outcome measures with clients. In North America and Canada, where ROM is currently not mandated, outcome measure usage

rates were found to be low. For example, a survey of Canadian psychologists found 13% were using measures routinely (Ionita & Fitzpatrick, 2014). However, it seems that clinicians may be increasingly choosing to use measures, as a later study by the same authors found that 36% were using measures in 2020 (Ionita et al., 2020). In Australia, Chung & Buchanan, (2019) found high rates of usage at 69% , although it is not certain whether the clinicians in that study were mandated to use outcome measures. Therapeutic discipline and preferred modality have been found to influence the voluntary uptake of measures (Garland et al., 2003; Hatfield & Ogles, 2007; Jensen-Doss et al., 2018), with psychologists and clinicians trained in Cognitive Behavioral Therapy (CBT) being more likely to utilize outcome measures. Even when outcome measure usage is mandated – as in the Australian Public Mental Health System, research has indicated a reluctance to fully embrace the practice – whilst clinicians collect the data, as they are mandated to, there is a tendency not to utilize the feedback from the measures in clinical practice (Klundt, 2014; Kwan et al., 2021; Trauer et al., 2006). This pattern seems to be an important area to explore further, in that it may reflect clinicians' attitudes towards outcome measures in a concrete manner.

The measures most commonly used in Australia tend to be behaviorally oriented and focused on assessing changes in symptoms, levels of functioning, and psychopathology (Bibb & Baker, 2016; Kilbourne et al., 2018). Although other types of outcome measures aligned with non-behavioral modalities (including process, relational, individualized and humanistic measures) exist, there is little research indicating the degree to which these are being used in clinical practice in Australia. I located one study conducted in the United States by Levitt et al (2005) who found that these types of measures are not regularly used and are not well known.

Although much has been written about the benefits and drawbacks associated with outcome measure usage, studies which attempt to elicit the views and experiences of

practicing clinicians are sparse, especially in Australia. Cross disciplinary studies are rarer still. Clinicians' attitudes towards the use of outcome measure usage have been found to be mixed (Jensen-Doss & Hawley, 2010; Norman et al., 2014; Sharples et al., 2017). Reported merits include aiding clinical direction, client empowerment, increased communication between client and counsellor, whilst reported drawbacks include the time burden involved, lack of relevancy of measures, the potential for their use to interfere with the therapy process, and the risk of causing harm to the client. These views, articulated by counsellors reflecting on their experiences of using outcome measures with clients strike me as being particularly significant and worthy of further research. Since counsellors' attitudes towards using measures are likely to influence decisions to use measures voluntarily or not, this aspect of usage trends seems a particularly important area to explore. Additionally, counsellors' attitudes towards the use of outcome measures are likely to be dependent on the types of measures they have had experience with (Hill, Chui & Baumann, 2013; Jensen- Doss et al, 2018), which makes it important to determine what types of measures are known about and being commonly used.

In order to identify the Australian experience, and address these above-mentioned knowledge gaps, the current research sought to capture baseline information regarding outcome measure usage trends, alongside more nuanced and subjective data in relation to counsellors' attitudes towards and experiences with using outcome measures with clients. Owing to the expansive scope of the information the study aimed to elicit, an online survey, utilizing a mixed methods design and targeting a cross disciplinary cohort of practicing clinicians was conducted in order to answer three research questions, as shown below.

1.2. Research Questions

1. To what extent are counsellors using outcome measures in NSW and to what degree is usage voluntary?
2. Are counsellors familiar with a variety of measures, and are a variety of measures being used?
3. What do counsellors have to say about their experiences of using outcome measures with clients?

1.3. Definitions and Use of Terms

1.3.1. Outcome Measures

Outcome measures can be described as psychological measurement tools which aim to assess therapeutic change. They can be administered by the counsellor or the client, with client reported measures having become increasingly popular over the past twenty-five years (Sales & Alves, 2016).

Rodgers emphasised quantifying measurement:

> Measures typically consist of a list of items in the form of questions, statements or observations relating to a person's symptoms, behavior, functioning, well-being, and quality of life. Each response to an item is assigned a numerical value. These values are then totaled to produce scores on one or more scales (e.g., psychological distress, level of functioning). Typically, a questionnaire is given to the client before therapy commences, then again, sometime later. The change in scores is calculated to give a representation of the success or otherwise of the therapy. (Rodgers, 2017 p1).

In this project, the term “outcome measures” generally relate to client reported (also known as self-reported) measures. Client reported measures usually take the form of questionnaires with a series of questions which are administered through pen and paper format or via electronic devices. I will note any event of a particular measure mentioned not being client reported.

For the purpose of this paper, the terms “outcome measures” and “measures” will be used interchangeably.

1.3.2. Routine Outcome Monitoring

Routine Outcome Monitoring (ROM) involves the use of outcome measures on a routine basis over the course of therapy - typically every session. The purpose of such monitoring is to provide timely feedback regarding outcome to both client and counsellor, with the aim of enhancing positive therapeutic change (Lambert & Harmon, 2018). ROM aims to promote dialogue between the counsellor and client around therapeutic progress, and the client’s experience of the therapeutic relationship and the therapist, in addition to increasing client involvement in, and commitment to therapy (Miller et al, 2015).

1.3.3. Counselling and Psychotherapy

For the purpose of this project, the terms Counselling and Psychotherapy are used interchangeably although it is acknowledged that there are differences, and that these differences are perceived by individuals, organizations and regulatory bodies to varying degrees. For example (Kwiatkowski, 1998) highlights that the British Counselling Association (BCA) minimises differences, whilst the British Psychological Society (BPS) asserts the difference is more robust. The Psychotherapy and Counselling Federation of Australia (PACFA) acknowledge the overlap between the two disciplines, yet also highlight the differences: “while the work of both Counsellors and Psychotherapists with clients may

be of considerable depth and length, the focus of Counselling is more likely to be on specific problems, changes in life adjustments, and fostering the client' s well- being. Psychotherapy is more concerned with the restructuring of the personality or self and the development of insight" (Psychotherapy and Counselling Federation of Australia, n.d.). Although I recognise these distinctions, I also agree with Crago (2000) who posits that in practice, these distinctions tend to break down. I can identify with this observation from my own clinical practice and on this basis elect to group Counselling and Psychotherapy together here. The following definition offered by the British Counselling Association perhaps best reflects this grouping: "Counselling and Psychotherapy are umbrella terms that cover a range of talking therapies. They are delivered by trained practitioners who work with people over the short or long term to help them bring about effective change or enhance their wellbeing" (British Association of Counselling and Psychotherapy, n.d.).

1.3.4. Use of terms "Counsellor", "Clinician" and "Therapist"

These terms are used interchangeably throughout the thesis. The terms refer to professionals who work in counselling positions and may choose to identify as Counsellors, Psychologists, Psychotherapists and Social Workers. When I am referencing individual disciplines, I will indicate this accordingly.

1.4. Significance of the study

This pilot study probed an important topic within the field of Counselling and Psychotherapy, with the aims of increasing clarity around outcome measure usage patterns in clinical practice and prioritising clinicians' perspectives regarding their effects on clients. In so doing, the research sought to promote a balanced dialogue within an area of the field characterised by opposing viewpoints and a general lack of input from clinical practice. The cross disciplinary nature of the study facilitated the presentation of a variety of clinical

perspectives for consideration. Given the increasing prevalence of outcome measure usage with clients - and the fact that the limited research stemming from clinical practice conveys conflicting views concerning the effects of using measures may have on clients, there exists a clinical and ethical responsibility to conduct ongoing and unbiased research in this area. This study represents an effort to promote this research. By clarifying usage patterns, determining the types of outcome measures being utilised and by considering a wide range of clinical perspectives, the study's findings led to a number of training, research and practice recommendations aimed to enhance outcome measure usage practices and more broadly, improve therapeutic experiences for clients.

1.5. Organization of Thesis

This chapter has provided an overview of what has been written about outcome measure usage and clinicians' attitudes in the literature. Key knowledge gaps were identified, the research questions presented and terms defined. Chapter two provides a more detailed review of the literature pertaining to outcome measure usage patterns and clinicians' attitudes. Chapter three describes the methodology underpinning the choice of methods used in conducting the research and outlines the application of these methods. In chapter four, the results are presented and some preliminary data integration outlined. Chapter five further integrates the qualitative and quantitative results, which in turn are interpreted and discussed with reference to existing literature and theory. Chapter six concludes the thesis by summarising the study's significant contributions to the field of Counselling and Psychotherapy. Strengths and limitations are outlined, and the chapter concludes by offering a number of recommendations for research, training, and clinical practice.

2. Chapter 2: Literature Review

Although the current research focuses on the application of outcome measures in clinical settings and counsellors' experiences in using them, I have found it important to review the historical, social and political factors contributing to their nature and significance over time. Additionally, it has been helpful to track the psychotherapeutic research which has influenced the development and prevalence of outcome measures; together, these two lines of enquiry provide a rich contextual framework in which to conduct my research. I will pay particularly close attention to studies involving the input of practicing (and non- research) clinicians, although these studies are rare, and detail what counsellors say about the benefits and challenges associated with using outcome measures, describing controversial aspects – and the efforts made to address these points of difference. This specific clinical focus stems from my own experience as a counsellor over the past 23 years – including using outcome measures with clients. I am interested in exploring how the broader body of non-clinical research knowledge pertaining to outcome measure usage intersects with what counsellors' report of their experience in clinical practice.

2.1. History

The first mention of a scaling system for psychological distress in the literature dates to Father Thomas Verner Moore who, in 1879 developed his "*Scheme for the Quantitative Measurement of Abnormal Emotional Conditions*". This system involved the classification and measurement of psychotic symptoms (Moore, 1933). However, subsequent psychological measures were not widely used again until the 1940's, when their development was driven by the alignment of a number of social, political and economic factors (Null et al, 2017). At the time behavioural modification techniques were becoming increasingly popular, largely

because these approaches for the treatment of psychological disorders aligned well with the prevailing positivist ideology in western culture. The behavioural approach, characterised by its' focus on bringing about observable changes in behaviour and psychopathology necessitated the development of psychological checklists and measures. The reliance on such measures increased throughout World War 2, as behavioural techniques were widely utilised to treat the influx of returning soldiers exhibiting symptoms of shellshock (Lloyd, 2015). Additionally, during the war, psychological assessment tools and measures fulfilled important economic and political functions, in that their use allowed Governments and military authorities to plan for training and deployment of troops. This factor, combined with the efforts of psychology to be recognised as a science led to an augmentation in the development of tools to measure the effectiveness of psychotherapy (Horvath, 2013; Wampold, 2013). As these evaluative tools were being developed by researchers in the behavioural modality, they were were especially suited to the behavioral approach to psychotherapy, with a strong focus on symptoms and psychopathological functioning. These early outcome measurement tools typically employed simple ratings scales or checklists which tracked observable changes, without exploring more complex, relational, or implicit aspects of therapeutic experiences – a tendency observed to persist in the nature of outcome measures in use today (Mcleod, 2001).

2.2. Outcomes in Counselling

What constitutes good outcome in counselling - and what factors lead to therapeutic change - has been a contentious issue since the beginning of counselling (Wampold, 2013). The infamous "Outcome Debate" in psychotherapy can be traced back to the 1950's and originally focused on the relative efficacy of various modalities (Eysenck, 2013; Hill et al., 2013; Strupp, 2013; Wampold, 2019). For example, behaviorists levelled criticism at psychoanalysis, noting that until the method could be empirically proven, it ought to be seen as ineffective (Eysenck, 2013). In response, psychoanalysts countered that changes in symptoms and functioning did not reflect genuine therapeutic change, as they were too simplistic – and the reason why psychoanalysis could not be proven was due to faulty measurement – the outcome measures were overly simplistic (Strupp, 2013). The argument reflects the philosophical differences underlying the various psychotherapeutic approaches. From a behavioural perspective, a good outcome might mean a reduction in symptom severity and increased functioning, whilst from a humanistic perspective, positive therapeutic change may be hard to observe and involve changes in internal processes, such as self -acceptance and increased insight ((Hill et al., 2013). The relationship between the outcome debate and outcome measures is a long standing one (over seven decades) and, as the research illustrates, continues to be a central focus within the field of Counselling & Psychotherapy. The cross disciplinary focus within the present study is expected to help identify how this relationship is reflected within the Australian context.

2.3. Common Factors Theory and Qualitative Measures

Theorists and researchers favoring non-behavioral approaches to counselling and psychotherapy became increasingly dissatisfied with behaviorally focused measures. This dissatisfaction eventually led to the development of other types of measures - which aimed to

better reflect what gives rise to psychotherapeutic change (Horvath, 2013). For example, Strupp highlighted the missed opportunities for researching transference in the therapeutic relationship due to the "furor for easy quantification" (Strupp, 1963, p3). Strupp was not alone in his belief in the significance of the therapeutic relationship in terms of influencing outcome. Decades earlier, its 'importance was recognized, along with other factors relating to the therapist, the client and expectations of counselling (Rosenzweig, 1936). Rosenzweig held that these factors were pivotal to therapeutic change and exerted a greater influence on outcome as opposed to any specific type of therapeutic intervention or approach. This theory came to be known as Common Factors Theory (CFT) and posited that there is no significant treatment effect difference observed across different psychotherapeutic modalities (Drisko, 2004). Therapy process measures aim to assess these common factors, designed to capture characteristics of the client, therapist, and the therapeutic relationship. Such measures focus on the experience of the therapy session and the interaction between counsellor and client, and not only changes in behaviour or symptoms (Suh et al., 1986). Some earlier process scales include *Therapist Client Interaction Analysis* (Wiseman & Rice, 1989) and *The Experiencing Scales* (Klein et al., 1986). The therapeutic relationship, in particular, received much attention and from the mid 1970's there has been a rapid growth in measures accessing the clients experience of the therapeutic relationship (Horvath, 2013). *The Relationship Inventory* is a notable early example (Barrett-Lennard, 2015). This expansion of the development and use of process measures indicates growing support for CFT – the recognition that the therapeutic relationship and therapist and client characteristics have a powerful effect on outcome in counselling.

In the United States, the drive to expand the range of outcome measures and psychotherapeutic assessment tools gained significant support at Government level, when in 1975, the *National Institute for Mental Health* commissioned an expert review into

psychotherapy evaluation methods. This resulted in a number of recommendations for employing a variety of measures, including individualized and qualitative tools - in addition to the traditional quantitative measures (Waskow & Parloff, 1975). Individualized measures have a standardized structured format; however, the client determines the items to be evaluated, choosing issues or domains of personal relevance to him (Sales & Alves, 2016). Qualitative evaluation methods commonly rely on client interviews and aim to elicit the individual's perception of the experience of therapy, and what may have changed for them as a result. The narrative element potentially provides a more nuanced account of therapeutic change (Rodgers & Elliott, 2015). These government endorsed efforts to promote the use of a variety of outcome measures perhaps indicates the level of dissatisfaction with utilizing behaviorally- focused measures only. Despite these early suggestions, however, progress towards such a multifaceted approach to evaluation has been slow, in part because of challenges with psychometric evidence associated with individualized, qualitative, and process measures (Elliott, 2002; Horvath, 2013).

2.4. Evidence Based Practice

Current outcome measure usage patterns have been greatly influenced by the above historical trends, in addition to the emerging need to adhere to using Evidence Based Practice (EBP) in counselling since the 1980's. EBP emerged on the heels of Evidence Based Medicine (EBM), which came to the fore in Australia in the 1970's. EBP emphasizes accountability via empirical evaluation, fits with the positivist paradigm (noted above) and also reflects what Rustin, (2015, p234) calls the "audit culture of our time" - and a more medicalized approach to therapy practice. An audit culture prioritizes answerability, reporting, and the demonstration of effectiveness. Such a philosophy underpins the

medicalized approach to mental health. Also referred to as the medical model or specificity model, the medicalized approach rests on the premise that particular types of therapeutic interventions are more effective than others in the treatment of specific psychological disorders, in much the same way as certain drugs and medical procedures are considered optimal for treating specific medical conditions (Elkins, 2009). For example, it is widely held that Cognitive Behavioral Therapy (CBT) is the most effective treatment for depression (Hansen, 2006). This example highlights the way in which the medical model is at odds with Common Factors Theory, which holds that therapeutic change occurs as a consequence of factors common to all psychotherapeutic modalities (therapist and client characteristics, and the therapeutic relationship) – and not because of factors inherent to any specific modality (Yates, 2013).

To be earn the status of EBP, The American Psychological Association stipulates that a psychotherapeutic intervention must prove its' efficacy by way of demonstrating success in two Randomized Controlled Trials (APA Presidential Taskforce, 2006). Success or otherwise in RCTs depends on outcome measures and therefore, measures are an integral component to EBP (Rodgers, 2017). Levitt (2005) highlights that the aspiration to consistently demonstrate success in RCTs motivated Cognitive Behavioral Researchers to continue to develop scales suited to that approach and these measures tended to focus on symptoms, functioning and psychopathology. The dominance of these types of measures is highlighted in a review of 85 humanistic studies, none of which use process or qualitative measures to evaluate outcomes – all studies reviewed utilized measures suited to CBT. The inference is that outcome measures suited to non-behavioral modalities may not be readily available or known about ((Levitt et al., 2005).

2.5. Rationale for Routine Outcome Monitoring

Stronger empirical support for Common Factors Theory emerged over time by way of a series of meta-analysis studies, confirming Rosenzweig's (1936) assertion that all psychotherapeutic approaches are effective (Cooper, 2008; Shapiro & Shapiro, 1982; Wampold, 2001). Continued interest in understanding the specifics of these common factors, particularly the significance of therapist's effects and the therapeutic relationship on outcome (Norcross & Lambert, 2018; Wampold & Imel, 2015). In 2018, the American Psychological Society highlighted these as neglected areas, asserting "what is missing in treatment guidelines, now, across five decades of research, are the person of the therapist and the therapeutic relationship" (Norcross & Lambert, 2018, p18). The authors strongly recommend the practice of "routinely monitoring patients' satisfaction with the therapy relationship, comfort with responsiveness efforts, and response to treatment. Such monitoring leads to increased opportunities to re-establish collaboration, improve the relationship, modify technical strategies, and investigate factors external to therapy that may be hindering its effects" (p12). This appears to provide strong support to move away from EBP informed by RCTs which focus only on changes in symptoms, use of treatment models and behavioural change towards practices which allow for increased communication between counsellor and client regarding the experience of the therapeutic relationship, and perceptions around therapeutic change. Apart from direct discussion within therapy, these practices might include the use of process measures to attend to the therapeutic relationship, and the utilization of individualised and qualitative measures to identify more nuanced therapeutic change, such as increased self- acceptance, for example.

The use of Routine Outcome Monitoring (ROM) measures mental health functioning (usually via self report) at the beginning of counselling and at frequent intervals during counselling thereafter - typically every session (Lambert & Shimokawa, 2011). The purpose of such monitoring is to provide feedback to the client and counsellor about client progress (or otherwise) at regular intervals with the aim of enhancing outcome. If progress is not being made, then the counsellor can collaborate with the client about how to proceed and what might need to be changed in the therapist's approach (Lambert & Harmon, 2018). ROM differs from the regular use of outcome measures, in that it goes beyond mere evaluation, prioritises feedback, aims to directly involve the client - and measures are utilised in every/most session. In ROM, client outcome is evaluated via self report measures focusing on symptom and behavioral change whilst an additional self report measure is frequently used to assess the clients experience of therapy and the therapist. A common ROM practice is the *Partners for Change Outcome Management System (PCOMS*; Miller & Duncan, 2004) which involves giving the client two measures in each session – *the Outcome Rating Scale (ORS)* assesses the clients symptoms functioning, quality of life, whilst the *Session Rating Scale (SRS)* asks the client about their experience of the session and the therapist. The practice is intended to promote ongoing feedback to both client and counsellor, encourage increased client involvement, and to focus attention on therapist behaviours and on the therapeutic alliance. This example of a ROM system demonstrates how, (at least in theory), the common factors deemed paramount for therapeutic change including the person of the therapist and the therapeutic relationship can be monitored and prioritised in counselling. Other ROM systems available include *Progress Monitoring Measuring Feedback System* (Bickman,2008), and *Feedback Informed Therapy* (Prescott et al., 2017).

2.6. The Rise of ROM

In the literature, much attention has been focused on the empirical evidence for ROM, and as a consequence of this, the practice has been widely endorsed by a range of regulatory bodies including the American Psychological Society (APA Presidential Task Force on Evidence-Based Practice & American Psychological Association, 2006), the Canadian Psychological Society (Dozois et al., 2014), and the American Counselling Association (Yates, 2013). Indeed, ROM is now regarded as an integral part of EBP, and is mandatory (in Public Health) in several countries such as Britain, the Netherlands and Australia (Miller et al., 2015). Strong proponents of ROM (Boswell, 2020; Lambert & Harmon, 2018; Miller et al., 2015) consistently attest to the clinical benefits associated with the practice, and insist that, therefore, it is essential for the effective and ethical provision of counselling. This ongoing promotion of ROM's clinical benefits seems to be impactful, in light of the its' afore mentioned formal endorsement by regulatory bodies, and increasingly, as a funding requirement (Lambert & Shimokawa, 2011). Miller (2015) acknowledges the growing industry around outcome measures, noting that supply of outcome measurement systems (frequently expensive) is increasing. Outcome measurement systems were developed with the aim of easing the time and administrative burden associated with administering and scoring measures and involves the use of computer software for the purpose of collecting and analyzing data and providing the clinician with outcome results. The systems are frequently sophisticated, often with built in "alert" mechanisms to signal to the counsellor when the client's outcome data is indicating deterioration or no change. The "alert" language utilized within these systems seems to convey a sense of assuredness by categorizing clients as being

“on track” (OT) versus “not on track” (NOT), in terms of expected client progress. When a client’s scores fail to reach a certain threshold, they are deemed to be NOT. In a computerized ROM system, NOT indicators would activate an alert to the counsellor, who in turn would then take steps to explore the causes of this failure to progress with the client and alter the therapeutic approach (Lambert & Harmon, 2018). In addition to the growth of computer assisted ROM systems, Miller (2015) refers to the exponential increase in scholarly literature promoting ROM in recent years – an observation I concur with, because of my own experience in reviewing the literature.

In 1992, Australian Public Mental Health Policy proposed regular reviews of treatment effectiveness via outcome monitoring (Australian Health Ministers., 1992) and in 2003, ROM was made mandatory. Since then, clinicians providing counselling in Public Mental Health – in every state - are required to collect outcome measurement utilizing specified measures (Australian Health Ministers’ Advisory Council, 2003). These measures comprise “*Health of the Nation Outcome Scales”* (HoNoS,Wing et al., 1998) the *Kessler -10* (K10; Andrews & Slade, 2001) and the *Life Skills Profile-16* (LSP-16; Rosen et al., 1989). HoNOS comprises a set of twelve clinician reported scales, with focus on behaviour impairment, symptom severity and social functioning. The K10 measures symptoms of anxiety and depression and the LSP-16 measures changes in behaviour and self- care capacity (Andresen et al., 2010). Psychologists and Social Workers providing counselling under *Medicare’s Better Outcome Scheme* are required to report on these measures (Kilbourne et al., 2018). Counselling organizations in the non- government and private sectors vary in their methods of program evaluation and the extent to which measures are employed for this purpose - and the types of measures being used (Posavac, 2015). Within the private sector and in private practice, it is not clear what proportion of clinicians use measures, although their use is strongly encouraged by regulatory bodies such as the

Australian Psychological Society (Australian Psychological Society, 2007), the Australian Association of Social Workers (Australian Association of Social Workers, 2013), and the Psychotherapy and Counselling Federation of Australia (Psychotherapy and Counselling Federation of Australia, 2019). A recent Australian survey of 202 psychologists determined that 60% of those who used measures were in private practice. However, it is not clear whether some of these clinicians were mandated to use measures for the purpose of the Medicare rebate, as identified above, or chose to use them freely (Chung & Buchanan, 2019).

2.7. Prior Research Findings From Clinical Practice

Key findings from existing research are presented in this section. These findings are grouped by research that has highlighted benefits associated with using outcome measures, research that has noted the drawbacks associated with the use of outcome measures, and research which has focused on usage patterns within clinical practice. This section draws on the research findings of studies which elicited the perspectives of practicing clinicians and outlines how these findings intersect with theory and non- practice - based research.

Studies on outcome measures involving clinicians are scare. I found fourteen in total, spanning from 2003 (Garland et al., 2003) to 2021 (Kwan et al., 2021). In Australia, I have been able to locate only one study involving clinicians outside Public Mental Health, and cross disciplinary studies (including counsellors trained originally as psychologists, social workers, counsellors or psychotherapists) are rare – I found none in Australia. However, the limited studies available do provide rich information about counsellors’ experiences with using outcome measures.

Although I acknowledge a distinction between ROM and the general use of outcome measures (when measures are used primarily for evaluative purposes and not implemented in every session), both contexts of usage display many commonalities. Going forward, the term “outcome measure usage” can be understood to include both ROM and the less frequent use of outcome measures. When / if it is beneficial to draw a distinction, I will expressly name this.

2.7.1 Benefits Associated with Outcome Measures

As mentioned, the clinical benefits associated with using outcome measures, particularly ROM, have received much attention in the literature. In reviewing the studies involving counsellors in clinical practice, I was particularly interested to note how these benefits are articulated by clinicians.

Hatfield and Ogles (2004) found that counsellors valued the capacity to track client progress, a finding echoed in a number of subsequent studies (Chung & Buchanan, 2019; Jensen-Doss & Hawley, 2010; Sharples et al., 2017). Counsellors identified that the feedback from outcome measures can help identify client problems and potential goals and thereby is useful for guiding clinical direction (Hatfield & Ogles, 2004, 2006 & 2007). The increased clarity around clinical direction as a consequence of using outcome measures was regarded highly by counsellors as the following comment illustrates “you could go on and on. It is useful to stop and reflect on what you are doing” (Norman et al., 2014, p581).

The above comment may also reflect some counsellors’ preference for being structured in their work with clients, and how the use of outcome measures can help create a sense of efficacy, as found by Sharples et al (2017). Similarly, Rye et al (2019) reported that for some counsellors the consistent use of outcome measures fostered a sense of developing expertise, and reassurance that they were adhering to EBP and thus being effective. Further

findings support the effect of increased counsellor confidence as a consequence of using outcome measures. Norman & Dean (2014) reported that counsellors expressed feeling reassured that the organization they worked for demonstrated efficacy via outcome measures, which led to a greater sense of job security. It seems that for some counsellors, using outcome measures can be personally helpful, and it is feasible that if a counsellor feels less anxious, he/she has more capacity to be present and engaged with the client, thereby potentially benefitting the client also. This potential "indirect" clinical benefit of using outcome measures does not seem to have been identified in the non- clinically based research, although the building of counsellor expertise as a consequence of ROM has been identified by Lambert (2018). It may be interesting to explore this within the current study.

The therapeutic benefits associated with providing clients with feedback regarding progress or otherwise has been identified as an important strength of ROM. Bickman et al (2011) outlines the relationship between feedback and performance. When people become aware (through objective feedback) that there is a discrepancy between their perceived progress and measured progress, they are likely to take action to alter their behavior and increase commitment to change. Further support for the utilization of outcome measures with regard the to the link between receiving feedback and positive therapeutic progress is offered by Amble et al. (2016) who found that people are likely to try harder when the feedback is non ambiguous, as in the case of objective (quantified) feedback from outcome measures. Counsellors in clinical practice were found to support this evidence, articulating that positive feedback on client progress worked to increase client motivation, confidence, and expectations of positive change (Boyce et al., 2014; Ionita & Fitzpatrick, 2014; Jensen-Doss & Hawley, 2010). The increased motivation described by counsellors in these studies seems to concur with assertion that ROM may help client improve quicker and in a fewer number of sessions (Lambert & Shimokawa, 2011).

Advocates of ROM posit that the practice is especially useful for identifying lack of progress or deterioration in therapy (Lambert & Harmon, 2018), highlighting evidence to suggest that clinicians may regularly fail to predict deterioration or no change by clinical judgement alone (Hannan et al., 2005). When therapists become aware of the discrepancy between their view of client progress and measured progress, they may be prompted to take corrective action, which may reduce dropout rates and improve client outcomes. For example, a meta- analytical study conducted by Sapyta et al (2005) found that using feedback from measures and altering the therapeutic approach improved client outcomes by 58%. Utilising feedback to inform clinical direction has also been credited with significantly minimizing deterioration and reducing dropout rates by 50% (Bickman et al., 2011; Janse et al., 2017). These claims regarding the usefulness of measures in identifying and discussing negative or no change are supported by findings from some clinical studies. A number of counsellors identified that when the feedback from outcome measures is negative, their attention is drawn to a possible problem which otherwise may have gone unnoticed (Garland et al, 2003; Hatfield & Ogles, 2004; Jensen-Doss & Hawley, 2010; Norman et al., 2014; Sharples et al., 2017). Clinicians also indicated that utilizing negative feedback from outcome measures can help both parties to discuss sensitive topics, which may otherwise not have been discussed (Overington et al., 2015). As one counsellor put it “the feedback opens the door for me to talk about something” (Garland et al., 2003 p400). Clients, too, appear to appreciate the way in which measures facilitate conversation about sensitive and important topics, as identified in a study eliciting client perspectives on outcome measures (Stasiak et al., 2013).

If a process measure outcome measure is utilised (such as the *Session Rating Scale*), the feedback may indicate that the client is not feeling satisfied with therapy or the therapist, and that these factors may be contributing to non- progress. Such feedback can signal an

opportunity to discuss the source of dissatisfaction and to repair ruptures in the therapeutic relationship. Some research indicates that counsellors may overestimate the strength of the therapeutic relationship, as well as their effectiveness as clinicians counsellors, and that the use of outcome measures is necessary because of these failures (Cooper, 2008; Walfish et al., 2012). Some clinicians' reports seem to lend support to these perspectives, identifying that quantified feedback from measures conveying the clients experience of the therapeutic relationship alerted them to problems they had not been aware of (Norman et al., 2014; Rye et al., 2019). Client feedback has been identified as an important part of counsellor development, along with supervision and practice (Sapyta et al., 2005) and additionally a clinicians' capacity to accept and embrace feedback demonstrates humility – a characteristic which has been found to be conducive to a strong therapeutic relationship and positive client outcomes (Norcross & Lambert, 2018).

It seems that the research highlighting the clinical benefits of using outcome measures simultaneously emphasises the importance of open dialogue between client and counsellor. However, the research outlined above neglects to consider the possibility that measuring may not be prerequisite for such clear and honest communication to occur.

Additionally, it is worth noting the non- clinical and obvious advantages associated with outcome measures. As evaluation tools, they are *efficient.* Data derived from them is relatively easy to collect and analyze. Numbers offer a concise way to "prove" effectiveness to service providers, regulatory and funding bodies (Elliott, 2011). This can make the task of decision making and allocation of funds on the part of funding bodies simpler from a logistical perspective.

2.7.2 Drawbacks Associated with Outcome Measures

The time taken to administer and score outcome measures, along with insufficient training and a lack of organizational support were commonly cited deterrents to utilising measures (Boswell, 2020; Garland et al., 2003; Gleacher et al., 2016; Hatfield & Ogles, 2004; Norman et al., 2014). This is particularly true in the case of ROM, where the process of gathering and interpreting data is more frequent and often requires access to technology, computer literacy and training (Gleacher et al., 2016).

Additionally, findings from the clinical studies indicate that a lack of transparency regarding the purpose of measures can create fear and suspicion for both counsellors and clients (Boyce et al., 2014; Trauer et al., 2006). Counsellors noted that they felt their personal performance was being scrutinized or that their service was being evaluated with the possibility of losing funding and potentially impacting job security (Norman et al., 2014; Sharples et al., 2017). Miller et al., (2015, p4) validates these concerns when he writes "clinicians favour the use of outcome information for improving clinical decision making, whilst administrators emphasize its utility for conducting audits and performance reviews". Some clinicians described how clients regularly exhibit suspicion whilst completing measures, by merely "ticking boxes" expediently (Rye et al, 2019). This observation is also borne out in studies with clients wherein clients report that they worry about what the results of the outcome measures may be used for (Börjesson & Boström, 2019; Solstad, Castonguay & Moltu, 2019). Romine (2018) found that deference to the counsellor may influence the client's choice of responses whilst completing measures, whilst other research determined that clients tend to be less honest when providing feedback via questionnaire, compared to providing feedback in an interview setting with the counsellor (Mcleod, 2001; Stanicke & Mcleod, 2021).

Concerns about the validity of outcome measures were identified in many of the clinician studies, with counsellors expressing that the constructs being measured were overly simplistic and failed to capture more nuanced and subjective therapeutic change (Garland et al., 2003; Ionita & Fitzpatrick, 2014; Jensen-Doss & Hawley, 2010; Rye et al., 2019; Trauer et al., 2006). Garland and Ruse (2003), for example found that 55% of the cohort said the measures were too behaviorally focused and not enough focus on internal processes (such as personal meaning, perceptions, feelings and sensations). These concerns are substantiated by a number of research findings described below.

The counselling process often helps people become more aware and accepting of their feelings, including negative emotions. Prior to therapy, a client may not have been able to articulate anxiety, for example, and after several sessions may develop capacity for this. Thus, an item measuring anxiety on a questionnaire could imply deterioration, as opposed to increased self- awareness and resilience. This is an example of the "response shift" phenomenon – whereby the experience of being in therapy changes the way the client might make sense of and respond to a questionnaire item and (Mcleod, 2001, p219).

Issues concerning the epistemological validity of measures have been illustrated in a series of mixed methods evaluation studies – whereby clients completed self- report measures in addition to being interviewed. The findings indicate that positive outcomes are not always captured by outcome measures and that clients' view of change is regularly broader that what outcome measures can capture (Binder et al., 2010; Bloch-Elkouby et al., 2019; De Smet et al., 2019a; Hill et al., 2013; Leibert et al., 2020; Moltu et al., 2017; Truijens et al., 2019).

A related epistemological concern is raised by Yalom & Bugental, (1997) who assert that it can be expected that clients in therapy may feel worse for a time and that this may not be a sign of an adverse therapeutic process - for example, as a consequence of suppressed

grief resurfacing during the counselling process, because of an increased capacity to self reflect. On a measure gauging depression, such a client may seem to be worsening, when in fact, he is engaged in the natural and healthy act of processing grief. By focusing attention only on measurable concepts, without exploring the broader context the client is facing or understanding the value in non-positive affective experiences, there is a risk of over simplification and directing both the therapists and client's attention to what is being negatively rated, while underlying processes that could in fact be helpful to the overall therapy process may be missed or misinterpreted (Morstyn, 2011; Rodgers, 2017). .

The idea of quantifying therapeutic change has been viewed as problematic for some counsellors (Garland et al., 2003; Gleacher et al., 2016; Hatfield & Ogles, 2007). Some individuals experience a conceptual barrier when it comes to assigning a numeric value to human experience. Additionally, numeric values may seek to impose a similar rating scale across divergent life experiences. Rodgers (2017) argues that this is inherently flawed, noting that various items within a measure cannot intrinsically all be of equal value i.e. Scoring a "4" on "*I feel sad most of the time*" and "4" on "*I believe I cannot trust people*" does not imply equal degrees of distress relating to these two aspects of subjective experience. Kazdin, (2014) suggests we view outcome measures as "arbitrary metrics" as we cannot truly know how the score translates into every-day experience (p389).

Many authors have highlighted counsellors' concerns regarding the potential harm outcome measure usage may cause to clients (Dozois et al., 2014; Gleacher et al., 2016; Hatfield & Ogles, 2006; Ionita et al., 2020; Ionita & Fitzpatrick, 2014; Sharples et al., 2017). These disquiets relate to the language used, possible adverse impact on client engagement and increasing client distress due to the nature of the questions being asked. The language utilized within measures was identified by counsellors as being potentially damaging by labelling and pathologizing (Boyce et al., 2014; Norman et al., 2014). Clinicians reported that

some clients disengage, become upset or stressed whilst completing questionnaires. They also query whether some clients understand what is being asked (Norman et al., 2014). Gleacher (2016) found that some clients became stressed whilst trying to complete computerized forms of ROM owing to not being sufficiently computer literate. These concerns may be supported by the findings from an Australian research study which reviewed seven common standardized outcome measurement tools and concluded that "although the average person may understand the meaning of the terms (in the measures), Mental Health consumer is likely to become overwhelmed and confused if they do not understand the meaning of complex words" (Bibb et al., 2016, p456). Additionally, a lack of cultural sensitivity within some measures has been noted (Garland et al.,2003). Clients may feel undermined if the measures reflect positivist or individualistic values, conveying that "betterment of self" is ideal and everything else is not, which may not be representative of collectivist cultural perspectives (Rodgers, 2017, p13).

Some counsellors report that using outcome measures can be damaging to the therapeutic relationship, particularly in the case of ROM, whereby measures are consistently used (Boyce et al., 2014; Gleacher et al., 2016; Sharples et al., 2017). Morstyn, (2011, p 221)) expresses that use of measures contributes to a "pseudo relationship" instead of a genuine therapeutic relationship - where clients may feel obliged to report and respond via forms and/or technology rather having the experience of being attended to and heard by the counsellor. In this way, the practice of using outcome measures has the potential to re traumatize clients who have already been traumatized by past relationships characterized by an imbalance of power and wherein they may have experienced abuse and/or neglect.

2.7.3 Usage Patterns and Attitudes

Despite the empirical evidence for the benefits of using measures, studies involving practicing counsellors indicate that unless mandated to use outcome measures, usage is low (Dozois et al., 2014; Hatfield & Ogles, 2007;Ionita & Fitzpatrick, 2014). For example, in the United States, Hatfield and Ogles (2007) found that only 37% of the 874 psychologists surveyed used measures. More recently, another North American survey indicated that only 14% of 504 clinicians utilized measures routinely (Jensen-Doss et al., 2018). The difference in results may be related to discipline; with the 2007 study involving psychologists, whilst the 2018 study was cross disciplinary. In Canada, usage rates also seem to be low. The Canadian Psychological Society, in a survey of its members found that only 12% used measures. (Dozois et al 2014). This corresponds with Ionita & Fitzpatrick's (2014) finding - in a large-scale study of 1668 psychologists indicating usage rates at 13% while two thirds of participants in their study were not even aware of ROM. However, a more recent survey by the same authors indicated that 36% of the 533 participants were using measures (Ionita et al., 2020).This may suggest that the use of measures is increasing or has been more widely promoted in recent years.

Within the local context, an Australian survey of 202 psychologists by Chung & Buchanan (2019) found that 69% of participants were using ROM. This may signal higher usage rates in Australia. However, it is not clear if participants in the survey were mandated to use ROM, although it is likely that this high rate of ROM use is partially attributable to the fact that all participants were psychologists. In North America, Garland and Kruse (2003) found no difference in terms of usage between social workers, psychologists, and psychotherapists, however, in another cross disciplinary study, it emerged that psychologists were more likely to use measures, particularly professionals who held a CBT orientation (Sharples et al., 2017). Hatfield and Ogles (2007) also found that CBT psychologists were

more likely to use measures than insight orientated psychologists - a finding replicated by Jensen Doss (2018) - whilst Kaiser (2018) found that CBT therapists expressed more positive attitudes towards ROM. It may be that an underlying positivist perspective and promotion of scientist-practitioner stance within the training of psychologists might promote use of objective measures -more so than may be the case for clinicians trained in other disciplines. Returning to the Australian context, the lack of cross disciplinary studies signals a gap in the research and similarly, there is an absence of studies which identify differences in mandated and voluntary use of measures. This was an area explored in the current research.

It has been suggested that counsellors' attitudes towards using outcome measures strongly affect usage rates (Jensen-Doss & Hawley, 2010; Rye et al., 2019). Despite findings indicating that counsellors attitudes are for the most part either neutral or positive (Garland et al., 2003; Norman et al., 2014; Sharples et al., 2017), voluntary outcome measure usage rates are not in accordance. It seems that positive attitudes only sometimes translate into usage - for example, Jensen Doss (2018), in her study of 504 clinicians found that although more than half expressed positive attitudes, only 14 % used chose to use them routinely. Even when mandated to use ROM (as is the case in Public Mental Health), clinicians may not always incorporate the feedback into clinical practice. For example, in a qualitative study of 50 American clinicians, Garland & Kruse (2003) found that most disregarded the feedback, preferencing their clinical judgement instead. In an Australian survey of Public Mental Health clinicians, Trauer et al. (2006), found similar results. The authors attributed this to lack of training, in- adequate access to technology, time burden and clinicians' negative views on the relevancy of the measures. More recently, a Belgium study found that only 37% of clinicians even viewed the feedback from the measures, never mind incorporating the feedback (Klundt, 2014). Similar to the aforementioned Australian study, time burden and lack of clinical relevance were identified as likely causes for this. In another Australian study

involving Headspace (Public Mental Health service for young people under 25 years) researchers found that although clinicians collect the data, they are less likely to use it to inform clinical practice and provide the feedback to clients (Kwan et al., 2021). Gaining further understanding of this reported reluctancy to utilize feedback from outcome measures in clinical practice may be helpful, in addition to exploring the factors contributing to the discrepancy between counsellors' attitudes and voluntary usage rate usage rates. This study sought to elicit clinicians' perspectives in order to explain these anomalies.

Other factors found to affect outcome measure usage rates include place of work, and years of practice. Counsellors in private practice were found to be less likely to use measures, (Hatfield & Ogles, 2007; Ionita & Fitzpatrick, 2014), although Chung (2019) found that 60 % of Australian psychologists who used measures in that study were in private practice. As mentioned previously, it is possible that some of these counsellors were required to use measures for the purpose of the Medicare rebate. Years of practice may also have a bearing on usage rates, with clinicians with more years of experience less likely to embrace measures and instead rely on their clinical judgement (Garland et al., 2003; Gleacher et al., 2016; Kwan et al., 2021). Trauer (2006) offers a possible explanation for this trend by highlighting that ROM, as a relatively novel practice, is resisted more by clinicians who have experience of the field without ROM being so prevalent. Gleacher (2016) indicates that computer literacy may also contribute to less use by older counsellors in the case of ROM.

2.8. Competing Stances, Compromise, Way Forward

Although ROM has attracted little outright criticism, the literature reviewed suggests that a range of concerns and competing considerations exist. Additionally, risk of researcher bias has been identified as a potential issue in how attitudes towards ROM are reported. As

Wampold (2015, p459) notes "most of the research cited in meta-analyses (supporting ROM) has been conducted by advocates of a particular system". Hence, authors reporting on a particular outcome measure or outcome management system aligned to their preferred way of working may be unlikely to portray it in a negative light. In contrast, a Cochrane review of seventeen studies with 8787 participants concluded that ROM has no proven merits, and proposed that future research needs to have increased focus on the potential harms and costs associated with ROM (Kendrick et al., 2016). Apart from two client studies highlighting the potential harms ROM can cause (Errázuriz & Zilcha-Mano, 2018; Paz, Adana-Diaz & Evans,2020), I have found no follow up research examining specific client harms and costs. However, two meta- analytical studies examining the benefits of the widely used *Partners for Change Outcome Management System* (PCOMS) which involves using the *Session Rating Scale* (SRS) and the *Outcome Rating Scale* (ORS) in every session found only negligible support for it (Østergård & Hougaard, 2020). In the same year, another (12 study) meta-analysis into PCOMS found no benefits associated with its use (Pejtersen & Viinholt, 2020). These findings have sparked ongoing debate in the literature, with the developers and license owners of the system defending the efficacy of the PCOMS and arguing that Østergård & Hougaard's review is misleading, and was not rigorously conducted (Duncan & Sparks, 2020), while Østergård & Hougaard have refuted these claims and come out in support of their study (Østergård & Hougaard, 2020b).

Apart from the above-mentioned three reviews and two studies, the literature overwhelming conveys an acceptance that ROM is here to stay - and that it is a positive thing. Strong advocates of ROM promote the practice, stressing its' clinical significance and empirical evidence (Bickman et al., 2011; Lambert & Harmon, 2018; Miller et al., 2015) Wampold (2015 p458) asserts "ROM is the most noteworthy advance in psychotherapy in the last 25 years" and "the pervasiveness of ROM attests to its' robustness" (p461). This view

contrasts with that of Mcleod who frames ROM as "an administratively created reality" (2001, p215) – conveying that the "pervasiveness" of ROM may be mainly due to the evaluative function it fulfills. Other researchers seem to share this resignation regarding ROMs' entrenchment, and the focus of their work is to alter ROM in ways to increase its' acceptability to a wider range of perspectives (Elliott, 2002; Hill et al., 2013 Rodgers & Elliott, 2015). Common to both groups, seemingly, is a recognition that the clinical utility of ROM is less important than the bureaucratic pressures prioritizing measurable evaluation (Elliott, 2002; Fugard, 2015; Lambert & Harmon, 2018; Wampold, 2015). It appears researchers have become focused on working to find solutions to the problems associated with ROM, in an effort to mitigate negative impacts, rather than researching alternatives or challenging the overall utility of ROM.

Advocates of ROM tend to focus research efforts on the reasons contributing to low and partial uptake of the practice, and the disparity between the reported general positive attitudes towards outcome measures and low usage rates. The aim is to understand, and work to overcome (what are frequently referred to in the literature as) "barriers" to adopting ROM (Lambert & Harmon, 2018). "Barriers" correspond with the drawbacks to using measures as identified by counsellors and have been categorized into two groups – practical and philosophical (Boswell et al., 2013; Hatfield & Ogles, 2004). Primarily, the research focus from advocates of ROM seems to be on the practical challenges (time and administration burdens, lack of organizational training and support), whilst the philosophical "barriers" are overlooked and even dismissed. For example, Lambert (2017) outrightly denies the claim that clients' symptoms may worsen as part of the healing process and disregards concerns about the epistemological validity of self- report measures. Research into the practical "barriers" to the uptake of ROM have resulted in the following outcomes/ suggestions/ solutions:

1. In response to counsellor's calls to have shorter and simpler measures (Garland et al., 2003; Ionita et al., 2020), shorter measures have been developed and computer software programs aim to simplify collection and analysis of data (Bickman,,2008; Lambert & Shimokawa, 2011; Miller & Duncan, 2004)
2. Research into the effects of increased organizational support for counsellors - in terms of providing enough time and training for counsellors to implement and interpret measures is seen to be vital for the successful uptake of ROM amongst clinicians (Lambert & Harmon, 2018; Willis et al., 2009). Research indicates that organizational support extends to adopting a culture of measuring using championing/ encouraging and ongoing training (Kwan et al., 2021; Rye et al., 2019).
3. Counsellors want their views to be respected more and to be taken seriously by their organizations/services. It has been suggested that the dialogue between researchers, managers and clinicians be intensified (Gleacher et al., 2016; Rye et al., 2019), with the aim of creating a balance between clinical utility and administrative need. Therapists expressed that they would like to have input in evaluation planning and choice of measures (Garland et al., 2003; Sharples et al., 2017; Trauer et al., 2006). Optimally, counsellors would have greater autonomy in determining when it may not be appropriate to use measures – when a client is very upset, for example (Norman et al., 2014).
4. The importance of acknowledging and validating Counsellors' fears in relation to ROM has been identified and in the interests of prioritizing ROM's clinical utility, researchers and regulatory bodies such as the Canadian Psychological Society, discourage the practice of using outcome measures data for the purpose of employee performance reviews (Dozois et al., 2014; Lambert & Harmon, 2018).

Theorists and researchers who express resignation to ROMs' systemic entrenchment work to alter the practice significantly, with the aim of reducing its' limitations and assuaging potential harms. Making reference to McLeod's framing of ROM as" an administrative reality" (McLeod, 2001, p215) Rodgers (2016, p8) articulates a strong sentiment underpinning this research position: "this administrative reality has a lot of 'reality' for a lot of people", inferring that client welfare is compromised due to the intense measuring culture within the field of Counselling and Psychotherapy. Researchers in this group focus primarily on the philosophical "barriers" to using measures - as expressed by counsellors. These concerns relate largely to the validity of the measures and the potential harm ROM may cause the client. A variety of suggestions and developments have been made and worked upon:

1. Some therapists asked that outcome measures better reflect their modality and include items other than levels of functioning, symptoms and psychopathology (Norman et al., 2014). To this end, alternative tools have been developed and refined. For example, *The Self Compassion Scale* aims to capture internal processes (Neff, 2003), and *The Relational Depth Inventory* seeks to isolate significant process moments (Di Malta et al., 2019).In Mental Health, the *Recovery Model Outcome Measures* (developed with significant client input) aim to capture concepts such as hope, acceptance, and resilience (Andresen et al., 2010). These, however, are slow to be endorsed by funding bodies owing (in part) to insufficient empirical evidence (Elliott, 2013).
2. The development and refinement of individualized outcome measures such as the *Global Assessment Scale* (*GAS*; Endicott et al., 1976)) and *Personnel Questionnaire* (*PQ*; Elliott et al., 2016) represents another advancement. Since items are generated by the client (in collaboration with the counsellor), the identified problems associated with language (too technical, complicated, not culturally sensitive, pathologizing) are

reduced. Since the desired outcomes are chosen by the client, the measures are likely to be more relevant (Hill et al., 2013; Rodgers, 2017). Again, these scales present problems with psychometric evidencing- and so have been slow to advance (Sales & Alves, 2016).

3. A combination of qualitative and quantitative tools for assessing client progress and experience of therapy has been suggested as the ideal solution to satisfying administrative requirements whilst retaining clinical utility and prioritizing the client (Elliott, 2002; Hill et al., 2013).Using qualitative feedback tools such as the *Client Change Interview* (*CCI;* Elliott, 1999) may help capture the more nuanced aspects of client change. Additionally, the inclusion of narrative tools may assuage concerns relating to harming the therapeutic relationship, as well as those concerns as well as allay counsellors' concerns with regard to quantifying therapeutic change (De Smet et al., 2019; Leibert et al., 2020).
4. Conducting Practice Based Evidence (PBE), whereby the evidence base for what works in counselling, is repositioned away from research trials to clinical settings) has been recommended (Elliott, 2002; Rodgers, 2017). Clinicians and services could evidence their work via outcome measures of their own choice – thereby promoting the acceptability of a wider range of outcome measures to funding bodies.

2.9. Conclusion

The literature review has resulted in a synthesis of the varied yet interrelated aspects of outcome measure usage in Counselling and Psychotherapy. Looking back to history, we can see how social, political and economic factors combined to necessitate the prioritization of evaluation in the field and how these same forces influenced the nature of outcome measures, with a strong emphasis on observable changes in symptoms, functioning and psychopathology being incorporated within measures. The review highlights that little may

have changed in terms of the types of measures being used over several decades, despite the development and availability of a broader range of measures, and that the focus on evaluation in Counselling and Psychotherapy is increasing. A scarcity of studies eliciting the perspectives of non- research clinicians is apparent, however, the limited studies available indicate that counsellors hold varying views regarding the benefits, drawbacks and potential harms associated with outcome measure usage, and signals that these views may be influenced by discipline and therapeutic approach.

The scarcity of clinical studies contrasts with the abundant research promoting the use of ROM and although the literature reveals that there are substantial objections to the practice, it seems that ROM is accepted as being entrenched in the field. Research efforts have historically focused on mitigating the disadvantages and harms associated with ROM, rather than exploring opportunities for alternative approaches. However, criticism of ROM has recently started to emerge, which may represent the beginning of a more balanced dialogue in the literature.

The current research aims to contribute to this dialogue by eliciting practicing counsellors' views on the subject of outcome measures in NSW with regard to potential benefits, drawbacks and perceived harms, from a cross disciplinary perspective. Although the literature points to the continuous increase in the rate of outcome measure usage in clinical practice, the rate of voluntary usage has not been determined, and likewise, the extent to which a variety of types of outcome measures may be utilized is not well known. This study seeks to gather baseline information regarding outcome measure usage patterns within NSW, in order to enhance and contextualize counsellors' responses relating to their experiences of, and responses to using outcome measures with clients in practice.

3. Chapter 3: Methodology and Methods

3.1 Overview

My chosen method for this project was an internet – based survey, adopting a mixed methods approach. In this chapter, I will outline the reasons for using this method and provide a rationale for choosing a mixed methods design. The process of designing the survey, the sampling approach and recruitment strategies will be described. Similarly, the methods used to analyze and integrate the data will be discussed. Throughout, I will outline the ethical considerations underlying the choices made in regard to methods and methodology.

3.2. Theoretical Lens

The literature reviewed revealed limited information on outcome measure usage patterns amongst Australian counsellors and, additionally, a deficiency in terms of input from clinical practice and accounts of clinicians' experiences of using measures with clients. It seemed equally important to begin to gather the quantitative information pertaining to usage trends and the qualitative data relating to the more subjective experiences of practicing counsellors. Thus, it was decided to pursue both lines of enquiry and endeavor to answer different types of questions about outcome measures in the study. This necessitated the adoption of a pragmatic theoretical lens, which allows for the merging of components from opposing research paradigms (Gross, 2018, Morgan, 2014). In this case, elements from both the positivist and phenomenological perspectives were combined in order to answer the research questions. The positivist lens holds that knowledge is derived from observing a phenomenon and interpreting it in an objective manner (Ryan, 2018) whilst a

phenomenological perspective holds that the creation of knowledge results from reflecting on and sharing of peoples' subjective experiences (Creswell and Plano Clark, 2017). Quantitative research, with its strong focus on observation, measurement and statistical analysis fits well within the positivist paradigm whilst qualitative research methods such as interviews and narrative accounts align well with a phenomenological perspective, as they allow for an open exploration of participants' subjective experiences.

In this study, two research questions focused on discovering trends, patterns, and assessing counsellors' knowledge. whilst one question focused on eliciting counsellors' subjective experiences. In keeping with the ethos of the pragmatic paradigm, the research questions were prioritized and therefore, a mixed methods approach was adopted.

3.3 Mixed Methods

This research approach involves the collection and analysis of both quantitative and qualitative data in a single study (Creswell & Plano Clark, 2017). Combining the two data types allows researchers to enrich their results in ways that one form of data does not allow. In the case of the current research, the quantitative data collected within the sample may indicate broader outcome measure usage patterns within the counselling field, whilst the qualitative data collected will likely enhance our understanding of what the counsellor's experience of using measures with clients may be. Thus, the quantitative and qualitative data sets provide a mix of objective and subjective ways of knowing (Cameron, 2011). Because of the existing lack of knowledge surrounding both the objective and subjective aspects of outcome measures, it seems particularly fitting that this pilot study attempts to address these gaps by way of using mixed methods. I note the strong parallels between the rationale for adopting mixed methods in this study, and that of adopting a similar approach for evaluating

therapeutic change. Just as the mix of quantitative and qualitative evaluative methods can be seen to be optimal, the mixed methods employed in this study provides the optimal means to best answer the research questions.

3.4. Data Collection

An online survey using Qualtrics software was used. This allowed for the gathering of information from a large, geographically diverse population in a cost -effective manner (Blackstone, 2018). The Qualtrics survey platform is powerful and efficient, cost effective, and allows for anonymity (Gill et al., 2013). Anonymity was perceived as very important for this study, as participants were being asked to comment on a topic which might be experienced by some counsellors as sensitive. Owing to its' demonstrable success over the past twenty years, Qualtrics is widely used within the fields of psychological and social science research. Some examples from the literature reviewed include Chung & Buchanan, (2019) and Kaiser et al. (2018).

3.5 Survey Design

The survey questions were based on the existing literature and aligned with the research aims in seeking to elicit information relating to usage trends, familiarity, and counsellor's responses towards outcome measures in NSW. According to De Vaus (2016), the typical survey model includes items relating to participants' demographics, behaviors, knowledge, beliefs and attitudes, and in these aspects, the current survey conformed. A copy of the survey is shown at Appendix C.

The survey included a total of nineteen questions. The first question sought confirmation that the participant was eligible for and consented to participate in the research. Participants self- screened based on the eligibility criteria provided in the participant information sheet. The next seven items related to demographic information deemed relevant to the research question. These included gender, age, discipline, preferred modality, geographic area, work setting, and years of practice. Previous studies indicated that all these variables may have a bearing on counsellors' usage trends and attitudes. A decision was made to exclude an ethnicity item, owing to no prior indication (in the research) that this would have an impact (relevant to this pilot study) and therefore, it seemed ethical to omit what potentially may seem like an invasive question.

Five items (Q9- Q13) were designed to elicit counsellors' behaviors' relating outcome measures – whether or not they used, what types they used, whether usage was voluntarily, whether some measures were obligatory, and the range of reasons for using. Questions 14 – 18 aimed to explore counsellors' attitudes towards, and beliefs around outcome measures – and more broadly, counsellors' conceptualization of what constitutes therapeutic change. In this section, two open ended questions (text box format) were included. One of these questions asked counsellors to comment on any perceived client responses to completing outcome measures they may notice, whilst the second open- ended question invited participants to openly comment on any aspect of outcome measures they wanted to add. To encourage participants to respond to these qualitative questions, it was indicated that "dot point" information was an acceptable format. The final question in the survey (Q19) comprised a list of twenty-seven outcome measures, most of which are not commonly used, according to the literature. Participants were asked to indicate any measures they were familiar with. This question aimed to ascertain to what extent various individualized, qualitative and process orientated measures may be known about in clinical practice. Despite

being an experienced counsellor myself, I was only vaguely familiar with many of these measures – and had not heard of some. This prompted me to consider that for some participants, being unfamiliar with the listed measures might create a sense of inadequacy as a counsellor. In an effort to allay any potential anxiety, therefore, this question was prefixed with a "note" normalizing that "many of these measures are less well known".

The survey was repeatedly tested throughout the design phase, with much collaboration with the project supervisors and counsellor colleagues. Several questions were reworked and reworded as a result, ensuring that the final edit of the survey had the optimal chance of eliciting information to best answer the research questions. Ethical considerations were constantly considered. Clarity and brevity were also prioritized, in the knowledge that counsellors are often very busy with client work, and may not be a group of professionals who necessarily enjoy administrative tasks (such as a survey) – and also to increase chances of good response rate. The survey itself was prefixed by a "project summary" and "participant information sheet", which was clear. I will refer to this in the next section.

Additionally, pilot testing was conducted with a supervisor and three colleagues to ensure that the material and survey presented clearly and logically on various devices – computers, smart phones, and tablets and that all the technology was working.

3.6. Sampling Approach and Inclusion/Exclusion Criteria

A non-probability purposive sampling approach was utilized for this project. This entails choosing participants based on their knowledge and experience in a specific setting which is relevant to the research subject (Creswell & Clark, 2017). In order to answer the research question, it was necessary to choose from a range of professionals who provide counselling and would likely be at least familiar with outcome measures. In Australia, a wide

variety of professionals provide counselling including social workers, psychologists, counsellors, psychotherapists, psychiatrists, and mental health nurses, and it was considered likely that all of these professionals would be familiar with outcome measures. To fit within the scope of the Masters of Research, however, this study was conceived as a pilot project and limited to NSW and to four professions – Counsellors, Psychologists, Psychotherapists and Social Workers. Given that the research question is focused on outcome measures in clinical practice, only practicing counsellors were chosen. Additionally, only those counsellors providing counselling to adults (18+ years) were invited to participate, owing to widely different outcome measures used for adults and children.

3.7. Recruitment

I employed two main recruitment strategies. The first involved emailing a range of organizations and individuals who provide counselling and the second involved advertising on Facebook. Recruitment was ongoing from December 2020 until February 2021. Invitation emails were sent to the managers, clinical directors or supervisors of government counselling services, non-government organizations and private corporations, requesting that they distribute the survey amongst counselling staff. Additionally, private practitioners were emailed directly, inviting them the to participate (and invite peers or colleagues to participate). Thus, a snowball method was employed, as participants were encouraged to share the link for the survey with professionals, they deemed appropriate. I utilized my professional and personal networks to facilitate the distribution. My supervisors assisted with this also, by circulating email invitations to participate within their networks. Whilst this strategy may represent a risk of bias, the anonymous nature of the survey may have worked

to mitigate this potential bias, and additionally the limited time available for data collection may have justified the potential risk.

Personalized greetings were contained in the introductory emails wherever appropriate, in line with a key principal of the *Tailored Design Survey Method* (Dillman, 2011), which highlights the likelihood of potential participants responding if they feel personally connected to the researchers. The email invitations were kept as brief as possible. After introducing myself and the purpose of the study, I clearly explained what was being asked of potential participants, noted the confidential and anonymous nature of the research and its possible benefits to themselves and to the field – and noted that any risk was minimal. I included the ethics approval reference and provided my contact details. The emails also included a link to the survey itself, which I indicated, highlighting that further relevant information was embedded within the link also (project summary and participant information sheets).

The Facebook advertisements were briefer than the email invites outlined above, and were designed to catch the eye of the reader. As such, bold type was utilized interspersed with capital letters and regular type. Care was taken to ensure that the eligibility criteria was clear, in order to save potential participants' time (should they not be eligible). The Western Sydney University logo was included, as was the Ethics approval reference and link to the survey was embedded in the advertisement, with an indication that further information was also available within the link. A sample of the Facebook advertisement and email invitation is included at Appendix A.

Previous online surveys exploring counsellors' behaviors and attitudes tend to be large, with numbers ranging between 100 and 200 (Chung & Buchanan, 2019; Ionita & Fitzpatrick, 2014). As response rates to online surveys vary greatly, I made every effort to

recruit on a large scale. Seven hundred and fifty emails were sent out during the data collection phase, and recipients were also asked to share the link amongst professionals they thought may be eligible. Email and Facebook reminders were sent at monthly intervals, as (Burns et al., 2008) highlight, reminders can have a powerful (positive affect) effect on low response rates; this being a major drawback to online surveys. Similar to email recipients, Facebook users were also invited to share the survey link as they thought appropriate.

3.8 Information for Participants

The *Project Summary and Participant Information Sheet*, preceded the survey itself and was embedded in the electronic link to the survey. Great care was taken to ensure that potential participants were supplied with all the information they might need in order to help them decide whether or not to participate. The attention to clarity had two purposes – to demonstrate respect for potential participants' time and knowledge, and to enhance the response rate. The document summarized and provided a brief rationale for the project. The overarching aims of the study were outlined and potential benefits the research might bring to the field, and more specifically to the participant were named. Potential risk to participants was also acknowledged – and framed as being low -as outlined in *Ethics Approval* from Human Research Ethics Committee, at Western Sydney University. A copy of this document can be found at Appendix D. Eligibility criteria was clearly outlined and potential participants were invited to self screen. Clear information was provided in relation to participant confidentiality, time required to complete the survey and dissemination of results. A definition of outcome measures was included and potential participants were made explicitly aware that responses to the survey could not be withdrawn, owing to the anonymous nature of the survey. Information about sharing the survey electronically with other professionals was

also included. The document contained the contact details of the researcher and project supervisors, along with the Ethics Approval Reference, and information regarding the complaints process to Human Research Ethics Committee (HREC) at Western Sydney University. A copy of the *Project Summary and Participant Information Sheet* can be found at Appendix B.

3.9. Data analysis

After undertaking a preliminary clean-up of submitted data, a quantitative data analysis was undertaken using the Statistical Package for Social Sciences, version 27 (SPSS 27). The exploratory nature of the study lent itself well to a range of descriptive analyses including frequency of responses. In order to explore possible relationships between the demographic variables and counsellors' usage patterns, familiarity with and responses to outcome measures, a series of linear regression were conducted and tested for statistical significance.

Data from the two open ended text box types questions were analyzed via thematic analysis (TA), utilizing the six- step approach outlined by (Braun & Clarke, 2006). TA was chosen as the qualitative analytical tool, because it seeks to look for themes across a data set as opposed to opposes to solely focusing on an individual's experience (Braun & Clarke, 2020). In the case of an online survey, where qualitative responses from many participants is anticipated, TA is better suited than Interpretative Phenomenological Analysis (IPA), which is an ideographic method suited to an in-depth exploration of smaller numbers of participants' subjective experiences (Smith, 2009). As the amount of text to analyze was not overly cumbersome, a manual compilation and review of themes was undertaken as opposed to using a tool such a software tool such as Nvivo (Leech & Onwuegbuzie, 2011). The table

below outlines Braun and Clarke's six stage approach to TA and summarizes how I worked through these stages.

Table 1

Braun and Clarkes Six Stage Thematic Analysis

Stage I Familiarize yourself with the data.	I wrote all responses by hand, and re- read multiple times.
Stage 2 Generate initial codes.	I identified codes within the text as I read, every response had at least one code. Most had several (codes).
Stage 3 Development of themes.	I grouped similar codes into themes.
Stage 4 Review the themes.	I re- read multiple times, ensuring that all codes were accounted for and best placed within the assigned theme.
Stage 5 Define and name the themes.	After much reflection, I decided upon suitable names for the themes and could define them clearly in a few sentences.
Stage 6 Produce the report.	I took care to write an accurate and comprehensive report.

Braun and Clarke (2006) highlight that, whilst conducting TA, "themes do not emerge" from the data. They note that researchers' own biases and personalities come to also influence the interpretation of data, thus TA is not an objective undertaking. In order to increase the level of integrity and trustworthiness of the data analysis, they recommend the researcher be "reflexive". Being reflexive means that the researcher remains aware of this tendency towards bias and takes steps to minimize it. As a counsellor, I am familiar with exercising self- awareness whilst working with clients, taking care to avoid projecting my own experiences onto theirs. I endeavored to remain self- aware in this context also, and took

frequent breaks from the analysis, returning to the material over a period of several days, as well as discussing aspects of the material and interpretation with my supervisors.

Braun and Clarke also identify various ways in which codes are generated and upon reflection, my codes were created via a mix of "deductive" and "inductive" process. (Braun and Clarke, 2016, p 4). The deductive method means that the way in which I identified codes was because of pre- existing knowledge regarding what clinicians in previous studies have said, (from the literature review). I would also have been influenced by my own experience as a counsellor and using outcome measures. The inductive process infers a more neutral approach to the text being analyzed, which I worked to adopt – and as I did identify codes which I had not expected, I infer that I succeeded in this.

3.10. Data Integration

Creswell et al (2003) identify a number of mixed methods research designs. The present study corresponds best with "concurrent triangulation design", (p179) meaning that the quantitative and qualitative data are collected simultaneously (in this case within the same tool - the survey, which includes both quantitative and qualitative questions/prompts). In this design, both quantitative and qualitative items are given equal priority and the data generated by both approaches is integrated primarily within the data interpretation phase of the research. The authors note that variations of this design exist (p184) and highlight the example of some data integration taking place during the analysis phase, as opposed to integration occurring solely within the interpretation/discussion phase. This study matches the example; whilst most of the data integration occurs within the interpretation phase, some significant integration occurred within the analysis phase also, as will become evident in the results section. Another variation to "concurrent triangulation design" is apparent within the

current research, in terms of the priority given to quantitative and qualitative methods. An alternative design "concurrent nested design" (Creswell et al 2003, p 184) assumes that one method is given priority to the other method, for example if more quantitative items are included in the research, it might be assumed that priority is given to the quantitative over the qualitative. In this study, however, although there were more quantitative questions in the survey (data collection phase), the analysis and interpretation phases reflected that both data types were regarded equally.

4. Chapter 4. Results

Quantitative and Qualitative results are presented separately in this section, followed by preliminary findings emerging from integrating the two data sets. As noted in the methods section, data integration will be expanded upon in the discussion chapter.

4.1. Quantitative Data

4.2. Demographics

One hundred and thirteen participants responded to the survey; however, it was necessary to eliminate seven responses owing to extensive incomplete survey items.

Demographics relating to gender, geographic area, setting and age are presented in Table 2.

4.3. Descriptive Statistics

Table 2

Participant Demographics – gender, age, location of practice

		N	%
Gender	Male	16	15.0
	Female	89	84.0
	Other	1	.9
	Total	106	100.0
Age	20- 30	10	9.4
	31- 45	48	45.3
	46- 60	42	39.6
	61+	6	5.7
	Total	106	100.0
Location	Metropolitan	95	89.6
	Rural	10	9.4
	Remote	1	0.9
	Total	106	100.0

Demographics relating to discipline, preferred modality, setting and years of practice are presented in Table 3. It is important to note that many counsellors indicate they work in two or more settings

Table 3

Employment Information – profession, preferred modality, employment, years' experience work

		N	%
Profession	Counsellor	31	29.2
	Psychologist	30	28.3
	Psychotherapist	15	14.2
	Social Worker	30	28.3
	Total	106	100.0
Preferred Modality	Person Centred	45	42.5
	Cognitive	19	18.0
	Behavioural	5	4.7
	Existential Therapy	1	0.9
	Psychoanalytic Therapy	4	3.8
	Gestalt	8	7.5
	Narrative	1	0.9
	Somatic	18	17.0
	Other	5	4.7
	No Preference	106	100.0
	Total		
Employment Type * % of responses, not participants	Government Funded	23	17.4
	Non-Government	61	46.2
	Private Corporation	7	5.3
	Self-Employed	40	30.3
	Other	1	0.8
	Total	132	100.0
Years' Experience	0-1	4	3.8
	2-3	7	6.6
	4-5	10	9.4
	6-10	26	24.5
	10-20	45	42.5
	20+	14	13.2
	Total	106	100.0

4.3.1. Overall Measure Usage

Ninety-seven participants (91.5%) reported using outcome measures in counselling – either currently using them, or having used them in the past. Nine participants (8.5%) reported having never used outcome measures.

4.3.2. Demographic Variables and Overall Measure Usage

A series of regression analyses were conducted to determine whether gender, age, discipline, modality, work setting, geographic location, and years of experience had a bearing on outcome measure usage. The only item that indicated a level of statistical significance was Years of Practice, as outlined in Table 4.

Table 4

The effect of age, gender, geographic location, profession, modality preference and years of experience, on the survey response to "Do you use outcome measures?"

Variable	t- value	p- value
Age	-1.410	0.162
Gender	0.283	0.778
Geographic Location	-0.038	0.970
Profession	0.0891	0.375
Modality Preference	-0.451	0.653
Years of Experience	-2.014	0.047*

It was not possible to relate specific work setting to outcome measure usage, as most participants ticked more than two settings. The indicated significance re Years of Experience will be considered in the discussion section.

4.3.3. Routine Outcome Monitoring Rates

Forty-five (42.5%) counsellors reported using or having used SRS & ORS and eighteen counsellors (16%) indicated that they are currently mandated to use these measures. Five counsellors (5.3%) indicated using HonOS routinely. In total, 47.8% of counsellors in this sample utilized ROM (either currently or in the past), and 37% indicated that they were currently obliged to use measures for work or funding reasons. Specifically, 45% of counsellors indicated that they had used PCOMs in the past, however the current rate of usage of this form of ROM was found to be lower at 19%.

4.3.4. Historical Usage vs. Current Usage

In asking counsellors if they used measures in the past ("historically") and/or were using measures as part of their current work ("currently"), it was reported that general usage was 91% historically compared to 80% currently. Reported rates of ROM usage were also higher at 45% historically, relative 37% currently. PCOMS was historically used at 47%, now at 19%.

Table 5

Historical Use vs Current Use

	Have ever used %	Currently using %
Any Outcome Measure	91%	80%
ROM	47%	37%
PCOMS (SRS & ORS)	45%	19%

4.3.5. Voluntary Usage vs. Involuntary Usage

Despite the fact that most counsellors in this study (84%) were mandated to use measures, it was possible to infer voluntary usage rates by analyzing the reasons for using measures provided by counsellors. When clinicians indicated that the only reason for using measures was for work or funding purposes, it was deduced that this amounted to involuntary use. The inferred rate of voluntary usage was found to be 47%.

Table 6 highlights the percentage of clinicians who use outcome measures voluntarily, according the discipline, whilst Table 7 outlines voluntary usage according to modality.

Table 6

Percentage of counsellors & voluntary use of measures voluntarily according to discipline

	% of discipline voluntary usage
Counsellor	62
Psychologist	74
Psychotherapist	14
Social worker	64

Table 7

Percentage of counsellors and voluntary use of measures according to modality

	% of modality, voluntary usage
Person Centred Therapy	47
Cognitive Behavioural Therapy	83.4
Narrative	50
Existential	0
Gestalt	0
Somatic	0
No preference	20
Other	0

Ninety counsellors indicated that they use (or did use in the past) measures for work purposes. They were asked whether they would be likely to use measures if they were not obliged to, by indicating likely usage on a 5- item Likert scale: 1= absolutely not, 2 = unlikely, 3 = possibly, 4 = likely, and 5 = definitely.

There was a very balanced response, with a slight trend towards using measures voluntarily. 10 counsellors indicating “absolutely not”, 22 said they were “unlikely” to use measures, 25 said they would “possibly use””, 29 indicated that they would “likely” use, and 4 said that they would “definitely” use measures.

Table 8 outlines the breakdown of responses according to discipline. Table 9 provides a breakdown of responses according to preferred modality.

Table 8

Discipline & likelihood to use measures if not mandated to

	Absolutely not	Unlikely	Possibly	Likely	Definitely	Total
Counsellor	2	8	6	8	2	
Psychologist	0	2	9	15	2	
Psychotherapist	7	5	1	0	0	
Social Worker	1	7	9	6	0	
Totals	10	22	25	29	4	90

Table 9

Preferred Modality & likelihood to use measures if not mandated to

	Absolutely Not	Unlikely	Possibly	Likely	Definitely	Total
Person Centred Therapy	3	14	9	7	1	34
Narrative	0	4	2	3	0	9
Cognitive Behavioural Therapy	0	0	11	16	2	29
Gestalt	2	1	0	0	0	3
Somatic	0	1	0	0	0	1
Psychoanalytical	0	1	0	0	0	1
Existential	4	0	0	0	0	4
No preference	1	1	3	3	1	9
Other	0	0	0	0	0	0
Totals	10	22	25	29	4	90

4.3.6. Demographic variables and voluntary usage

A series of regression analyses were conducted to determine whether gender, age, discipline, modality, work setting, geographic location, and years of experience had a bearing on voluntary outcome measure usage. Owing to the small numbers involved, it was not possible to demonstrate statistical significance.

4.3.7. Time spent using measures in session

Table 10 outlines the various times counsellors spend on outcome measure usage per session. This included counsellors' responses regarding both current and historical use of measures.

Table 10

Time spent on outcome measures per session

		N	% (of responses)
Time spent on measures in session	<2 minutes	22	20.8
	2-5 minutes	37	34.9
	5-10 minutes	20	18.9
	10-15 minutes	10	9.4
	>15 minutes	6	5.6
	Unsure/ do not use	11	10.4
	Total	106	100

4.3.8. Commonly Used Measures

Table 11 outlines the usage of specific measures among respondents. Table 12 outlines "Other measure" responses. The *DASS (21/42), K10, ORS & SRS, GAF* and *BDI* being the most common, in that order. "Other" measures included *HoNOS, WHODAS, LSP-16, Edinburgh Depression Scale, Adult Needs and Strengths Assessment, MHQ14, PHQ 9,*

GAD-7, Readiness to Change, Severity of Dependence, Audit and ATOP, WISC, WIAT. These measures focus on symptoms, functioning, and psychopathology (including substance abuse).

Eight counsellors identified that they use – or have used individualised measures - including the *Outcome Star* (n = 4), *Values Bullseye,* (n = 1), *the Personnel Questionnaire* (n = 2) and the *GAS* (n=1). Four counsellors identified that they use or have used a humanistic measure (the *Self Compassion Scale*). Apart from the *Session Rating Scale*, no relational or process measure was identified as having been used.

Table 11

Types of Measures counsellors use, or have used in the past

		N	%
DASS 21/ DASS 42 Depression Anxiety and Stress Scale	Yes	67	63.2
	No	39	36.8
K10 Kessler Psychological Distress Scale	Yes	57	53.8
	No	49	46.2
Session Rating Scale	Yes	45	42.5
	No	61	57.5
Outcome Rating Scale	Yes	45	42.5
	No	61	57.5
Global Assessment of Functioning (GAF)	Yes	41	38.7
	No	65	61.3
Beck Depression Inventory	Yes	26	24.5
	No	80	75.5
PCL-5 (PTSD checklist)	Yes	24	22.6
	No	82	77.4
Other	Yes	23	21.7
	No	83	78.3

Quality of Life Questionnaire	Yes	15	14.2
	No	91	85.8
Satisfaction with Life Scale	Yes	6	5.7
	No	100	94.3
Hamilton Rating Scale for Depression	Yes	2	1.9
	No	104	98.1
Hopkins Symptom Checklist	Yes	2	1.9
	No	104	98.1

Table 12

Additional measures counsellors have used

Other Measures Used	Number of Counsellors who used (n)
HoNOS	5
Self-compassion Questionnaire	4
Outcome Star	4
Edinburgh Depression Scale	2
WHODAS	2
Personnel Questionnaire	2
LSP-16	2
GAD-7	1
PHQ-9	1
ATOP	1
AUDIT	1
Values Bullseye	1
MHq14	1
Readiness to Change	1
Severity of Dependence	1
GAS	1

4.3.9 Specified Measures for Work Purposes

Of the 90 participants who indicated they are obliged to use measures for work purposes, 66 (74.4%) identified that they were mandated to use specific ones, whilst 24 (25.6%) participants indicated that although obliged to use some measure, they had choice around which one/s to use. Table 13 highlights the range of mandated measures. Note that counsellors could identify multiple mandated measures. Five clinicians indicated that they were required to use individualised measures including *Outcome Star* (n=4), and *the Personnel Questionnaire* (n=1).

Table 13

Mandatory Measures

Measure	Obliged to Use n
K10	18
DASS	17
ORS/SRS	18
GAF	16
SUDS	13
HoNOS	5
Outcome Star	4
LSP-16	4
Organization specific	2
WHODAS	2
Personnel Questionnaire	1
YESS – Experience of Service	1
MHq14	1
ATOP	1
Severity of Dependence Scale	1
BDI	1
AUDIT	1
SDQ	1

4.3.10. Familiarity with a Variety of Measures

Counsellors indicated which measures they were familiar with by ticking from a list provided. Measures comprised a mix of individualised, qualitative, relational/process and humanistic evaluative tools. Ninety -seven counsellors answered the question, with the 28 measures listed attracting 177 responses in total. The *GAF* (clinician rated) was familiar to 68.2% of counsellors, the PCOMS familiar to 54.7%, *the GAS* (individualised) measure was familiar to 45.3% of respondents, the *Self- Compassion Scale* familiar to 34.9%, and the *Narrative Interviews* (qualitative) was known to 20.8% of counsellors. The remaining 23 listed measures were not well known, only 20% of counsellors had heard of some of these. Four process scales were unfamiliar to all respondents, a further 15 measures were known to less than 10% of respondents and another four measures were known to 10% - 20% of counsellors. These measures, that may be considered to relatively obscure (based on these respondents' ratings) are largely process measures, qualitative in nature. Table 14 outlines the number of responses each measure attracted.

Table 14

Familiarity with measures

Outcome Measure	Type of Measure	Number of Counsellors n	Percentage of Counsellors %
Global Assessment of Functioning	Clinician rated questionnaire	68	64.2
Outcome Rating Scale and Session Rating Scale	Quantitative, Therapeutic Relationship	58	54.7
Goal Attainment Scale	Individualized	48	45.3

Self- Compassion Scale	Humanistic self - report	37	34.9
Narrative Interviews	Qualitative	22	20.8
Session Questionnaire – PSQ		15	14.2
Outcome Questionnaire	Quantitative	15	14.2
Feedback Letter	Qualitative	15	14.2
Client Change Interview	Interview	8	7.5
The Personal Questionnaire	Individualised	7	6.6
Significant Events Form	Individualised	6	5.7
Client Post-Therapy Questionnaire	Qualitative	6	5.7
Evaluation of Therapy Form	Individualised	5	4.7
Client Assessment of Change	Process	5	4.7
Client Evaluation of Treatment Questionnaire	Individualised	4	3.8
Helpful Aspects of Therapy Form	Qualitative/ process	4	3.8
Personal Orientation Inventory	Interview	3	2.8
Psychological Outcome Profiles	Individualised	1	0.9
Interpersonal Process Recall	Process	1	0.9
Important Events Questionnaire	Process	2	1.9
Working Alliance Questionnaire	Relational/process	2	1.9
Critical Incidents Technique	Process interview	1	0.9
Brief Structured Recall	Process	1	0.9
Barrett-Lennard Relationship Inventory	Relational/process	1	0.9
Cross-Contextual Qualitative Diaries	Qualitative	0	0
Corrective Experiences Questionnaire	Process	0	0
Role Analysis	Individualised	0	0
Relational Depth Inventory	Relational/process	0	0

4.3.11. Reasons for Using Measures

Table 15 outlines the various reasons for using measures, as indicated by counsellors. Please note that respondents could tick multiple reasons.

Table 15

Reason for using measures

	Responses	% of Responses
Obligated to by external requirement.	83	78.3
Delivers better therapeutic outcomes.	34	32.1
Receive timely feedback.	33	31.1
Personal preference	15	14.2
Other reasons	7	6.6
Client preference	5	4.7
	177	

4.3.12. Reasons for not using Outcome Measures

Counsellors who choose not to use outcome measures unless obligated to were asked to select their reasons for not using measures. Forty- four participants provided 143 responses in total. The belief that therapeutic change cannot be quantified received the most responses (29), followed by perceived lack of relevance (26), being too time consuming (25), therapy

interfering (24), having negative impact on client (18), and a negative impact on the counsellor (14). Seven counsellors provided "other" responses which will be addressed later. Table 16 summarises this information.

Table 16

Reasons for not using measures

	n	% of Responses
Therapeutic change cannot be quantified	29	64
Not relevant/don't capture client's experience	26	57
Time consuming	25	55
Interfere with the therapeutic process.	24	53
Negative impact on client	20	45.4
Negative impact on counsellor	14	31
Other	7	
Total	145	100

4.3.13. Potential Harms

Of the 44 counsellors who indicated they were not currently using measures, 20 identified "negative impact on client" as one of the reasons for not doing so. Psychotherapists were most likely to perceive harm (73%), followed by counsellors (16%), whilst social workers and psychologists were much less inclined to perceive outcome measures as being harmful to clients (both at 6.6%).

Differences in terms of modality were also noted. Of the 20 clinicians who indicated potential harm to client, 70% were PCT, 10% Gestalt, 10% other and CBT counsellors were not represented in this group.

4.3.14. Perceived Indicators of Therapeutic Change

Clinicians were asked to indicate the ways in which they gauge therapeutic change in a client – improvement, deterioration, or no change. Participants were able to select multiple indicators. In total, counsellors provided 374 responses. The breakdown is outlined in Table 17. "Other" responses will be analysed separately and incorporated in the next section where qualitative data will be analysed.

Table 17

Therapeutic change indicators

	Number of counsellors identifying as signalling change
Client functioning (client reported)	94
Clinical presentation	92
Changes in client relationships (client reported)	75
Changes in how client relates to clinician	71
Third party report of client change	35
Other	7

4.3.15. Perceptions of the Therapeutic Relationship as Indicator of Therapeutic Change

Seventy- one clinicians agreed that changes in the way clients relate to the therapist was an indicator of therapeutic change. Cross disciplinary and modality differences were observed in relation to this. Tables 18 and 19 highlight the details of these differences respectively.

Table 18

Perceptions on significance of therapeutic relationship and outcome (discipline)

	n	% of discipline
Counsellors	24	78
Psychologists	15	50
Psychotherapists	15	100
Social workers	24	74

Table 19

Perceptions on significance of therapeutic relationship on outcome (modality)

	n	% of modality
Person Centred Therapy	36	80
Cognitive Behavioural Therapy	10	53
Narrative	4	50
Other/no preference	16	70

4.4. Qualitative Findings

Fifty- two counsellors responded to one or both of the two qualitative prompts provided. The first prompt invited therapists to comment on any observations they have made regarding client responses to using outcome measures. The second prompt was broader, asking counsellors to comment on any aspect of outcome measure usage they found relevant or important to them. A further six counsellors provided qualitative responses to "other reasons for using measures", "other reasons for not using measures", and "other indicators of client change". The qualitative data from these fifty- eight counsellors was coded and grouped into broader themes and subthemes, in line with Braun and Clarke's (2020) six step thematic analysis model – as discussed in the methodology chapter. Sixty- one codes were identified and grouped into five themes and thirteen sub- themes.

Most respondents included a response within one of the first three themes: 1) "**Outcome measures are beneficial",** 2) **"Limits to outcome measures", and** 3) **"Outcome measures can be harmful to client".** The fourth theme **"Suited to some – (clients and counsellors)"** was particularly salient, as many counsellors with neutral or mixed views identified with the sentiment of this theme. The fifth theme **"Clinical use versus administrative demands"** was evident in a large number of the responses, indicative of the struggle many counsellors reported experiencing.

4.4.1. Theme One- Outcome Measures are Beneficial

Most counsellors identified that there are at least some benefits to using outcome measures while all counsellors with CBT as their favored modality indicated that their entire experience of outcome measure usage was positive. Three subthemes were identified within

this theme – namely 1) clinical direction, 2) increased communication, and 3) client empowerment.

Clinical Direction

Counsellors asserted that outcome measures help to frame clients' problems and formulate therapeutic goals. One CBT counsellor reported that "*they are beneficial in identifying areas of difficulty in clients' lives which may otherwise not have presented in session*". The same counsellor added that "*the ORS has been useful to guide the goals of the session*". Another psychologist (CBT) expressed that "*the tools (ORS & SRS) are therapeutically useful for monitoring the Therapeutic Relationship*", whilst another counsellor (PCT) said she "*likes to use measures to gather information and help in my assessment and decision making*". One comment made by a PCT counsellor struck me as reflecting more novel clinical uses of outcome measures. They said, "*they can be helpful to teach how to track how one is doing, and they can be helpful too, as an indicator of congruence – how a client may present may be different to the stated mood on the outcome measure*". The counsellor in this instance points to the educative role of outcome measure usage, as well as their potential to help the clinician assess how self- aware and self-accepting a client may currently be.

Increased Communication

Some counsellors noted that outcome measures can help clients communicate. As one CBT psychologist highlighted *"they seem to help my younger clients communicate, for example talk about feeling flat or anxious. Because it is in writing, it is helpful"*. Another social worker (CBT) identified that "*they can promote conversation around difficult things like when a client can admit to feeling down but cannot in session*". Another PCT

psychologist indicated that *"they allowed them to share how they were feeling with me without needing to find the words themselves"*.

Client Empowerment

Counsellors spoke about the effect of providing positive feedback (via improvement on outcome measures) to clients. One (holistic) counsellor noted that "*they can offer encouragement and confidence – that they (client) have changed and is capable of changing"*. Another PCT counsellor said, "*they can offer proof that they are 'doing' counselling correctly"* whilst another PCT social worker commented that "*the majority of clients enjoy doing the measures to see their improvement",* a sentiment echoed in the statement "*clients benefit from and like to see their progress over time"*.

A newly qualified social worker (one years' experience) highlighted a point which indicates how outcome measures can help validate a client's experience. She expressed "*the measures sometimes provide the client with something tangible. Example 'I felt this way! Now I know it really is an issue!' or 'things have really improved!'"*.

4.4.2. Theme Two- There are Limits to Outcome Measures

Because of the diverse range of issues inherent in this broad theme, it was subdivided into the following sub themes 1) quantifying human experience is a problem, 2) not capturing the right/enough stuff, misrepresenting the work of therapy, 3) other ways to assess therapeutic change and 4), homogeneity of measures used.

Quantifying human experience is problematic.

The idea of quantifying therapeutic change and client experience was problematic for some counsellors. The following two comments highlight this difficulty:

"Clients often have trouble quantifying how they feel" – social worker, PCT

"It is confronting for clients to have to score their lives and situation" - psychotherapist, PCT

The next comment relates to a specific item from the ORS wherein the client is asked to rate their experience of close and family relationships. The counsellor expressed *"clients have difficulty putting a number score on the questions asking about family/relationships, which can be ambiguous and complex".*

Misrepresenting/ not capturing the right stuff

Counsellors reported that outcome measures did not accurately represent the work done in counselling and did not gauge therapeutic change accurately.

The following comments from two less experienced counsellors (social worker and counsellor, in practice less than five years) highlight the perceived irrelevance of the measures used. "*There is little emphasis on personal growth and more weight given to what can be measured quantitatively"* and "*The measures are often irrelevant and measure things incorrectly".*

A gestalt therapist gave an example of measures being misrepresentative. She spoke about clients deteriorating whilst in counselling due to external reasons and how the DASS 21 (her example) would miss the external causation, "*making it seem as though the therapy was not working".*

Another person- centered psychotherapist highlighted the notion that outcome measures are simplistic and naïve when she remarked that "*outcome measures presume an end, whereas internalized therapeutic work will hopefully be life -long".*

Several counsellors spoke about their beliefs that clients will frequently and consciously falsify the measures owing to their desire to please and protect the counsellor. Consider the following comments:

- From a somatic counsellor "*I used SRS and ORS in private practice and found that clients did not embrace these measures freely nor provide honest and open feedback*".
- From a PCT counsellor *"The measures cause the client not to say the truth as they want to protect the counsellor from repercussions if the second test is worse".*
- From a social worker *"I often get the sense that the client is trying to please me".*

Homogeneity of measures used

Only two counsellors (from a total of 58 who provided qualitative feedback) indicated that they used individualized measures – and there was no mention of any process measures (other than the SRS) being used. There was no mention of qualitative evaluation tools. The two counsellors who identified using individualized measures expressed positive experiences. One counsellor using the *Outcome Star* talked about the advantage of the client being able to view their progress visually, and another counsellor using the *Values Bullseye* spoke about the personalized nature of the measure driving client commitment to therapy.

Two counsellors (both social workers) explicitly stated that they were unfamiliar with most of the listed measures and wondered whether these unfamiliar measures (a range of individualized and qualitative process measures) would be more helpful to their work.

Several other comments signaled the lack of working experience with measures other than those focused on symptoms, functioning and psychopathology, such as the DASS and K10. The following quotes are examples:

- From a counsellor – “*To adequately capture therapeutic change, we do not yet have the knowledge of any measures or processes to do this”.*
- From a social worker – “*The difficulty is in finding a measure that fits every client unique experience”.*

Other ways to monitor therapeutic change.

Several counsellors spoke about ways in which they gauge client change and how they know the client has indeed changed. These comments invariably followed on from their comments regarding the limitations of measures.

One PCT counsellor asserted that “*having a direct conversation with clients about the therapeutic relationship, inviting client to express needs and openly explore stuckness” would be superior to the measures she was using (ORS, SRS).*

Other counsellors said they found it better just to listen to their client and have a conversation – one social worker said “*listening is better and more natural”.*

Some counsellors provided qualitative responses to “indicators of client change” and *“signs of increased integration*” was mentioned more than once. One counsellor wrote *“when the client integrates what they learned during counselling in a positive way”.*

One psychotherapist identified that for some clients, being able to express humour was an indicator of therapeutic change “*clients sometimes find their sense of humour and can laugh at tings with me in session. They seem freer and less burdened then”.*

<u>4.4.3. Theme Three- Outcome Measures Can be Harmful to Client</u>

Three distinct subthemes were identified. 1) Language can be triggering and pathologising, 2) Literacy problems, and 3) Outcome measures can interfere with the therapeutic relationship.

<u>Language – triggering and pathologizing</u>

Counsellors said that the type of language used in measures contributes to "client overwhelm", a term which appeared within the data set frequently. One social worker (narrative) remarked that she "*struggles with the way in which measures can pathologise and talk about normalcy. Language is usually negative and jargon".* Some counsellors highlighted specific measures in their comments. A somatic counsellor said the DASS21 had the effect of making her clients realize how *"bad"* they were, because "*DASS 21 items are negative".* A PCT counsellor spoke about the PCL retraumatizing her client because of the triggering nature of the items and another psychotherapist mentioned that a scale measuring self-efficacy was entirely unsuited and disempowering for the clients she worked with (Domestic Violence). She said "*the questions would make the client feel worse about themselves".*

<u>Literacy Struggles</u>

Some counsellors identified that some clients have difficulty understanding the measures and may not understand the jargon. One social worker spoke about working with non-English-speaking clients and that "*they often don't understand what is being asked of them".* Several other counsellors noted that some clients are not very literate, and the formality of the measures lead to stress and overwhelm. One counsellor said that misunderstanding scales is common among her clients.

Can interfere with the Therapeutic Relationship

Counsellors with varying levels of experiences identified that using outcome measures can harm the therapeutic relationship and interfere with the flow of the session. One experienced counsellor (20 years +) said that it "*makes it harder to build initial connection*" when one has to administer a measure on the first occasion. Another counsellor with 6-10 years of experience concurred, commenting that "*it inserts a task, interrupting the reason the client is coming for therapy"*. A social worker with less than one years' experience commented that the "*clinical and impersonal nature of the questions disrupt the therapeutic relationship"*. A counsellor working with homeless men identified that the clientele seems to really appreciate the fact that the organization he works for does not make outcome measure obligatory, and that there is consequently more invested in building the therapeutic relationship.

4.4.4. Theme Four - Suited to Some (Clients and Counsellors)

Many counsellors expressed mixed views regarding their attitudes towards and experiences of using outcome measures with their clients, meaning they could identify both positive and negative aspects of their use. One commonly held sentiment I noticed was the belief that for some clients, outcome measures were beneficial, whilst for other clients, outcome measure usage was perceived to be unhelpful – and/or even harmful. One psychologist (PCT) expressed "*some clients like completing them, people who are driven by their head – they almost express relief at having something to do. Some clients are not like that at all and prefer to talk"*. Another social worker (PCT) identified that some clients struggle with literacy and that this leads to overwhelm yet added "*and for particularly*

measure-literate clientele, they seem to appreciate it". Another counsellor (PCT) succinctly remarked "*they can be an ice-breaker, or they can be an icer!"*.

I also noticed that some counsellors either explicitly categorized themselves as either being drawn to measures or not, or used decisive language reflecting their strong position on the matter. The following three comments strike me as being reflective of the counsellors' strong stance against the use of measures:

- A social worker (PCT) – "*I also generally don't think it is my style to do more assessments, as this doesn't feel person-centered to me"*.
- From a psychotherapist (PCT) – *"I dislike using them, they feel inauthentic"*.
- From a counsellor (PCT) – "*Outcome measure usage feels like too much admin, takes too long, they are often incorrect and measure data incorrectly"*.

Counsellors very much in favor of using measures offered some contrasting comments such as "*I love the idea of being in a position to evaluate the efficacy of a session and my work"* from a social worker (narrative). Another comment from a psychologist (CBT) was *"it is nice to see the progress of clients*". Another psychologist (PCT) remarked *"I think they are essential. Objectivity is essential for both therapist and client"*. The following comment was offered by an experienced social worker "*I like to provide something else for my clients, some additional information"*.

One highly experienced counsellor provided a comment which seems to confirm the identified theme (suited to some). Additionally, her comment offers an interesting perspective on the issue. "*In my experience, I find that clients who like measures work with counsellors who like measures and vice versa"*.

<u>4.4.5. Theme Five- Clinical Use Versus Administrative Demands</u>

Counsellors' comments frequently described the tensions experienced as a consequence of endeavoring to use measures therapeutically and simultaneously providing the data in line with the needs of service providers and funding bodies. This was a big theme and therefore I present three subthemes. 1) clinical use is compromised", 2) "the power of the data" and 3) "counsellor autonomy".

<u>Clinical use is compromised</u>

Time constraints and administrative burden were regularly mentioned by counsellors. Clinicians identified that these factors frequently got in the way of using the measures in a meaningful way. Counsellors regularly referred to the process resembling a "tick the box task". The following comment provided by a counsellor (PCT) is indicative of the problem *"I might feel that the ORS/SRS could provide valuable insights but in my current role, I don't feel I have the time to do them properly – to have more like a therapeutic tool rather than tokenistic".* Another social worker expressed her preference to use measures as a reflective tool, however, has often had the experience of being unable to do so.

<u>The (non-clinical) power of the data</u>

Counsellors frequently indicated that they noticed clients approached the task of completing outcome measures in a disengaged or desensitised manner. Some counsellors attribute this to client suspicion. As one psychologist (PCT) remarked *"clients can sometimes wonder where the information is being stored, for what purpose, and shared with who?".*

Another counsellor perceived clients felt pressure to present in a certain way and were expedient whilst filling out the form "*Clients have also just scored the ORS the same regardless of what happens, e.g., 10/10, as a matter of course*". This idea of clients being expedient whilst approaching the task of completing measures is further reflected in the comments *"clients seem resigned, price of free counselling*" and "*clients seem to be used to it, in NGOs, and there's a 'here we go again' air to it".*

One counsellor (PCT) indicated that she is aware of how influential the data from measures can be, when she wrote "*I prefer to use only at preference of the client. e.g., to support a referral or access to other services. Positive feedback supports clients to access services or communications with employers, educational institutions etc..".* Similarly, another social worker mentioned that in order for her clients to qualify for NDIS, their outcome measures must present in a *"certain way".*

Counsellors also expressed concerns about the data from outcome measures being used to evaluate the work of the therapist, or the service. One Gestalt counsellor shared her concern about being her performance being evaluated on the basis of the measures "*the ORS/SRS is very subjective and yet being used to draw conclusions".* Her concern was echoed by this social worker's remark "*my concern arises when the measures are being used by organizations and funding bodies etc.".*

Counsellor autonomy

Counsellors regularly expressed concerns about being obliged to implement measures at times when they felt it therapeutically inappropriate. One therapist identified that giving a measure in the first session interfered with rapport building and numerous other counsellors said it felt wrong to ask a very distressed client to complete a measure.

Therapists' comments reflected varying levels of counsellor autonomy around the obligated use of outcome measures. One counsellor expressed appreciation for working in an organization which does not require the administration of outcome measures and identified that the therapeutic relationship with his clients feels more authentic as a consequence. Conversely, another psychotherapist described a conflict between the clinical staff and management in her organization, when they were mandated by management to use a measure the clinical team deemed in appropriate for the traumatized clientele. The counsellor said that the clinical team suggested a different measure, but management refused to allow this and instead proposed another alternative. She commented "*Counsellors should be the ones making decisions about what to use – not management, as they don't have direct contact with the clients*". A further comment from another therapist reflected a middle ground "*we used to use the ORS/SRS, which we have ceased using. We are now able to choose from a variety of measures, choosing the one we feel is appropriate for each client*".

4.5. Data Integration

The breakdown of the 58 counsellors who provided qualitative data according to discipline is outlined in table 20.

Table 20

Counsellors who provided qualitative responses, according to discipline

	Number	Percentage of total
Counsellors	13	41%(discipline)
Psychologists	16	53% (discipline)
Psychotherapists	11	73% (discipline)
Social Workers	18	60% (discipline)

Table 21 highlights the breakdown of counsellors who provided qualitative data based on modality.

Table 21

Counsellors who provided qualitative responses, according to modality

	Number	Percentage of total
PCT	29	67% (modality)
CBT	13	61% (modality)
No preference	5	100% (modality)
Existential	3	80% (modality)
Gestalt	4	100% (modality)
Narrative	3	37% (modality)
Somatic	1	100% (modality)
Total	58	61.4% (all respondents)

Counsellors' qualitative responses were grouped into three categories – "positive only" responses, "negative only" responses, and "mixed" responses. Table 22 summarizes counsellors' disciplines and modalities according to these categories, as well as the likelihood of counsellors within each category to use outcome measures voluntarily, as indicated in tables 8 & 9 (p 67). Clinicians who provided "positive only" responses were more likely to indicate voluntary use, whilst those who provided "negative only" responses were less likely to use measures voluntarily. Cross disciplinary and cross modality differences were evident.

Table 22

Views towards measures according to discipline, modality and likelihood to use voluntarily

	Positive Only	Negative Only	Mixed Views
Discipline			
Counsellors	2	7	4
Psychologists	11	3	2
Psychotherapists	0	9	1
Social Workers	7	6	6
Modality			
CBT	13	0	0
Person Centred	5	15	10
Gestalt	1	3	0
Narrative	1	0	2
Existential	0	3	0
Somatic	0	1	0
No Preference	0	3	1
Likelihood to Use Voluntarily			
Definitely Use	2	0	0
Likely Use	15	2	6
Possibly Use	3	5	5
Unlikely Use	0	11	2
Absolutely Not Use	0	7	0
Total	20	25	13

5. Chapter 5 Discussion

The current research makes a significant contribution to the understanding of outcome measure usage patterns and counsellors' attitudes toward using them within clinical practice in NSW. The study sought to determine the extent to which outcome measures are being used with clients and the degree to which counsellors may be using measures by choice. The second aim of the study was to determine the types of measures being used and counsellors' familiarity with a variety of measures, and thirdly, the research sought to elicit practicing clinicians' attitudes and views in relation to using outcome measures with clients. The results indicated widespread general use of outcome measures within clinical practice (80%) compared to lower voluntary usage rates (47%). Counsellors were not found to be using a wide variety of measures, with the majority of measures used being behaviorally focused. Similarly, counsellors did not indicate sound familiarity with a variety of measures. Clinicians' attitudes towards using measures in clinical practice were found to be mixed, in line with previous research findings (Norman et al, 2014; Sharples et al, 2017). Strong cross disciplinary differences and variations stemming from preferred therapeutic modality were noted in voluntary usage trends, and in counsellors' opinions around the use of outcome measures. Although these were not found to be statistically significant within the quantitative data set analysed, there were variations worthy of further consideration identified within the qualitative data analysis.

5.1. Widespread Use

The high rate of current outcome measure usage (80%) within this sample is not surprising, considering that usage is mandatory within the Public Mental Health System in Australia. Although only 17% counsellors work within Public Mental Health, the vast majority (78%) indicate that they are obliged to use measures for work/ funding or other external reasons. This indicates that the mandatory use of measures is widespread across the other sectors, including non- government organisations and the private sector. The high rate of use contrasts with lower rates reported in the United States and Canada, where outcome measure usage is not mandated within Public Health. For example, Hatfield & Ogles (2007) found that 37% of clinicians in their (United States study) used measures and Ionita & Fitzpatrick (2020) found that 36% of counsellors in their Canadian study were utilizing outcome measures in clinical practice. The relatively high usage rates in the current study are more aligned with the findings of another Australian study, wherein the authors found that at least 69% of clinicians were using measures (Chung & Buchanan, 2019). The authors in that study reported on rates of ROM only (69%) and did not report on general outcome measure use, which would likely have been higher. It may be that when ROM is mandatory within Public Health, other sectors are more likely to make measures obligatory, leading to more widespread use. This could account for the disparity in usage rates between North America and Australia. This perspective is in agreement with Kaiser (2018) who attributes the low rates of outcome measure usage in Austria to the fact that ROM is not mandated in the Public Health System there.

Compared to the high rates of general use of measures found in the current study, ROM rates were found to be lower, (37%). This appears to be consistent with fewer counsellors outside of the Public Health System being obliged to use ROM in Australia. It might be that unless ROM is absolutely necessary for funding purposes, organizations choose

not to utilize it because of the considerable resources required to employ it. Additionally, the rate of ROM determined in this study differs significantly from the ROM rate found in Chung & Buchanan's (2019) Australian study, where 69% of the 202 clinicians surveyed indicated using ROM. This is likely due to the fact that all clinicians in Chung & Buchanan's study were psychologists, and in this study, clinicians came from a variety of disciplines.

It is also interesting to note that counsellors in this study indicated a higher rate of a common form of ROM (SRS & ORS) historically (at 45%), compared to current usage of SRS & ORS at 19%, meaning that they ceased using it for some reason. This may be because some counsellors no longer work for organizations which required them to use it, however, some counsellors indicated that they chose to stop using SRS & ORS because they did not find it clinically useful. (Please refer to subthemes *"quantifying human experience is problematic" & "other ways to monitor therapeutic change"*). This finding lends support to the findings of Kendrick (2016), questioning the usefulness of ROM generally, and those of Østergård, & Hougaard, (2020) who found little evidence to suggest that PCOMS (SRS & ORS) are useful in clinical practice.

The fluctuation in rates of ROM over time are paralleled in general outcome measure usage rates, albeit to a lesser degree. (Please see table 5). In this sample, 91% of counsellors indicated that they used outcome measures historically, compared to 80% reporting current use. This may have to do with change of employment type and decreased obligation to utilise measures (as noted above), or it may reflect personal choice, as was the case with one counsellor who remarked that because he now works solely in private practice, he "no longer uses measures".

In previous studies, counsellors age, preferred modality and discipline were found to influence outcome measure usage trends (Boyce et al, 2014; Hatfield & Ogles, 2007; Rye et

al, 2019). In this study, these variables were not found to be statistically significant in determining usage/non usage of measures and this is unsurprising, given the high rates of mandated usage across the sample. What was very unexpected was the fact that "years of practice" did show statistical significance. In previous studies, it has been found that those clinicians with more years of experience were less likely to use measures (Kaiser, 2018; Trauer, 2006). In this study, the opposite was found – counsellors with less years of experience were found to be using measures less. This finding warrants a cautioned interpretation, however, as the overall number of counsellors reporting having never used measures was very low (9), the sample may have been skewed. Additionally, some of the qualitative responses indicated that some clinicians were not personally responsible for administering outcome measures as this task befell to a clinical administration worker. The finding, along with the fact that no other variable was found to be statistically significant in determining usage/non usage of measures reflect the broader epistemological challenges associated with the quest for knowledge. If something cannot be empirically proven, does it automatically mean it is invalid – and conversely if something is empirically evidenced, does this mean it to be true? The strong parallels between the conundrum described here and the problem of evaluating counselling via the use of outcome measures strikes me as particularly salient.

5.2. Voluntary Usage

The voluntary usage rate (47%) is in in keeping with the information contained in tables 8 & 9, where counsellors indicated their likelihood of using measures if they were not mandated to for work or funding purposes. Although the 2019 Australian study did not explicitly report on rates of voluntary usage, it might be inferred that at least 69% of the clinicians in that study were using voluntarily, as the primary reason for using outcome measures was found to be for perceived therapeutic benefits (Chung and Buchanan, 2019). In

the current study most clinicians (78%) cite obligation to use measures for work or funding purposes as a primary reason for using measures, as opposed to, only 33% who indicate they use measures for clinical reasons. (Please see table 15). Based on these figures, it seems that perceived therapeutic benefits associated with using measures influences voluntary uptake – a finding which replicates previous research (Jensen – Doss & Hawley, 2018). As discussed below, the differences between the findings in these two studies regarding voluntary usage and perceived therapeutic benefits is likely due to the cross disciplinary nature of this study.

Although the numbers are too small to determine statistical significance with regard to demographic variables and voluntary usage rates, very clear differences can be observed between disciplines and various modalities (please see tables 6-9). Due to the scarcity of cross disciplinary studies and studies wherein voluntary uptake of outcome measures is determined, it is difficult to compare the findings here to previous research. However, some older study findings seem to concur. Garland and Kruse (2003) found that psychologists were more likely to employ outcome measures, whilst Hatfield and Ogles (2007) found that CBT therapists were more likely to embrace measures than insight -oriented clinicians. Kaiser (2018) also found that CBT clinicians were more likely to view outcome measures positively and utilize them in practice. When the widely varying perspectives on what constitutes therapeutic change between modalities is considered, the differences in the voluntary uptake of measures seems logical, especially in light of the fact that behaviorally oriented measures are predominantly used. It is interesting to note that whilst psychologists are mostly in favour of using measures, psychotherapists are least likely to use them and whilst all CBT clinicians in this sample are in favor of using outcome measures, counselors with Gestalt, Somatic Psychoanalytical and Existential approaches are wholly against their use. It is likely that differences in the training programs pertaining to the various disciplines play an instrumental role here, and, more fundamentally, underlying philosophical differences relating to

perspectives on what contributes to therapeutic change. In Australia, psychologists are trained predominantly in CBT, whilst psychotherapy training focuses on the relational aspects of therapy, and additionally, acknowledges the importance of unconscious processes. (Crago, 2011).

The link between counsellors' attitudes towards using measures and the voluntary uptake of the same that has been identified in previous research (Jensen - Doss & Hawley, 2010; Kaiser, 2018) was also observed in the present study. (Please see table 22). Clinicians who provided all positive feedback in the qualitative prompts were more likely to use measures voluntarily than those who held all negative or mixed views. Notable differences relating to discipline and modality were identified. It is striking that all CBT clinicians provided only positive feedback regarding outcome measure usage and all indicated that they use measures voluntarily. Compared to other modalities, this stance seems rigid, as at least some counsellors from all other modalities expressed mixed views towards outcome measures. This divergence may warrant further research on these differences, in order to elaborate upon the current findings.

Whilst psychologists were more likely to use measures voluntarily and psychotherapists least likely to, a proportion of clinicians from all four disciplines indicated an openness to using measures – and as the qualitative responses imply, this openness to using measures comes from a position of client centeredness. The term "voluntary use of outcome measures" becomes imbued with more nuanced meaning when counsellors' reflections are considered. The themes "*suited to some clients*" and "*clinician autonomy"* identified in the qualitative data highlight this point wherein clinicians identify how outcome measures can be both beneficial and harmful – depending on the client and the timing of their use within the counselling process. For the majority of clinicians in this study, "voluntary" usage, therefore, does not imply that counsellors are willing to use measures across the board,

but wish instead to make informed, client centered choices about when, with whom and under what circumstance it is beneficial to use measures. The fact that ROM rigidly demands measuring in every session seems unsuited with this stance.

5.3. Types of Measures in Use

The majority of counsellors using outcome measures in this study are using measures focused on symptoms changes, levels of functioning and psychopathology. Please refer to tables 11, 12 &13). As expected, all measures mandated within Public Mental Health System (HonOS, LSP -16 and K10) were identified as having been used, while the small number of counsellors utilizing individualized measures (8) and humanistic measures (4) indicates that behaviorally focused outcome measures continue to dominate the field. This is in keeping with the findings of Bibb and Baker (2014) in their Australian review of the research literature which indicated a reliance on the part of researchers on the *DASS and K10.* It seems that little has changed in the seven years since that review. Indeed, it may be true to say that little has changed since the original outcome measures were developed in the 1940's.

Counsellors indicated that they were familiar with a broader range of measures than they were using. For example, 45% of counsellors indicated they were aware of the individualized measure - the *Goal Attainment Scale* (GAS; Kiresuk & Sherman, 1968), however, none were utilizing it. Similarly, although 39% of counsellors were familiar with the (humanistic oriented) *Self- Compassion Scale* (Neff, 2003), only 4% actually had experience of using it. Interestingly, process and relational measures (apart from SRS) were almost entirely unfamiliar to most clinicians in the study, therefore it follows that these measures are not being utilized in clinical practice. This finding is in line with Levitt et al (2005) who identified that non- behavioral measures are not widely known about or used.

This is very valuable information regarding the types of measures being used, as it helps to contextualize the objections towards using measures counsellors may articulate. For example, criticisms targeting the irrelevancy of measures, and potential harm related to the language of the outcome measures used may be largely attributable to the type of measure utilized – and not on the fact that measures are being used in the first place. However, Jensen Doss (2018) found that although individualized measures were found to be more acceptable to counsellors, they were not any more likely to be used voluntarily in practice. This might suggest that factors other than just the types of measures are likely deterring clinicians from using them. Despite this, in the current study, the qualitative remarks offered by counsellors who used individualized measures reflected that they found the client - tailored nature of the individualized measures more beneficial in practice. Additionally, some qualitative responses convey a sense of dissatisfaction with the current measures being utilized; curiosity around the alternative types of measures available, and whether these measures may be more beneficial to counselor's practice. (Please see subtheme "*homogeneity of measures uses*"). Hence this may suggest that counsellors' criticisms pertaining to the use of outcome measures stems largely from the types of measures they have been exposed to.

The finding that five counsellors indicated that they were mandated to use individualized measures, may represent a modest move to an endorsement of a wider variety of measures. Additionally, given that 25% of counsellors indicate that they can choose which measures they use with clients, it seems that there may also be an opportunity for choosing measures that may be more relevant and more sensitive to the needs of clients. It strikes me that counselling service managers (like counsellors) may also be largely unaware of the range of measures available. Further education regarding types of measures and their usage may be indicated. However, it may also be the case that non- traditional and non- behaviorally aligned measures are not as readily acceptable to funding bodies and service managers. For

example, the authors of the *Power, Threat & Meaning Framework* (a movement which challenges the *Diagnostic and Statistical Manual of Mental Disorders – DSM* - and the concept of EBP) highlight an example in a Mental Health service in the UK, wherein established and effective individualized evaluation methods were discontinued by management in favor of the more traditional measures associated with EBP models of treatment – despite the effective results individualized evaluation demonstrated (Johnstone et al, 2018). It may be that behaviourally oriented measures are favoured by funding bodies and key stakeholders owing to their concreteness, which in turn may simplify the decision-making process regarding the allocation of Mental Health funding. The literature highlights those non- behaviorally focused measures have been "slow to progress" (Horvath, 2013, p10), and the findings of the present study confirm this assertion. It is possible that the reluctance to endorse a variety of measures may represent a conflict of interests by those parties who are benefiting from the status quo, and it will be interesting to track the success or otherwise of individualized, process and humanistic measures going forward. As Rodgers (2017, p4) maintains "outcome measures are political devices which control the flow of resources, finance and influence".

5.4 Counsellors' Mixed Responses

Counsellors expressed a variety of responses towards the use of outcome measures, and these tended to be mostly mixed or positive. This finding concurs with previous findings relating to clinicians' attitudes (Norman et al, 2014; Sharples et al, 2017). In this study, the qualitative responses revealed that those counsellors with mixed views occupied a strong client-centered position, in that they were open to using measures with clients they felt would benefit from the practice, and reluctant to use them with clients whom they felt would be

disadvantaged as a result. This finding fits with the nuanced nature of voluntary use identified above. To illustrate this point, I refer to one counsellor's remark "measures can be harmful to some clients because of the language, yet I find that clients who are literally inclined appreciate them". Please refer to *"suited to some"* theme for further examples.

5.5. Reported Benefits

Almost one third of counsellors using measures indicated that they valued the feedback and believed outcome measures led to better therapeutic outcomes. (Please see table 15). Some of the qualitative responses help to specify the ways in which counsellors believe these enhanced outcomes are achieved. Increased involvement and commitment to therapy on the part of the client as result of having their progress monitored were noted. Several comments conveyed the perceived usefulness of outcome measures in identifying problem areas and setting goals for the client. Clinicians also commented how clients seem to be empowered, encouraged, and validated as a consequence of receiving and providing feedback. Additionally, several counsellors highlighted that using outcome measures aids communication between counsellor and client, especially if the content of conversation is sensitive, such as a client feeling anxious or depressed. These benefits echo the findings reported in previous studies, where a proportion of counsellors identify similar benefits (Chung & Buchanan, 2019; Ionita & Fitzpatrick, 2014; Sharples et al, 2017). The findings also serve to illustrate the reported benefits associated with ROM, as outlined by proponents of the practice (Hannan et al, 2005; Lambert & Harmon, 2018; Duncan, Miller & Sparkes, 2011). Despite this, the number of clinicians who view outcome measures as being clinically useful seems low, (33%), compared to the findings in a previous Australian study, wherein the majority of clinicians attested to the therapeutic benefits of measures (Chung &

Buchanan, 2019). This difference might well be because all clinicians in that study were psychologists, and in this one, clinicians come from a mix of professional backgrounds. However, the relatively low number of clinicians who indicate the clinical usefulness of measures in this research concurs with findings in other studies. In a German survey, for example, only 37% of clinicians indicated that they found information derived from measures to be clinically useful (Klundt, 2014) and similarly Kwan (2021) reported a reluctance amongst clinicians to incorporate feedback from measures into their clinical work with clients.

It strikes me as being odd that the voluntary outcome measure usage rate (47%) is higher than the percentage of counsellors who deem measures as being clinically useful (33%). Upon reflection, I offer that this discrepancy may reflect the "*suited to some clients*" and "*counsellor autonomy*" themes described earlier. Whilst two thirds of clinicians in this sample indicate that they do not perceive outcome measures as therapeutically beneficial to clients generally, a proportion of this group do believe that outcome measures can be useful for some clients and at certain times throughout the counselling process.

5.6. Reported Limitations

The concept of quantifying human experience and therapeutic change was dismissed by 64% of the 44 counsellors who were not currently using measures in this study. This figure represents the primary reason counsellors cited for not using measures and this belief correlates with previous research, wherein counsellors expressed similar sentiments (Gleacher et al, 2016; Norman & Dean, 2014; Kaiser, 2018). Psychotherapists were most likely to express this belief and it is interesting to note that clinicians from this profession were the most likely to provide qualitative responses in the survey. This fact may illustrate psychotherapists preference to express their viewpoints and experiences in narrative format –

and it might also suggest that they welcome the rare opportunity to express their high levels of dissatisfaction with using measures. The idea of "arbitrary metrics" posited by Kazdin (2014, p389) is perfectly encapsulated by the following comment from a Gestalt psychotherapist when she wrote (referencing the SRS) "clients have difficulty putting a number score on the questions asking about family/relationships, which can be ambiguous and complex". These comments, along with the quantitative findings lend support to the viewpoint which asserts that a mixed method approach to assessing therapeutic change is superior to quantitative methods alone (Bloch-Elkouby et al, 2019, DeSmet et al, 2019, Hill et al, 2013).

Another reported limitation associated with outcome measures identified in the study's findings centers on the issue of relevancy. Over half of the counsellors who are not currently using measures indicated that they believe the measures to be irrelevant. (Please see table 16). A relatively small number of these counsellors (9) indicated they had never actually used outcome measures, which may indicate a rigid perspective. However, most of the clinicians who are not currently using measures had previous experience with them, signaling that their views regarding the relevancy of outcome measures is based on clinical experience. Additionally, the qualitative data suggests that a proportion of counsellors who are currently mandated to use outcome measures believe them to be irrelevant also, as illustrated in the subtheme "not capturing the right stuff". Given the fact that the vast majority of measures being used by counsellors are behaviorally oriented (focused on symptoms, psychopathology and functioning), it is not surprising that clinicians who are not aligned with behavioral approaches would have concerns about the relevancy of measures used. This comment from a Person- Centered social worker illustrates the point: "There is little emphasis on personal growth and more weight given to what can be measured quantitatively", and highlights how differences in perceptions of what constitutes therapeutic change influences

satisfaction/dissatisfaction with outcome measures. Previous studies report similar concerns on the part of some clinicians, and as expected non- CBT counsellors were more likely to articulate concerns around the use of measures (Garland & Kruse, 2003; Overington et al, 2015; Sharples et al,2017). In this study, no CBT counsellor (informed by both quantitative and qualitative data) expressed irrelevancy of outcome measures as an issue. Unfortunately, although four counsellors in the sample indicated they had used a humanistic measure (assessing self compassion,) they did not elaborate on what their experience of this was. It seems likely, however, that measures which aim to capture more nuanced and subjective therapeutic change could be experienced as being more acceptable to a broader range of counselors than those measures which are focused on behavioural change only. Relatedly, adopting a mixed methods approach to the practice of assessing therapeutic change may help assuage the concerns regarding relevancy of measures and their capacity to capture a broader range of therapeutic outcomes. That is, integrating more qualitative aspects into outcome measures may offer benefits to help address concerns identified by counsellors related to using purely quantitative measures. Hill (2013) illustrates the superiority of this mixed method approach in a case example which involved the client completing a self -report questionnaire and a follow up interview. The results of the questionnaire indicated that the client had made enough progress to warrant ending therapy whereas the qualitative information showed that the client had been "putting on a brave face" (for the questionnaire) and was in fact very depressed and very much in need of further therapeutic support.

5.7. Therapy Interfering

Over half of the counsellors not using measures indicated that they felt measures interfered with the therapeutic process. It is important to note that some counsellors who are using measures feel this way too, as demonstrated the qualitative data, specifically within the subtheme *"outcome measures can interfere with the therapeutic relationship".* Cross

disciplinary and modality differences were observed with regard to this perception. Psychotherapists were more likely to express the view, whilst no CBT counsellor articulated having this concern. These findings are in line with similar studies also (Boyce & Brown & Greenhalgh, 2014; Hatfield & Ogles, 2007; Jensen-Doss & Hawley,2018). The qualitative data illustrates how some counsellors perceive that the use of outcome measures can reduce the flow of empathy and attunement with the client, especially when the client is upset. The following comment offered by a Person-Centered counsellor working with homeless men conveys the idea that using measures leads to inauthenticity within the therapeutic alliance "we are very focused on the therapeutic relationship and not taking away from that with external/our own processes. Most of the clients (male, homeless) express gratitude for attending a service which does not have parameters around assessment –, having often had histories of these types of services. We are going against this". This comment highlights the position held by Morstyn (2011) when he argues that over adherence to assessment processes in psychotherapy can lead to a lack of emotional availability of the part of the counsellor and amount to a "pseudo therapeutic relationship which can lead to missed opportunities to engage with clients and to the reinforcement of their damaging sense of alienation" (p221). In such a relationship, clients are likely to feel dehumanized, invisible, and disempowered, which Morstyn holds can retraumatize vulnerable clients. The link between the strength of the therapeutic relationship and positive therapeutic change has been proven repeatedly. In 2018, Norcross and Lambert reiterated this finding in the *American Psychological Association Task Force on Evidence Based Relationships and Responsiveness*, highlighting that EBP had contributed to the devaluing of the counselling relationship for decades. In the same publication the authors advocate that the therapeutic relationship be monitored – and therapeutic outcomes measured on a routine basis, arguing that these monitoring processes would best ensure that the therapeutic relationship be prioritized, and thus, therapeutic

outcome enhanced. These arguments are similar to those posited by Miller, Duncan and Sparkes (2014) who argue that the medical model has the effect of disempowering the client and assert that routinely monitoring clients' progress and experience of therapy is the optimal way in which to demonstrate respect and regard for the client and consequently enhance outcomes. Whilst the goal of creating a more client centered therapeutic experience proposed by these authors and other proponents of ROM appears sound, the irony may be that the inauthenticity in the therapeutic relationship they sought to target may in fact be replicated by the proposed means of targeting it - ROM. ROM aimed to rectify what was wrong with the dehumanizing aspects of EBP. Now ROM *is* an EBP, and, is experienced by some – and at least 53% of clinicians in this study as therapy interfering and more seriously, potentially harmful to clients. I will discuss the harms later in this discussion.

5.8. Perceptions on the Therapeutic Relationship

Sixty-eight respondents indicated that changes in the therapeutic relationship could signal therapeutic change (Please see table 17). Given the strong, and much cited evidence proving the correlation between the strength of the therapeutic alliance and positive therapeutic outcomes, this figure seems relatively low (Norcross & Lambert, 2018; Wampold & Imel, 2015). It may be that this specific aspect of change was overlooked, in part based on the check- list nature of the question asked (Question 17: "Apart from outcome measures, how do you gauge therapeutic change? Please tick….."). Never the less, it is interesting to see that strong interdisciplinary and modality differences were observed when it came to reflecting on changes in the therapeutic relationship as a driver of change (Please refer to tables 18 and 19). The most striking difference in terms of discipline was that whilst only half of the psychologists indicated the therapeutic relationship as a way to gauge change, all

psychotherapists signaled that they saw a clear association. CBT clinicians were also less likely to identify the relationship, compared to counsellors from other modalities. The varying ideologies underpinning the different professions and therapeutic approaches, along with the different types of training programs associated with these are highly likely to have contributed to this finding. Traditionally, Counselling and Psychotherapy are relationally focused, and so perhaps it is not surprising that clinicians from these disciplines are more attuned to the central role of the therapeutic relationship (Carkhuff, 2017). In Australia, psychologists (at least at undergraduate level) are widely trained in CBT, a modality which has not traditionally prioritized the relational aspects of therapy (Crago, 2011). The differences in ideologies and focus on the respective training programs may also help explain the finding that whilst psychotherapists are most likely to recognize the link between the therapeutic alliance and positive outcomes, they are least likely to view outcome measures positively or to use them voluntarily. On the other hand, psychologists in this sample were less likely to perceive the link between the therapeutic relationship and therapeutic change, yet they were most likely to view outcome measures favorably and utilize them voluntarily. Considering that one of the main rationales for the introduction of ROM was based on the robust evidence linking the therapeutic relationship to positive outcomes, it seems as though this knowledge may have become somewhat "lost" in practice – and yet the practice of *monitoring* has flourished. This strikes me as an example of how the practice of measuring a phenomenon of interest - in this case the link between the therapeutic relationship and therapeutic change – can create distraction and lead to a preoccupation with a manifestation of the phenomenon, whilst the actual phenomenon is overlooked, or as Blauw, 2020, p113 highlights "The numbers that should have captured reality have replaced it".

Some of the qualitative comments (categorized within the subtheme "*other ways to monitor therapeutic change"*) provided help to illustrate how counsellors gauge therapeutic

change – several remarks conveyed counsellors' beliefs that more naturalistic methods such as listening to the clients' concerns were superior to using outcome measures. The following remark "having a direct conversation with clients about the therapeutic relationship, inviting the client to express needs and openly explore stuckness" strikes me as an organic way in which to involve the client, prioritize their needs and pay attention to the therapeutic relationship without the need to measure. Such an approach may demand a degree of confidence on the part of the counsellor and importantly may help model both authenticity and assertiveness to the client. Additionally, this natural approach to attending to the needs of the client and being actively attuned to the therapeutic relationship strikes me as being far more aligned to qualitative methods of collecting client feedback, as opposed to quantitative methods. Qualitative tools such as the *Client Change Interview* (CCI; Elliott, 1999) or the *Relational Depth Inventory* (RDI; Di Malta, Evans & Cooper,2019) may be more successful in eliciting the clients' experience of therapy and the therapist, as well as capturing a broader range of indicators of therapeutic change. Unfortunately, it appears that ROM methods almost wholly constitute quantitative measures and that the focus in these are limited mainly to changes in symptoms, functioning and psychopathology. The finding that only 10 counsellors have used either a humanistic or individualized measure, and that the only process measure in use is the SRS (quantitative method) reflects a very narrow scope of evaluating therapeutic change currently.

5.9. Harms

Apart from the perceived harms arising from a "pseudo relationship" (Morstyn,2011, p221), counsellors indicated further ways in which they thought outcome measures may be harmful to clients. Over 30% of counsellors who choose not to use measures indicated that "harm to client" was a factor for not using. Most of those clinicians concerned about harm to client identified as being person centered, a finding in line with previous research. For

example, Hatfield & Ogles (2007) and Jensen & Hawley (2018) found insight- oriented counsellors more likely to perceive outcome measure usages as being harmful to clients.

In this study, several counsellors commented about the language used in the measures as being potentially pathologizing, full of jargon and some counsellors expressed their doubts about clients being able to understand what was being asked. For example, one counsellor identified that she worked with non-English-speaking clients and perceived that they felt self-conscious about not having a good command of English. In previous studies, counsellors have reported similar concerns (Norman and Dean, 2014; Sharples, 2017). This present study returned some relatively novel results in terms of the potential harms arising from outcome measures. In the qualitative responses, multiple counsellors made reference to the types of clienteles they worked with, and how for some clients, the use of outcome measures may be especially harmful. For example, one counsellor said that a measure she was required to use by management (assessing levels of self-efficacy) was entirely unsuited to her clients – survivors of Domestic and Family Violence. For those clients, the counsellor said, such a measure would serve to make her clients feel invalidated and more disempowered. The inference is that clients recovering from the trauma of Domestic Violence are frequently in positions wherein they are unable to be safely assertive and self -governing due to circumstances out with their control (external abuse by others). Another clinician gave the example of the *Depression, Anxiety & Stress Scales* (DASS21) causing her client to feel worse about himself, as he realized how “bad” he was, instilling feelings of hopelessness. These examples concur with the findings of Errazuriz & Zilcha – Mano (2018) and Paz, Adana-Diaz & Evans (2020). In these studies, ROM were found to have a detrimental effect on psychotic clients and hospitalized clients respectively, because the feedback from the measures underscored the problems the clients were experiencing and engendered a sense of hopelessness and inadequacy for the client. These examples impress me as being very serious

ethical concerns which deserve to be explored thoroughly, and I agree with Kendrick's (2016) recommendation that ongoing research be conducted into harms associated with outcome measure usage. When I consider the thorough process of seeking ethics approval in order to distribute the survey in this study to trained professionals, it seems ironic that non-clinical personnel can prescribe what measures clients (often vulnerable and traumatized) are asked to complete.

5.10. Measuring – Who is it Suited To?

It is interesting to note that clinicians were three times more likely to rate "personal preference" compared to "client preference" when asked about reasons for using measures. It impresses me that this may be due to two reasons. The first reason relates to the personality of the therapist. Like some clients, some counsellors are perhaps drawn to using outcome measures. The theme "suited to some" indicates that a proportion of clients and counsellors may enjoy the concreteness measuring affords, and in the case of clinicians, this preference for the concrete and certainty may influence their preferred choice of modality, meaning that they may more readily identify with CBT. However, counsellors who identified with other modalities also indicated that personal choice was a motivator for using outcome measures and in part, I believe that this may have to do with anxiety regarding their effectiveness. For example, the decisive and emotive language within the following comments "I think they are essential. Objectivity is essential for both therapist and client" or "I like to be able to offer the client something more" prompts me to consider counsellor anxiety as a contributing factor to outcome measure adherence. Such anxiety is potentially experienced by many counsellors, working in a field where outcome is hard to define, and even harder to prove – and within a culture which promotes certainty and accountability so vigorously (McGilchrist, 2009; Rustin, 2015). For some counsellors (and counselling service managers), receiving reassurance regarding their effectiveness via outcome measures may be especially important.

This concurs with previous research, wherein counsellors indicated that using measures gave them a sense of being "effective", sticking to EBP and having a sense of job security (Sharples et al, 2017; Rye et al, 2019). Additionally, strong proponents of ROM in the field promote this reliance on empirical evidencing via the use of outcome measures by dissuading counsellors to rely on their clinical judgement and intuition, by repeatedly citing evidence that these methods of assessing client change are frequently flawed (Hannan et al, 2005; Lambert & Shimokawa, 2011). Yet this is contradictory to robust neuroscientific research evidence which highlights the benefits of clinical intuition, working with implicit processes, and prioritising the relational aspects of therapy. (Cozzolino, 2017; Porges & Dana, 2018; Schore.2012; Siegel, 2010). This negative messaging around the value of implicit communication and intuition may well fuel counsellor anxiety and diminish confidence, in addition to encouraging a reliance on quantitative outcome measures. It may be that if counsellors were supported in utilising their intuition more – via exposure to a wider range of research and supported experiential learning in their training, their confidence may increase, thus allowing them to be more fully present in the therapeutic relationship.

5.11. Navigating the System, Prioritising the Client

The discrepancy between the percentage of counsellors (78%) who use outcome measures for work or funding purposes and the percentage of clinicians (32%) who use them for their clinical utility, as illustrated in table 15, highlights that outcome measures are predominantly used for the purpose of evaluation and less likely to be used on clinical grounds. This finding may call into the question the clinical value associated with using outcome measures and bears striking resemblances to the findings by Klunt (2014) and Kwan (2020), in terms of the *percentage* of clinicians who attested to the clinical value of outcome

measures in the samples. In both these studies, all clinicians were mandated to use the measures, however in former context, only 34% of counsellors were using the measures clinically, and in the latter, one third of clinicians utilized them for clinical purposes. Although most clinicians in this study agreed that outcome measures are time consuming and some qualitative responses indicated that time constraints meant that their usage was "tokenistic", the overall findings suggest that practical constraints are not the primary reason counsellors tend to decline to utilize them clinically. The objections placed by clinicians tended to focus on epistemological concerns including the problem of quantifying therapeutic change, the question regarding the relevancy of measures, the therapy interfering issues and the potential to cause the client harm. (Please refer to table 16).

Some qualitative comments point to how counsellors and clients navigate the system wherein outcome measures prevail. Some counsellors inferred that they viewed outcome measures as a way of helping their clients get access to services such as the NDIS, meaning that an expedient "tick box" approach was employed and that measures were not being used for clinical purposes. Ironically, it seems likely that in instances such as this, the non-clinical use of outcome measures may well enhance the therapeutic alliance.

Other counsellors expressed that they observed clients to be adopting a similar "tick box" strategy, as though clients are sensitized to the practice of filling in measures, and do not take them exercise seriously. Other comments illustrated how clients exhibit suspicion whilst completing measures. One counsellor commented that some clients just "score 10/10" always – perhaps out of deference to the counsellor – or due to a fear that a record of poor mental health may work against her in the future. These findings echo previous research findings, wherein clients were found to be expediently completing measures (McLeod, 2001; Stänicke & McLeod.2021). On a similar note, Börjesson, & Boström, (2019) found that clients voiced concerns regarding the ramifications of having the results on their file. It seems

entirely understandable that clients may worry about what goes on record and that this might lead to falsifying the truth on outcome measures. One example could be case of a parent falsifying a substance dependency measure if there is a goal of having a child who has been removed by Family and Community Services restored to her.

Some counsellors in the study expressed their own suspicions arising from a lack of transparency regarding the purpose of outcome measures, and how this may personally affect them, indicating that the results from outcome measures may sometimes be used by management to assess their performance. This concern has been identified previously (Dozois et al, 2014; Lambert & Harmon, 2018), and strikes me as being a very valid concern, which could well lead to an inaccurate representation of a client's outcome.

6.Chapter 6. Conclusion

In this concluding chapter, I will outline the ways in which the current research has contributed to our understanding of outcome measures usage patterns and effects in clinical practice. Strengths and limitations associated with this study will be highlighted and suggestions provided for future research. Theoretical implications will be identified, and additionally, training and clinical recommendations offered, following a brief recap of the study's major findings.

6.1 Strengths of the Study

This study is unique, in that it is one of the first of its kind in Australia, and the first to explore voluntary outcome measure usage patterns in addition to the views of counsellors in clinical practice. Additionally, (to my knowledge), this study constitutes the only research which explicitly sought to assess practicing counsellors' familiarity with and utilization of a variety of measures.

The cross disciplinary and modality nature of the study represents a key strength, as this allowed for the representation of a broad range of perspectives, leading to a mix of findings. Further, the research prioritized the voice of the clinicians, resulting in a deeper understanding of the effects of outcome measures usage on clients.

6.2. Contribution to Knowledge

This pilot study has resulted in a clearer understanding of outcome measures usage patterns in clinical practice in NSW. This increased clarity has helped contextualise the findings relating to counsellors' varying perspectives regarding their use. Given the

ambiguity surrounding outcome measure usage patterns, the range of measures potentially being used, and the scarcity of existing research on the subject involving clinicians, this study probed a substantial gap in our knowledge. The literature indicates that the promotion and prevalence of outcome measure usage in clinical practice is growing (Ionita, 2020; Wampold, 2015). There exists, therefore, an ethical obligation to ensure that this practice is best serving the client by conducting ongoing and unbiased research. This study made some solid contributions to this goal and the findings have a range of implications for theory, training, clinical practice and future research, as discussed below. In sum, the study has highlighted the potential to enhance evaluation processes by increasing clinicians' awareness of the availability of a wider range of measures. By prioritising the voice of the clinician, the research has made a unique contribution to our understanding of the clinical utility of outcome measure usage, and additionally indicates how a flexible and nuanced approach to the application of measures may optimize this, in turn contributing to enhanced therapeutic experiences for clients.

6.3. Major Findings in Brief

To recap, this research signals that outcome measure usage is prevalent in NSW and that most counsellors are mandated to utilize them. Outcome measures aligned to the behavioural approaches are almost exclusively used and a wide range of measures are largely unfamiliar to counsellors. The study found that counsellors hold a variety of perspectives relating to outcome measure usage including positive, negative and mixed views. Strong cross disciplinary and modality differences regarding these perspectives were noted, and also these differences were again observed with regard to voluntary usage. Psychologists and CBT clinicians were more likely to hold positive views on outcome measures and most likely to use measures voluntarily, whilst Psychotherapists and Existential and Gestalt counsellors were more likely to view measures negatively and least likely to use voluntarily. The study

found that one third of the respondents indicated that they find using outcome measures clinically useful in general, and that almost half expressed that they have used measures voluntarily, with some clients. The study revealed that whilst most clinicians recognised the importance of the therapeutic relationship in facilitating client change, those who did not indicate this were more likely to view outcome measures favourably and use them voluntarily. Finally, the research indicated that some counsellors were more likely to use measures for personal reasons than others, and that this may be linked to the personality of the counsellor.

6.4. Theoretical Implications

Some findings challenge the theoretical framework underpinning ROM, which stipulates that monitoring client progress and the client's experience of the therapeutic relationship and therapist in every session via the use of outcome measures leads to enhanced therapeutic outcomes (Miller ,2015). The finding that less than one third of clinicians in this study deem outcome measures to be clinically useful with all clients highlights that the clinical benefits purported to be associated with ROM (at least in its' present form) may not be borne out in clinical practice. Whilst the study revealed that a proportion of counsellors do find ROM beneficial, the findings simultaneously indicate that these benefits are only applicable to certain clients and when measures are used at appropriate times within therapy. Generally, therefore, the experiences of clinicians in the therapy room, according to this sample, do not fit with the ethos of ROM, which involves the use of outcome measures in every session.

Some of the study's finding lend support to Common Factors Theory, specifically the association between the therapeutic relationship and therapeutic change (Norcross &

Lambert, 2018). 68% of all clinicians surveyed indicated that they observed this association in their clinical practice.

Another aspect of CFT relates to the therapist effect on outcome - the idea that the personality of the therapist effects client outcome (Wampold and Imel, 2015). This theory has been expanded to consider the potential of matching counsellors with particular characteristics and ways of working with clients who may share similar characteristics and perspectives (Boswell et al 2017). The finding that some clients and counsellors in the present study are more naturally drawn to and comfortable with the concrete task of applying and completing quantitative outcome measures seems to support this perspective.

The numerous findings relating to cross disciplinary and modality differences relating to satisfaction or otherwise with (largely behaviourally - focused) outcome measures signals that the outcome debate is a current issue within the field. The outcome debate refers to competing perspectives relating to what contributes to therapeutic change (Strupp, 1963; Wampold, 2019), an issue which was soundly supported by the findings in this research.

6.5. Implications for Training

The findings in this study indicate that a variety of measures are not known about and subsequently not used. Hence, it may be beneficial to expose counsellors in training to a variety of measures and their applications – including individualized, process and qualitative measures. Further, the process of training counsellors in the application of outcome measures would ideally emphasise the rationale for the clinical use of measures, particularly the association between the therapeutic relationship and therapeutic outcome.

6.6. Clinical Implications

Given that a broad range of measures exist and not known about, it seems that there is an opportunity to educate clinicians, service managers and key stakeholders regarding the

various types of measures available. Clinicians would ideally be supported to research, select and apply relevant outcome measures with sensitivity to particular client groups. There may be a role for regulatory bodies to occupy with regard to this endeavour also. Instead of endorsing the general use of outcome measures, these bodies might provide more specific guidelines relating to the appropriateness of certain types of measures for various clientele.

As many of the available measures including qualitative process measures and individualized measures are largely unfamiliar within the field, these may be initially need to be trialed by clinicians, and if successful, for management to advocate for their continued use with funding bodies.

In addition to being supported to choose the types of measures used with clients, clinicians would ideally be supported to use their clinical judgement around the frequency of application of measures. This recommendation is offered based on the findings relating to counsellors concerns about the use of outcome measures with some clients and at certain critical points in counselling as therapy interfering and thus counter-productive.

The findings suggest that there is a greater need for transparency regarding the purpose of outcome measures, for clients and clinicians. It seems that management plays a key role is leading this process, by explicitly differentiating between the data being utilised for program evaluation and performance appraisal of staff, and outcome measure data which is collected for clinical purposes only. Similarly, clients would be fully informed of the consequences of completing measures, whether the scores would be attached to client notes, who may have access to the data and what decisions might be made based on the results.

6.7. Limitations of the Study

This research was conducted over a relatively short period of time, in line with the Master of Research program. Additionally, this pilot study aimed to begin to explore a broad range of aspects relating to outcome measure usage and consequently identified numerous areas of interest without achieving an in-depth exploration of any specific facet.

The relatively low numbers of respondents did not allow for extensive statistical analysis, which impacts the generalizability of the quantitative results. Further, the Public Mental Health System may have been under represented (17%), meaning that data pertaining to ROM was limited in this study. Future studies may combat this issue by including Mental Health Nursing professionals in their research.

The fact that only 64% of clinicians provided qualitative responses represents another limitation, in that the subjective experiences of one third of the respondents were not expressed. The qualitative responses provided were for the most part short and accessed via self- report questionnaire, which did not allow for a more in-depth exploration of counsellors' experiences such as might be possible via focus groups or interview, for example. Future research may combat this shortcoming by including the aforementioned more intensive qualitative methods.

6.8. Implications for Future Research

Further cross disciplinary, mixed methods research involving clinicians and clients is indicated in order to expand on the current findings regarding perceived benefits, limitations and harms associated with outcome measure usage.

The issue of potential to cause harm to certain types of clients, and at certain times in the therapeutic process is particularly in need of further attention. Future research might focus on vulnerable groups of clients, such as survivors of Family and Domestic Violence and marginalized groups such as homeless persons (groups which were identified in this study). Additionally, the effects of using specific, commonly used measures such as the (DASS & K10) might be explored, with a view to identifying which groups of clients might be disadvantaged by completing these measures. Such research is likely to simultaneously identify client groups who are likely to benefit from the use of these commonly used measures, for example "clients who are driven by their head" or are "especially measure literate", to draw on examples from this study.

Future mixed methods research involving clinicians may also seek to expand on other findings from the current research including the ways in which counsellors gauge therapeutic change apart from using outcome measures, and the other ways in which the therapeutic relationship may be prioritised by counsellors. Additionally, future research involving both clinicians and clients may also seek to arrive at a more nuanced concept of "outcome", and how this may perceived differently by different client groups and different clinicians. Relatedly, the finding "suited to some counsellors and clients" suggests that further research on the potential of matching specific therapists and clients based on personality type and preferred way of working may be indicated.

The wide range of individualised, process, qualitative, and non-behaviourally focused measures currently available (but under-used) present important research opportunities going forward. Such measures may be trialed with clients in clinical practice, and followed up by eliciting client and counsellor feedback regarding the experience of using the various types of measures. Such practice- based research may advance the endorsement of a wider range of measures with funding bodies.

References

Amble, I., Gude, T., Ulvenes, P., Stubdal, S., & Wampold, B. E. (2016). How and when feedback works in psychotherapy: Is it the signal? *Psychotherapy Research*, *26*(5), 545–555. doi.org/10.1080/10503307.2015.1053552

Andresen, R., Caputi, P., & Oades, L. G. (2010). Do clinical outcome measures assess consumer-defined recovery? *Psychiatry Research*, *177*(3), 309–317. doi-org.ezproxy.uws.edu.au/10.1016/j.psychres.2010.02.013

Andrews, G., & Slade, T. (2001). Interpreting scores on the Kessler psychological distress scale (K10). *Australian and New Zealand Journal of Public Health*, *25*(6), 494–497. doi.org/10.1111/j.1467-842X.2001.tb00310.x

APA Presidential Task Force on Evidence-Based Practice, & American Psychological Association. (2006). Evidence-Based Practice in Psychology. *The American Psychologist*, *61*(4), 271–285. doi.org/10.1037/0003-066X.61.4.271

Ashworth, M., Shepherd, M., Christey, J., Matthews, V., Wright, K., Parmentier, H., Robinson, S., & Godfrey, E. (2004). A client-generated psychometric instrument: The development of ‘PSYCHLOPS.’ *Counselling and Psychotherapy Research*, *4*(2), 27–31. doi.org/10.1080/14733140412331383913

Australian Health Ministers. (1992). *National Mental Health Policy.* Australian Government Publishing Services, Canberra. Department of Health | References

Australian Health Ministers’ Advisory Council. (2003). *National Mental Health Plan, 2003-2008*. Commonwealth of Australia. Department of Health | 1.4 - National Mental Health Plan 2003-2008

Australian Psychological Society. (2007). *Australian Psychological Society: Code of Ethics*. Retrieved from https://www.psychology.org.au/.../APS-Code-of-Ethics.

Australian Association of Social Workers, 2013). Practice Standards Retrieved from http://www.aasw.asn.au/ document/item/4551

Barrett-Lennard, G. T., author. (2015). *The relationship inventory: A complete resource and guide*. Chichester, England : Wiley Blackwell, 2015.

Bech, P., Bille, J., Møller, S. B., Hellström, L. C., & Østergaard, S. D. (2014). Psychometric validation of the Hopkins Symptom Checklist (SCL-90) subscales for depression, anxiety, and interpersonal sensitivity. *Journal of Affective Disorders*, *160*, 98–103. doi.org/10.1016/j.jad.2013.12.00

Beck, A. T., author. (2009). *Depression: Causes and treatment* (Second edition.). Philadelphia, Pennsylvania: University of Pennsylvania Press, 2009. doi-org/ 10.1080/00029157.1974.10403697

Bibb, J., Baker, F. A., & Skewes Mcferran, K. (2016). A critical interpretive synthesis of the most commonly used self-report measures in Australian mental health research. *Australasian Psychiatry*, *24*(5), 453–458. doi.org/10.1177/1039856215626646

Bickman, L. (2008). A measurement feedback system (MFS) is necessary to improve mental health outcomes. *Journal of the American Academy of Child and Adolescent Psychiatry*, *47*(10), 1114. doi:10.1097/CHI.0b013e3181825af8

Bickman, L., Kelley, S. D., Breda, C., de Andrade, A. R., & Riemer, M. (2011). Effects of routine feedback to clinicians on mental health outcomes of youths: Results of a randomized trial. *Psychiatric Services*, *62*(12), 1423–1429. doi: 10.1176/appi.ps.002052011

Binder, P.-E., Holgersen, H., & Nielsen, G. H. stmark. (2010). What is a “good outcome” in psychotherapy? A qualitative exploration of former patients’ point of view. *Psychotherapy Research*, *20*(3), 285–294. doi: 10.1080/10503300903376338

Blackstone, A. (2018). *Principles of sociological inquiry: Qualitative and quantitative methods*. Retrieved from https://2012books.lardbucket.org/books/sociological-inquiry-principles-qualitative-and-quantitative-methods/index.html

Blauw, S. (2020). *The numbers bias: How numbers lead and mislead us.* London: Hodder & Stoughton.

Bloch-Elkouby, S., Eubanks, C. F., Knopf, L., Gorman, B. S., & Muran, J. C. (2019). The Difficult Task of Assessing and Interpreting Treatment Deterioration: An Evidence-Based Case Study. *Frontiers in Psychology*, *10*, 1180. doi.org/10.3389/fpsyg.2019.01180

Blow, A., J. & Karam, E., A. (2017). The Therapist’s Role in Effective Marriage and Family Therapy Practice: The Case for Evidence Based Therapists. Administration and Policy in Mental Health and Mental Health Services Research, 44(5), 716-723. doi: 10.1007/s10488-016-0768-8

Börjesson, S., & Boström, P. K. (2019). “I want to know what it is used for”: Clients’ perspectives on completing a routine outcome measure (ROM) while undergoing sdoi.org/10.1080/10503307.2019.1630780

Boswell, J. F. (2020). Monitoring processes and outcomes in routine clinical practice: A promising approach to plugging the holes of the practice-based evidence colander. *Psychotherapy Research*, *30*(7), 829–842. doi: 10.1080/10503307.2019.1686192

Boswell, J. F., Kraus, D. R., Miller, S. D., & Lambert, M. J. (2013). Implementing routine outcome monitoring in clinical practice: Benefits, challenges, and solutions. *Psychotherapy Research*, 1–14. doi.org/10.1080/10503307.2013.817696

Boswell, J.F., Constantino, M.J., & Kraus, D.R., (2017). Harnessing the Therapist Effect in Patient-Centred Mental Health Care Decision Making. *Adm Policy Mental Health, 44* (5), 724-728. doi:10.1007/s10488-016-0789-3

Boyce, M. B., Browne, J. P., & Greenhalgh, J. (2014). The experiences of professionals with using information from patient-reported outcome measures to improve the quality of healthcare: A systematic review of qualitative research. *BMJ Quality & Safety*, *23*(6), 508–518. doi.org/10.1136/bmjqs-2013-002524

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. doi: 10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2020). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*. doi: 10.1002/capr.12360

Burns, K. E. A., Duffett, M., Kho, M. E., Meade, M. O., Adhikari, N. K. J., Sinuff, T., & Cook, D. J. (2008). A guide for the design and conduct of self-administered surveys of clinicians. *CMAJ : Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne*, *179*(3), 245–252. doi.org/10.1503/cmaj.080372

Cameron, R. (2011). Mixed methods research: The five Ps framework. *Electronic Journal of Business Research Methods*, *9*(2).

Carkhuff, R. (2017). *Toward effective counselling and psychotherapy: Training and practice*. Routledge.

Chung, J., & Buchanan, B. (2019). A Self-Report Survey: Australian Clinicians' Attitudes Towards Progress Monitoring Measures. *Australian Psychologist*, *54*(1), 3–12. doi.org/10.1111/ap.12352

Clayton, G. M., & Black, D. (1992). *Enhancing life & relationships: A role training manual*. Royal Victorian Institute for the Blind. Tertiary Resource/Production Service.

Cohen, S. R., Mount, B. M., Strobel, M. G., & Bui, F. (1995). The McGill Quality of Life Questionnaire: A measure of quality of life appropriate for people with advanced disease. A preliminary study of validity and acceptability. *Palliative Medicine*, *9*(3), 207–219. doi.org/10.1177/026921639500900306

Cooper, M. (2008). *Essential research findings in counselling and psychotherapy the facts are friendly*. Los Angeles. Sage publications.

Cozolino, L. (2017). The neuroscience of psychotherapy: Healing the social brain (Third ed., Norton series on interpersonal neurobiology). WW Norton & Company.

Cox, J. L., Chapman, G., Murray, D., & Jones, P. (1996). Validation of the Edinburgh Postnatal Depression Scale (EPDS) in non-postnatal women. *Journal of Affective Disorders*, *39*(3), 185–189. doi: 10.1016/0165-0327(96)00008-0

Crago, H. (2000). Counselling and psychotherapy: Is there a difference? Does it matter? *Australian and New Zealand Journal of Family Therapy*, *21*(2), 73–80. doi.org/10.1002/j.1467-8438. 2000.tb00418.x

Crago, Hugh. (2011). Straight talk on training: Training for a relational art. Psychotherapy in Australia, 17(3), 30-31.

Creswell, J. W., & Clark, V. L. P. (2017). *Designing and conducting mixed methods research*. Sage publications.

Crown, S., & Crisp, A. (1966). A short clinical diagnostic self-rating scale for psychoneurotic patients: The Middlesex Hospital Questionnaire (MHQ). *The British Journal of Psychiatry*, *112*(490), 917–923. doi: 10.1192/bjp.112.490.917

Cummings, A. L., Hallberg, E. T., Slemon, A., & Martin, J. (1992). Participants' memories for therapeutic events and ratings of session effectiveness. *Journal of Cognitive Psychotherapy*, *6*(2), 113–124. doi:10.1891/0889-8391.6.2.113

De Smet, M. M., Meganck, R., Van Nieuwenhove, K., Truijens, F. L., & Desmet, M. (2019a). No Change? A Grounded Theory Analysis of Depressed Patients' Perspectives on Non-improvement in Psychotherapy. *Frontiers in Psychology*, *10*, 588–588. doi.org/10.3389/fpsyg.2019.00588

De Smet, M. M., Meganck, R., Van Nieuwenhove, K., Truijens, F. L., & Desmet, M. (2019b). No Change? A Grounded Theory Analysis of Depressed Patients' Perspectives on Non-improvement in Psychotherapy. *Frontiers in Psychology*, *10*, 588–588. doi.org/10.3389/fpsyg.2019.00588

De Vaus, D. (2016). Survey research. In T Greenfield & S Greener (Eds.),*Research Methods for Postgraduates*, 202–213.

Deacon, R. M., Mammen, K., Bruno, R., Mills, L., Dunlop, A., Holmes, J., Jefferies, M., Hall, M., Shakeshaft, A., & Farrell, M. (2021). Assessing the concurrent validity, inter-rater reliability and test–re-test reliability of the Australian Treatment Outcomes Profile (ATOP) in alcohol and opioid treatment populations. *Addiction*, *116*(5), 1245–1255. doi: 10.1111/add.15331

Di Malta, G., Evans, C., & Cooper, M. (2019). Development and validation of the relational depth frequency scale. *Psychotherapy Research*, 1–15. doi.org/10.1080/10503307.2019.1585590

Dillman, D. A. (2011). *Mail and Internet surveys: The tailored design method—2007 Update with new Internet, visual, and mixed-mode guide*. John Wiley & Sons.

Dozois, D., Mikail, S., Alden, L., Bieling, P., Bourgon, G., Clark, D., Drapeau, M., Gallson, D., Greenberg, L., Hunsley, J., & Johnston, C. (2014). The CPA Presidential Task Force on Evidence-Based Practice of Psychological Treatments. *Canadian Psychology*, *55*(3), 153–160. doi.org/10.1037/a0035767

Drisko, J. W. (2004). Common factors in psychotherapy outcome: Meta-analytic findings and their implications for practice and research. *Families in Society*, *85*(1), 81–90. doi.org/10.1606%2F1044-3894.239

Duncan, B. L., Miller, S. D., & Sparks, J. A. (2011). *The heroic client: A revolutionary way to improve effectiveness through client-directed, outcome-informed therapy*. John Wiley & Sons.

Duncan, B. L., & Sparks, J. A. (2020). When meta-analysis misleads: A critical case study of a meta-analysis of client feedback. *Psychological Services*, *17*(4), 487. doi.org/10.1037/ser0000398

Elkins, D. N. (2009). The medical model in psychotherapy: Its limitations and failures. *Journal of Humanistic Psychology*, *49*(1), 66-84. DOI: 10.1177/0022167807307901

Elliott, R. (1999). Client change interview protocol. *Network for Research on Experiential Therapies*. doi: 10.1111/cpsp.12162

Elliott, R, Mack, C., & Shapiro, D. (1999). Simplified personal questionnaire procedure. *Network for Research on Experiential Psychotherapies Website:< Http://Experiential-Researchers. Org/Instruments/Elliott/Pqprocedure. Html*.

Elliott, R. (1986). *Interpersonal Process Recall (IPR) as a psychotherapy process research method* In L. S. Greenberg & W. M. Pinsof (Eds.), *Guilford clinical psychology and psychotherapy series. The psychotherapeutic process: A research handbook* (p. 503–527). Guilford Press.

Elliott, R. (2002). Render unto Caesar: Quantitative and qualitative knowing in research on humanistic therapies / Gebt dem Kaiser, was des Kaisers ist: Quantitatives and qualitatives Wissen in der Forschung zu Humanistischen Therapien / Dar al César lo

que es del César: Saber Cuantitativo y Cualitativo en la Investigación en Terapias Humanisticas. *Person-Centered & Experiential Psychotherapies*, *1*(1–2), 102–117. doi.org/10.1080/14779757.2002.9688281

Elliott, R., & Shapiro, D. A. (1988). Brief structured recall: A more efficient method for studying significant therapy events. *British Journal of Medical Psychology*, *61*(2), 141–153. doi.org/10.1111/j.2044-8341.1988.tb02773.x

Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on psychotherapy: Alternative strategies. *Psychological Test and Assessment Modeling*, *43*(3), 69-111.

Elliott, R., Wagner, J., Sales, C., Rodgers, B., Alves, P., & Café, M. J. (2016). Psychometrics of the Personal Questionnaire: A client-generated outcome measure. *Psychological Assessment*, *28*(3), 263-278. doi: 10.1037/pas0000174

Endicott, J., Spitzer, R. L., Fleiss, J. L., & Cohen, J. (1976). The Global Assessment Scale: A procedure for measuring overall severity of psychiatric disturbance. *Archives of General Psychiatry*, *33*(6), 766–771. doi:10.1001/archpsyc.1976.01770060086012

Errázuriz, P., & Zilcha-Mano, S. (2018). In psychotherapy with severe patients discouraging news may be worse than no news: The impact of providing feedback to therapists on psychotherapy outcome, session attendance, and the alliance. *Journal of Consulting and Clinical Psychology*, *86*(2), 125-139. doi.org/10.1037/ccp0000277

Eysenck, H. J. (2013). The outcome problem in psychotherapy: A reply. *Psychotherapy (Chicago, Ill.)*, *50*(1), 12-4: discussion 15. doi.org/10.1037/h0094490

Field, T. A. (2014). Integrating Left-Brain and Right-Brain: The Neuroscience of Effective Counseling. *Professional Counsellor*, *4*(1) 19-27. doi: 10.15241/taf.4.1.19

Finlay, L. (2011). *Phenomenology for Therapists Researching the Lived World*. Hoboken: Wiley. doi: 10.2989/IPJP.2013.13.1.8.1174

Friedlander, M., Haetherington, L., Constantino, M., Messer, S., Kortz, L., & Shaffer, K. (2011). *What's therapy got to do with it? Clients' explanations of corrective change*. 42nd Meeting of the Society for Psychotherapy Research, Bern, Switzerland. doi: 10.1111/cpsp.12162

Fugard, A. (2015). *The ethics of national routine outcome monitoring policies; a case for taking action*. Clinical Psychology Forum *267*, 11–15.

Garland, A., Kruse, M., & Aarons, G. (2003). Clinicians and outcome measurement: What's the use? *The Journal of Behavioral Health Services & Research*, *30*(4), 393–405. doi.org/10.1007/BF02287427

Gershefski, J., Arnkoff, D., Glass, C., & Elkin, I. (1996). Clients' perceptions of treatment for depression: I. Helpful aspects. *Psychotherapy Research*, *6*(4), 233–247. doi.org/10.1080/10503309612331331768

Gill, F. J., Leslie, G. D., Grech, C., & Latour, J. M. (2013). Using a web-based survey tool to undertake a Delphi study: Application for nurse education research. *Nurse Education Today*, *33*(11), 1322–1328. doi.org/10.1016/j.nedt.2013.02.016

Gleacher, A. A., Olin, S. S., Nadeem, E., Pollock, M., Ringle, V., Bickman, L., Douglas, S., & Hoagwood, K. (2016). Implementing a measurement feedback system in community mental health clinics: A case study of multilevel barriers and facilitators. *Administration and Policy in Mental Health and Mental Health Services Research*, *43*(3), 426–440. doi.org/10.1007/s10488-015-0642-0

Gossop, M., Best, D., Marsden, J., & Strang, J. (1997). *Test-retest reliability of the Severity of Dependence Scale* Mar:92(3):353. *https://psycnet.apa.org/doi/10.1111/j.1360-0443.1997.tb03205.x*

Greenberg, L. S., James, P. S., & Conry, R. F. (1988). Perceived change processes in emotionally focused couples therapy. *Journal of Family Psychology*, *2*(1), 5-23. https://psycnet.apa.org/doi/10.1037/h0080484

Gross, N. (2018). Pragmatism and the study of large-scale social phenomena. *Theory and Society*, *47*(1), 87–111. doi.org/10.1007/s11186-018-9307-9

Hannan, C., Lambert, M. J., Harmon, C., Nielsen, S. L., Smart, D. W., Shimokawa, K., & Sutton, S. W. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology*, *61*(2), 155–163. doi.org/10.1002/jclp.20108

Hansen, J. (2006). Is the Best Practices Movement Consistent With the Values of the Counseling Profession? A Critical Analysis of Best Practices Ideology. *Counseling and Values*, *50*(2), 154–160. doi.org/10.1002/j.2161-007X.2006.tb00051.x

Hatfield, D., & Ogles, B. (2007). Why Some Clinicians Use Outcome Measures and Others Do Not. *Administration and Policy in Mental Health and Mental Health Services Research*, *34*(3), 283–291. doi.org/10.1007/s10488-006-0110-y

Hatfield, D. R., & Ogles, B. M. (2004). The use of outcome measures by psychologists in clinical practice. *Professional Psychology, Research and Practice*, *35*(5), 485-491. doi.org/10.1037/0735-7028.35.5.485

Hatfield, D. R., & Ogles, B. M. (2006). The influence of outcome measures in assessing client change and treatment decisions. *Journal of Clinical Psychology*, *62*(3), 325–337. doi.org/10.1002/jclp.20235

Hill, C. E., Chui, H., & Baumann, E. (2013a). Revisiting and reenvisioning the outcome problem in psychotherapy: An argument to include individualized and qualitative measurement. *Psychotherapy (Chicago, Ill.)*, *50*(1), 68-76. doi.org/10.1037/a0030571

Hill, C. E., Chui, H., & Baumann, E. (2013b). Revisiting and reenvisioning the outcome problem in psychotherapy: An argument to include individualized and qualitative measurement. *Psychotherapy (Chicago, Ill.)*, *50*(1), 68. doi.org/10.1037/a0030571

Horvath, A. O. (2013a). You Can't Step Into the Same River Twice, but You Can Stub Your Toes on the Same Rock: Psychotherapy Outcome From a 50-Year Perspective. *Psychotherapy (Chicago, Ill.)*, *50*(1), 25–32. doi.org/10.1037/a0030899

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, *36*(2), 223-233. https://psycnet.apa.org/doi/10.1037/0022-0167.36.2.223

Ionita, G., Ciquier, G., & Fitzpatrick, M. (2020). Barriers and facilitators to the use of progress-monitoring measures in psychotherapy. *Canadian Psychology/Psychologie Canadienne*.61(3). 245-256. https://psycnet.apa.org/doi/10.1037/cap0000205

Ionita, G., & Fitzpatrick, M. (2014). Bringing Science to Clinical Practice: A Canadian Survey of Psychological Practice and Usage of Progress Monitoring Measures. *Canadian Psychology*, *55*(3), 187–196. doi.org/10.1037/a0037355

Janse, P. D., De Jong, K., Van Dijk, M. K., Hutschemaekers, G. J., & Verbraak, M. J. (2017). Improving the efficiency of cognitive-behavioural therapy by using formal client feedback. *Psychotherapy Research*, *27*(5), 525–538. doi.org/10.1080/10503307.2016.1152408

Jensen-Doss, A., Haimes, E. M. B., Smith, A. M., Lyon, A. R., Lewis, C. C., Stanick, C. F., & Hawley, K. M. (2018). Monitoring Treatment Progress and Providing Feedback is Viewed Favorably but Rarely Used in Practice. *Administration and Policy in Mental Health*, *45*(1), 48–61. doi.org/10.1007/s10488-016-0763-0

Jensen-Doss, A., & Hawley, K. M. (2010). Understanding Barriers to Evidence-Based Assessment: Clinician Attitudes Toward Standardized Assessment Tools. *Journal of*

Clinical Child & Adolescent Psychology, *39*(6), 885–896. doi.org/10.1080/15374416.2010.517169

Jones, T., Baxter, M., & Khanduja, V. (2013). A quick guide to survey research. *The Annals of The Royal College of Surgeons of England*, *95*(1), 5–7. doi.org/10.1308/003588414X13824511649454

Kaiser, T., Schmutzhart, L., & Laireiter, A.-R. (2018). Attitudes of Austrian psychotherapists towards process and outcome monitoring. *Administration and Policy in Mental Health and Mental Health Services Research*, *45*(5), 765–779. doi.org/10.1007/s10488-018-0862-1

Kazdin, A. E. (2014). Evidence-based psychotherapies I: Qualifiers and limitations in what we know. *South African Journal of Psychology*, *44*(4), 381–403. doi.org/10.1177%2F0081246314533750

Kendrick, T., El-Gohary, M., Stuart, B., Gilbody, S., Churchill, R., Aiken, L., Bhattacharya, A., Gimson, A., Brütt, A. L., de Jong, K., & Moore, M. (2016). Routine use of patient reported outcome measures (PROMs) for improving treatment of common mental health disorders in adults. *The Cochrane Database of Systematic Reviews*, *7*(7), CD011119–CD011119. doi.org/10.1002/14651858.CD011119.pub2

Kilbourne, A. M., Beck, K., Spaeth-Rublee, B., Ramanuj, P., O'Brien, R. W., Tomoyasu, N., & Pincus, H. A. (2018). Measuring and improving the quality of mental health care: A global perspective. *World Psychiatry*, *17*(1), 30–38. doi.org/10.1002/wps.20482

Kiresuk, T. J., & Sherman, R. E. (1968). Goal attainment scaling: A general method for evaluating comprehensive community mental health programs. *Community Mental Health Journal*, *4*(6), 443–453. doi.org/10.1007/BF01530764

Klein, M. H., Mathieu-Coughlan, P., & Kiesler, D. J. (1986). The experiencing scales. L.S. Greenberg & W.M. Pinsoff (Eds).In *The Psychotherapeutic Process: A Research Handbook*, *21*, 71.

Klundt, J. (2014). *Are Therapists Using Outcome Measures and Does It Matter? A Naturalistic Usage Study*. Theses and Dissertations. 4028. https://scholarsarchive.byu.edu/etd/4028

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, *16*(9), 606–613. doi.org/10.1046/j.1525-1497.2001.016009606.x

Kwan, B., Rickwood, D. J., & Brown, P. M. (2021). Factors affecting the implementation of an outcome measurement feedback system in youth mental health settings. *Psychotherapy Research*, *31*(2), 171–183. doi.org/10.1080/10503307.2020.1829738

Kwiatkowski, R. (1998). Counselling and psychotherapy: Are they different and should we care? *Counselling Psychology Quarterly*, *11*(1), 5–14. doi.org/10.1080/09515079808254038

Lambert, M. J., Burlingame, G. M., Umphress, V., Hansen, N. B., Vermeersch, D. A., Clouse, G. C., & Yanchar, S. C. (1996). The reliability and validity of the Outcome Questionnaire. *Clinical Psychology & Psychotherapy: An International Journal of Theory and Practice*, *3*(4), 249–258. doi.org/10.1002/(SICI)1099-0879(199612)3:4%3C249::AID-CPP106%3E3.0.CO;2-S

Lambert, M. J., & Harmon, K. L. (2018). The merits of implementing routine outcome monitoring in clinical practice. *Clinical Psychology (New York, N.Y.)*, *25*(4). doi.org/10.1111/cpsp.12268

Lambert, M., & Shimokawa, K. (2011). Collecting client feedback. *Psychotherapy: Theory/Research/Practice/Training*, *48*(1), 72–79. https://doi.org/10.1037/a0022238

Leech, N. L., & Onwuegbuzie, A. J. (2011). Beyond constant comparison qualitative data analysis: Using NVivo. *School Psychology Quarterly*, *26*(1), 70-84. https://psycnet.apa.org/doi/10.1037/a0022711

Leibert, T. W., Powell, R. N., & Fonseca, F. D. (2020). Client descriptions of outcomes compared with quantitative data: A mixed-methods investigation of a quantitative outcome measure. *Counselling and Psychotherapy Research*, *20*(1), 9–18. doi.org/10.1002/capr.12260

Levitt, H. M., Stanley, C. M., Frankel, Z., & Raina, K. (2005). An Evaluation of Outcome Measures Used in Humanistic Psychotherapy Research: Using Thermometers to Weigh Oranges. *The Humanistic Psychologist*, *33*(2), 113–130. doi.org/10.1207/s15473333thp3302_3

Lloyd, A. S. (2015). *Mental Health for the Everyman: World War II's impact on American psychology*. History Undergraduate Theses.20. https://digitalcommons.tacoma.uw.edu/history theses/20

Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy*, *33*(3), 335–343. doi.org/10.1016/0005-7967(94)00075-U

Mackeith, J. (2014). Assessing the reliability of the Outcomes Star in research and practice. *Housing, Care and Support*. doi.org/10.1108/HCS-11-2014-0027

Mackrill, T. (2007). Using a cross-contextual qualitative diary design to explore client experiences of psychotherapy. *Counselling and Psychotherapy Research*, *7*(4), 233–239. doi.org/10.1080/14733140701722455

McGilchrist, I. (2009). The master and his emissary: The divided brain and the making of the western world. Yale University Press. doi.org/: 10.1162/JINH_r_00158

Mcleod, J. (2001). An administratively created reality: Some problems with the use of self-report questionnaire measures of adjustment in counselling/psychotherapy outcome research. *Counselling and Psychotherapy Research*, *1*(3), 215–226. doi.org/10.1080/14733140112331385100

Miller, S. D., & Duncan, B. L. (2004). *The outcome and session rating scales: Administration and scoring manual*. Institute of the Study of Therapeutic Change, Chicago, Il.

Miller, S. D., Hubble, M. A., Chow, D., & Seidel, J. (2015). Beyond measures and monitoring: Realizing the potential of feedback-informed treatment. *Psychotherapy (Chicago, Ill.)*, *52*(4), 449–457. doi.org/10.1037/pst0000031

Moltu, C., Stefansen, J., Nøtnes, J. C., Skjølberg, Å., & Veseth, M. (2017). What are "good outcomes" in public mental health settings? A qualitative exploration of clients' and therapists' experiences. *International Journal of Mental Health Systems*, *11*(1), 12–12. doi.org/10.1186/s13033-017-0119-5

Moore, T. V. (1933). The essential psychoses and their fundamental syndromes. *Studies in Psychology & Psychiatry*.3 (3).128

Moulding, Richard, Nedeljkovic, Maja, & King, Ross. (2020). Cognitive-Behaviour Therapy and Psychological Treatments in Australia. Australian Psychologist, 55(6), 590 -597. doi.org/10.1111/ap. 12358

Moreno, J. K., Fuhriman, A., & Hileman, E. (1995). Significant events in a psychodynamic psychotherapy group for eating disorders. *Group*, *19*(1), 56–62. doi.org/10.1007/BF01458191

Morgan, D. L. (2014). Pragmatism as a paradigm for mixed methods research. *Integrating Qualitative and Quantitative Methods*, *55*, 25–44. https://dx.doi.org/10.4135/9781544304533.n2

Morstyn, R. (2010). How the Philosophy of Merleau-Ponty Can Help Us Understand the Gulf Between Clinical Experience and the Doctrine of Evidence-Based Psychotherapy. *Australasian Psychiatry*, *18*(3), 221–225. doi.org/10.3109/10398561003686789

Morstyn, R. (2011). Dangerous "Spin": The Probability Myth of Evidence-Based Prescribing – a Merleau-Pontyian Approach. *Australasian Psychiatry*, *19*(4), 295–300. doi.org/10.3109/10398562.2011.603333

Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. *Self and Identity*, *2*(3), 223–250. doi.org/10.1080/15298860309027

Noll, R., DeYoung, C. G., & Kendler, K. S. (2017). Thomas Verner Moore. *The American Journal of Psychiatry*, *174*(8), 729–730. doi.org/10.1176/appi.ajp.2017.17030248

Norcross, J. C., & Lambert, M. J. (2018). Psychotherapy relationships that work III. *Psychotherapy (Chicago, Ill.)*, *55*(4), 303-315. doi.org/10.1037/pst0000193

Norman, S., Dean, S., Hansford, L., & Ford, T. (2014). Clinical practitioner's attitudes towards the use of Routine Outcome Monitoring within Child and Adolescent Mental Health Services: A qualitative study of two Child and Adolescent Mental Health Services. *Clinical Child Psychology and Psychiatry*, *19*(4), 576–595. doi.org/10.1177/1359104513492348

Østergård, O. K., & Hougaard, E. (2020). *The evidence for the partners for change outcome management system is insufficient: Reply to Duncan and Sparks (2020). Psychological Services, 17 (4), 497-498. https://psycnet.apa.org/doi/10.1037/ser0000419*

Østergård, O. K., & Hougaard, E. (2020). The Effect of Implementing the Partners for Change Outcome Management System in a Nationwide Student Counseling Service. *Journal of Counselling Psychology, 67*(1), 90d-103. doi: 10.1037/cou0000353

Overall, J. E., & Gorham, D. R. (1962). The Brief Psychiatric Rating Scale. *Psychological Reports*, *10*(3), 799–812. doi.org/10.2466/pr0.1962.10.3.799

Overington, L., Fitzpatrick, M., Hunsley, J., & Drapeau, M. (2015). Trainees' experiences using progress monitoring measures. *Training and Education in Professional Psychology*, *9*(3), 202-209. https://psycnet.apa.org/doi/10.1037/tep0000088

Paz, Clara, Adana-Díaz, Lila, and Evans, Chris (2020). "Clients with Different Problems Are Different and Questionnaires Are Not Blood Tests: A Template Analysis of Psychiatric and Psychotherapy Clients' Experiences of the CORE-OM." *Counselling and Psychotherapy Research* 20(2) 274-83. doi: 10.1002/capr.12290

Pejtersen, J. H., Viinholt, B. C. A., & Hansen, H. (2020). Feedback-informed treatment: A systematic review and meta-analysis of the partners for change outcome management system. *Journal of counselling psychology*.67 (6), 723-735. doi: 10.1037/cou0000420

Porges, S. W., & Dana, D. (2018). *Clinical applications of the polyvagal theory: The emergence of polyvagal-informed therapies (Norton Series on Interpersonal Neurobiology)*. WW Norton & Company.

Psychotherapy and Counselling Federation of Australia (2019). *Evidence-informed practice statement*. Melbourne, Australia: Author. Retrieved from https://portal.pacfa.org.au/Portal/Publications-and-Research/EI-Prac-Stmnt.aspx?WebsiteKey=663df354-bb4c-40db-9f44-9f1e672224ed

Posavac, E. J. (2015). *Program evaluation: Methods and case studies*. Routledge.

Prescott, D. S., Maeschalck, C. L., & Miller, S. D. (2017). *Feedback-informed treatment in clinical practice: Reaching for excellence*. American Psychological Association Washington, DC. https://psycnet.apa.org/doi/10.1037/0000039-002

Rodgers, B. (2017). The trouble with numbers: Some fundamental flaws with using standardised outcome measures. *Psychotherapy and Politics International*, *15*(3), n/a-n/a. doi.org/10.1002/ppi.1423

Rodgers, B., & Elliott, R. (2015). Qualitative methods in psychotherapy outcome research. In *Psychotherapy research: Foundations, process and outcome* (pp. 559–578). Springer - Verlag Publishing. doi: 10.1007/978-3-7091-1382-0_27

Rollnick, S., Heather, N., Gold, R., & Hall, W. (1992). Development of a short 'readiness to change'questionnaire for use in brief, opportunistic interventions among excessive drinkers. *British Journal of Addiction*, *87*(5), 743–754. doi.org/10.1111/j.1360-0443.1992.tb02720.x

Romine, K. (2018). *Deference in psychotherapy influences how clients complete outcome measures.* (Doctoral dissertation, PACIFIC UNIVERSITY).

Rosen, A., Hadzi-Pavlovic, D., & Parker, G. (1989). The life skills profile: A measure assessing function and disability in schizophrenia. *Schizophrenia Bulletin*, *15*(2), 325–337. doi.org/10.1093/schbul/15.2.325

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry*, *6*(3), 412-415. https://psycnet.apa.org/doi/10.1111/j.1939-0025.1936.tb05248.x

Rustin, M. (2015) Psychotherapy in a neoliberal world, European Journal of Psychotherapy & Counselling, 17:3, 225-239, doi.org/: 10.1080/13642537.2015.1059869

Ryan, G. (2018). Introduction to positivism, interpretivism and critical theory. *Nurse Researcher*, *25*(4), 14–20. doi.org/10.7748/nr.2018.e1466

Rye, M., Rognmo, K., Aarons, G. A., & Skre, I. (2019). Attitudes Towards the Use of Routine Outcome Monitoring of Psychological Therapies Among Mental Health Providers: The EBPAS–ROM. *Administration and Policy in Mental Health and Mental Health Services Research*, *46*(6), 833–846. doi.org/10.1007/s10488-019-00968-5

Sales, C., & Alves, P. C. (2012). Individualized patient-progress systems: Why we need to move towards a personalized evaluation of psychological treatments. *Canadian Psychology/Psychologie Canadienne*, *53*(2), 115-121. https://psycnet.apa.org/doi/10.1037/a0028053

Sales, C. M. D., & Alves, P. C. G. (2016). Patient-Centered Assessment in Psychotherapy: A Review of Individualized Tools. *Clinical Psychology: Science and Practice*, *23*(3), 265–283. doi.org/10.1111/cpsp.12162

Sapyta, J., Riemer, M., & Bickman, L. (2005). Feedback to clinicians: Theory, research, and practice. *Journal of Clinical Psychology*, *61*(2), 145–153. doi.org/10.1002/jclp.20107

Saunders, J. B., Aasland, O. G., Babor, T. F., De La Fuente, J. R., & Grant, M. (1993). Development of the alcohol use disorders identification test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption-II. *Addiction*, *88*(6), 791–804. doi.org/10.1111/j.1360-0443.1993.tb02093.x

Schore, A. N. (2012). *The science of the art of psychotherapy (Norton series on interpersonal neurobiology)*. WW Norton & Company.

Shapiro, D. A., & Shapiro, D. (1982). Meta-analysis of comparative therapy outcome studies: A replication and refinement. *Psychological Bulletin*, *92*(3), 581-604. https://psycnet.apa.org/doi/10.1037/0033-2909.92.3.581

Sharples, E., Qin, C., Goveas, V., Gondek, D., Deighton, J., Wolpert, M., & Edbrooke-Childs, J. (2017a). A qualitative exploration of attitudes towards the use of outcome

measures in child and adolescent mental health services. *Clinical Child Psychology and Psychiatry*, *22*(2), 219–228. doi.org/10.1177/1359104516652929

Siegel, D. J. (2010). The mindful therapist: A clinician's guide to mindsight and neural integration. Norton

Smith, J. A. (2009). *Interpretative phenomenological analysis: Theory, method and research*. SAGE. https://psycnet.apa.org/doi/10.1037/13620-005

Solstad, S. M., Castonguay, L. G., & Moltu, C. (2019). Patients' experiences with routine outcome monitoring and clinical feedback systems: A systematic review and synthesis of qualitative empirical literature. Psychotherapy Research, 29(2), 157-170. doi: 10.1080/10503307.2017.1326645

Sperry, L. (2016). *Subjective Units of Distress Scale SUDS*. 1107–1108 in Mental Health and Mental Disorders: An Encyclopedia of Conditions, Treatments and Wellbeing.

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, *166*(10), 1092–1097. doi:10.1001/archinte.166.10.1092

Stänicke, E., & McLeod, J. (2021). Paradoxical outcomes in psychotherapy: Theoretical perspectives, research agenda and practice implications. *European Journal of Psychotherapy & Counselling*, 1-24. doi.org/10.1080/13642537.2021.1923050

Stasiak, K., Parkin, A., Seymour, F., Lambie, I., Crengle, S., Pasene-Mizziebo, E., & Merry, S. (2013). Measuring outcome in child and adolescent mental health services: Consumers' views of measures. *Clinical Child Psychology and Psychiatry*, *18*(4), 519–535. doi.org/10.1177/1359104512460860

Strupp, H. H. (2013). The outcome problem in psychotherapy revisited. 1963. *Psychotherapy (Chicago, Ill.)*, *50*(1), 3–11. https://psycnet.apa.org/doi/10.1037/h0088591

Strupp, H. H., Wallach, M. S., & Wogan, M. (1964). Psychotherapy experience in retrospect: Questionnaire survey of former patients and their therapists. *Psychological Monographs: General and Applied*, *78*(11), 1. https://psycnet.apa.org/doi/10.1037/h0093869

Suh, C. S., Strupp, H. H., & O'Malley, S. S. (1986). *The Vanderbilt process measures: The Psychotherapy Process Scale (VPPS) and the Negative Indicators Scale (VNIS).*In L.S. Greenberg & W.M Pinsof (Eds). *The psychotherapeutic process: A research handbook* (pp.285-323). Guildford Press

Swift, J., & Callahan, J. (2009). Early psychotherapy processes: An examination of client and trainee clinician perspective convergence. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, *16*(3), 228–236. doi.org/10.1002/cpp.617

Trauer, T., Gill, L., Pedwell, G., & Slattery, P. (2006). Routine outcome measurement in public mental health—What do clinicians think? *Australian Health Review*, *30*(2), 144–147. doi.org/10.1071/AH060144

Truijens, F. L., Desmet, M., De Coster, E., Uyttenhove, H., Deeren, B., & Meganck, R. (2019). When quantitative measures become a qualitative storybook: A phenomenological case analysis of validity and performativity of questionnaire administration in psychotherapy research. *Qualitative Research in Psychology*, 1–44. doi.org/10.1080/14780887.2019.1579287

Truijens, F. L., & Truijens, F. L. (2017). Do the numbers speak for themselves? A critical analysis of procedural objectivity in psychotherapeutic efficacy research. *Synthese (Dordrecht)*, *194*(12), 4721–4740. doi.org/10.1007/s11229-016-1188-8

Villatte, J. L., Vilardaga, R., Villatte, M., Vilardaga, J. C. P., Atkins, D. C., & Hayes, S. C. (2016). Acceptance and Commitment Therapy modules: Differential impact on

treatment processes bias in mental health providers. *Psychological Reports*, *110*(2), 639–644. doi.org/10.2466%2F02.07.17.PR0.110.2.639-644

Walton, B. A., & Kim, H.-W. (2019). *Co-occurring Substance Use and Mental Health Needs: Enhancing the Adult Needs and Strengths Assessment (ANSA) to Manage Services*. Presentation at the 15th Annual TCOM Conference. Palm Springs, CA.

Wampold, B. E. (2013). The good, the bad, and the ugly: A 50-year perspective on the outcome problem. *Psychotherapy (Chicago, Ill.)*, *50*(1), 16–24. doi.org/10.1037/a0030570

Wampold, B. E. (2015). Routine Outcome Monitoring: Coming of Age-With the Usual Developmental Ch allenges. *Psychotherapy (Chicago, Ill.)*, *52*(4), 458–462. doi.org/10.1037/pst0000037

Wampold, B. E., 1948- author. (2019). *The basics of psychotherapy: An introduction to theory and practice* (Second edition.). Washington, District of Columbia : American Psychological Association, 2019. https://psycnet.apa.org/doi/10.1037/0000117-000

Wampold, B.E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work* (2nd ed.). New York: Routledge. doi: 10.4324/9780203582015

Waskow, I. E., & Parloff, M. B. (1975). *Psychotherapy, change, measures: Report* (Vol. 74). National Institute of Mental Health.

Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). The ptsd checklist for dsm-5 (pcl-5). *Scale Available from the National Center for PTSD at Www. Ptsd. va. Gov*, *10*.

Willis, A., Deane, F. P., & Coombs, T. (2009). Improving clinicians’ attitudes toward providing feedback on routine outcome assessments. *International Journal of Mental Health Nursing*, *18*(3), 211–215. doi.org/10.1111/j.1447-0349.2009.00596.x

Wing, J., Beevor, A., Curtis, R., Park, S., Hadden, J., & Burns, A. (1998). Health of the nation outcome scales (HoNOS). *The British Journal of Psychiatry*, *172*(1), 11–18. doi:10.1192/bjp.172.1.11

Wiseman, H., & Rice, L. N. (1989). Sequential analyses of therapist-client interaction during change events: A task-focused approach. *Journal of Consulting and Clinical Psychology*, *57*(2), 281-286. https://psycnet.apa.org/doi/10.1037/0022-006X.57.2.281

Worboys, M. (2013). The Hamilton Rating Scale for Depression: The making of a "gold standard" and the unmaking of a chronic illness, 1960–1980. *Chronic Illness*, *9*(3), 202–219. doi.org/10.1177/1742395312467658

World Health Organization. (2000). *World Health Organization disabilty assessment schedule: WHODAS II. Phase 2 field trials. Health services research*.

Yalom, V., & Bugental, J. F. T. (1997). Support in existential-humanistic psychotherapy. *Journal of Psychotherapy Integration*, *7*(2), 119–128. doi.org/10.1037/h0101140

Yates, C. (2013). Evidence-Based Practice: The Components, History, and Process. *Counseling Outcome Research and Evaluation*, *4*(1), 41–54. doi.org/10.1177/2150137812472193

Appendix A: Recruitment Material

1) Example of email to send to counselling organizations.

Dear Manager/Coordinator/Director of Counselling services,

I hope this this email finds you well. I want to let you know about some research I am conducting on the topic of **outcome measure usage** in counselling which I would like to invite you and/or your staff to participate in.

I am a second year Master of Research Student with Western Sydney University (School of Social Sciences), and a highly experienced clinician, with over twenty years of counselling experience. I have two supervisors overseeing the research and have included their contact details below.

The research topic stems primarily from my clinical experience with the complex nature of evaluation in counselling. An extensive review of the literature reveals that little is known about outcome measure usage trends amongst clinicians in Australia (including types used, frequency of use and motivation for using). My research seeks to help fill that gap and in addition, elicit information about clinicians' attitudes towards using measures.

Therefore, I am conducting a cross-disciplinary study, involving counsellors, psychologists, psychotherapists, and social workers by way of a **brief online survey**. It is expected that this anonymous survey will take 5-10 minutes to complete. To be eligible, participants must 1) identify as a counsellor, psychologist, psychotherapist, or social worker, 2) currently reside in NSW, and 3) provide counselling to adults (18+).

It would be great if you would circulate an invitation to participate to relevant staff or colleagues. The survey is open until 28th February 2021. The link to the survey, which includes further information about the project can be found here:

This project has Western Sydney University HREC ethics approval H14080.
If you have any further questions, please do not hesitate to contact me.

Kind regards,

Carmel Hamilton

C.Hamilton@westernsydney.edu.au
P.Gardner@westernsydney.edu.au - Principal supervisor
A.Webb2@westernsydney.edu.au - Supervisor

2) Example of Facebook Advertisement.

Attention all **clinicians currently providing counselling** to adults (18+) in NSW.

I am seeking VOLUNTEERS to participate in a RESEARCH STUDY looking at OUTCOME MEASURE USAGE for the purpose of evaluation in counselling in NSW.

If you are a COUNSELLOR, PSYCHOLOGIST, PSYCHOTHERAPIST or SOCIAL WORKER and currently providing counselling to adults (18+), I would love to hear from you.

By participating, you will be contributing to our understanding of this important aspect of counselling

This study has Ethics Approval from Western Sydney University. H14080

See here for further information, including link to study.

Appendix B: Project Summary and Information Sheet

Counsellors and Outcome Measures: Usage Trends, Familiarity and Attitudes - A NSW Pilot Study

Project Summary and Participant Information Sheet

Thank you for considering being a part of this research study.

You are eligible to participate if you are:

1) a counsellor, psychotherapist, social worker or psychologist

and

2) currently providing counselling to adults (18+) in NSW.

If you meet these criteria, it would be great to hear from you.

Please read on for information about the project, and what is involved for you, should you choose to participate.

Project Title

Counsellors and Outcome Measures: Usage Trends, Attitudes and Familiarity – A NSW Pilot Study.

Project Team

Carmel Hamilton –Student Investigator, Masters of Research (2nd year). School of Social Sciences, Western Sydney University.

Penelope Gardner - Principal Supervisor.

Amanda Webb - Supervisor.

Please see below for contact details.

Project Summary

This project aims to gather current information pertaining to Outcome Measure Usage trends amongst counsellors in NSW. It also aims to assess clinicians' familiarity with different types of measures, and to uncover clinicians' attitudes towards outcome measure usage in the evaluation of counselling.

What will I be asked to do?

You are being asked to complete a short online survey about outcome measures. All information you provide is anonymous.

Definition of outcome measures (for purpose of this survey)

For the purpose of this survey, *outcome measures* refer to both the standardized outcome measures used primarily for evaluation purposes - and routine outcome monitoring measures. Some common examples of measures include DASS, K10 and Quality of Life Questionnaire, Outcome Rating Scale (ORS), Session Rating Scale (SRS) and the Outcome Questionnaire (OQ45).

How much of my time will I need to give?

The survey comprises 19 questions, most of which are multiple choice. Two questions invite you to provide a written response in a text box. The survey is likely to take 10 – 20 minutes

to complete, depending on how much you write in the text box. You have the option of omitting questions.

Rationale for project

Evaluation is an integral aspect of counselling - from an ethical perspective, and often, as a funding requirement. Outcome measures are the tools we overwhelmingly rely on to determine whether counselling is effective. Existing research to date confirms that the practice of measuring the effectiveness of counselling is fraught with disagreement and difficulty - a phenomenon widely reported by counsellors in clinical settings. Yet, the research involving counsellors is sparse, particularly in Australia. A major knowledge gap regarding outcome measure usage in practice exists. This study seeks to fill that gap – by reporting on current usage trends, and by eliciting Australian clinicians' attitudes towards measuring, as well as assessing to what degree clinicians are aware of and/or using a variety of measures.

What benefits will I and the broader community, receive for participating?

By participating in this research, you will be making a valuable contribution to our understanding of the current picture of evaluation in counselling in NSW. It is anticipated that increased knowledge as a result of this study will create an important baseline for further research on the topic. The ultimate aim is to identify and influence enhanced evaluation processes in therapy - thereby potentially contributing to better client and counsellor experience - and outcomes. As a participant, you may feel empowered because your views on the topic are being recorded.

Will the study involve any risk or discomfort for me? If so, what will be done to rectify it?

Any risk associated with participation is low. These low risks include:

- Risk of inconvenience related to time burden.

- Risk of feeling uncomfortable as a result of the research topic itself, as for some counsellors, evaluation may represent an administrative task which causes some degree of tension.

To mediate these risks, I have kept the survey short and note that written responses are optional and can be provided in dot point form. You can discontinue your participation in the survey by closing the web browser containing the survey.

How do you intend to publish or disseminate the results?

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. Please see below.

- You can email me to register your interest in receiving a summary of the results. (Contact details below).

- A summary of results will be sent to all counselling organizations initially approached for the purposes of recruitment.

- Results will be incorporated in my thesis which will be freely available in Research Direct.

Is my confidentiality guaranteed? - What will happen to the data?

- Survey data will initially be stored on the Qualtrics platform, accessible only by the researcher and supervisors named on this protocol. Once downloaded, the data will be securely stored in password protected files on servers at Western Sydney University, with access limited to authorized personnel.

- If you choose to email me to express interest in receiving results, I will be unable to link your email to your survey response, ensuring that all information you provide remains confidential and anonymous.

- Upon completion of this project, the data (de-identified) will be archived in an open access location for possible future research. The data will be stored for at least five years, as specified in the Australian Code for the Responsible Conduct of Research.

Can I withdraw from the study?

No. Once you submit your response, it cannot be withdrawn. This is because the survey is completely anonymous and therefore, I am unable to link your response to your name or email address. Prior to submission, you can choose to cease participating by closing the web browser at any time - without any negative consequence.

Can I tell other people about the study?

Yes, if you know of other professionals within NSW who you think may meet the inclusion criteria and may like to participate, please feel free to share the following URL - via social media or email.

…………………………………………………………..

What if I require further information?

Please contact Carmel Hamilton*: C. Hamilton @westernsydney.edu.au* ,should you wish to discuss the research further before deciding whether or not to participate

Supervisors Contact Information

Penny Gardner - P.Gardner@westernsydney.edu.au

Amanda Webb - A.Webb2@westernsydney.edu.au

What if I have a complaint?

The study has been approved by Human Research Ethics Committee at Western Sydney University. The approval number is 111111111.

If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through Research Engagement, Development and Innovation (REDI) on Tel +61 2 4736 0229 or email humanethics@westernsydney.edu.au

Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

Appendix C: Survey Questions

Q1 To commence the survey, please confirm that you are either a Counsellor, Psychologist, Psychotherapist or Social worker providing counselling to adults (18+) in NSW, that you have read and understood information above, and that you agree to participate in the survey

- ○ Yes, I meet the above inclusion criteria understand the information and agree to participate.

Q2 Are you?

- ○ Male
- ○ Female
- ○ Other
- ○ Prefer not to say

Q3 What is your age?

- ○ 20- 30 years
- ○ 31-45 years
- ○ 46-60 years
- ○ 61+

Q4 What professional role do you identify with?

- ○ Counsellor
- ○ Psychologist
- ○ Psychotherapist
- ○ Social Worker

Q5 In what type of area do you provide counselling?

- ○ Metropolitan area
- ○ Rural area
- ○ Remote area

Q6 In regards to clinical work with clients, please identify if your work is conducted at (tick all that apply)

- ○ Government funded organization
- ○ Non -government funded organization
- ○ Private Corporation
- ○ Self- employed /private practice
- ○ Other -please specify

Q7 What is your preferred modality in providing counselling?

- ◯ Person Centred Therapy
- ◯ Cognitive Behavioral Therapy
- ◯ Existential Therapy
- ◯ Psychoanalytic Therapy
- ◯ Gestalt
- ◯ Narrative
- ◯ Somatic
- ◯ Other, please specify
- ◯ No preference

Q8 How many years have you been practicing as a counsellor?

- ◯ 0-1
- ◯ 2-3
- ◯ 4-5
- ◯ 6-10
- ◯ 10 +

Q9 Do you, or have you ever used outcome measures in counselling?

- Yes
- No

Q10 If you have used outcome measures, please indicate which ones.

- K10 Kessler Psychological Distress Scale
- Dass 21 / Dass 42 Depression, Anxiety & Stress Scale
- Beck Depression Inventory
- Quality of Life Questionnaire
- Session Rating Scale
- Outcome Rating Scale
- Satisfaction with Life Scale
- Hamilton rating Scale for Depression
- Single Units of Distress Scale (SUDS)
- Hopkins Symptom Checklist
- Harvard Trauma Questionnaire
- PCL-5 (PTSD Checklist)
- Workplace specific measures
- Other, please specify

Q11 If you use outcome measures, what are your primary reasons for using them?

○ Obligated to use via external requirement (agency, funding body, insurance, employer, etc

○ Personal preference

○ Client preference

○ Deliver better therapeutic outcomes

○ Receive timely client feedback etc.

○ Other, please specify

Q12 If you use outcome measures for work purposes are you required to use any specific ones?

○ Yes

○ No

Q13 If you use outcome measures**,** please indicate how much time, *per session* is spent in this process. (Even if you do not implement measures every session, please provide an average estimate).

○ 2-5 minutes

○ 5-10 minutes

○ 15-20 minutes

○ 20 + minutes

Q14 If you use outcome measures due to work requirements, would you use them if this was not the case?

	Click to write Scale Point 1 (1)
Absolutely not	○
Unlikely	○
Possibly	○
Likely	○
Very likely	○
Definitely	○

Q15, Have you got any additional input you would like to share regarding any aspect of standardized measure usage? Limit of 150 words. Dot point format is also acceptable.

____

Q16 If you do not use outcome measures, what are your primary reasons for not doing so?

- ☐ Not relevant – don't capture client's experience
- ☐ Therapeutic change cannot be quantified
- ☐ Interfere with therapeutic process
- ☐ Negative impact on client
- ☐ Negative impact on clinician
- ☐ Time consuming
- ☐ Other, please specify

Q17 Apart from outcome measures, how do you identify that a client is improving, deteriorating or remaining the same?

- ☐ Clinical presentation
- ☐ Changes in how client relates to clinician
- ☐ Client functioning (client reported)
- ☐ Changes in client's relationships, as reported by client
- ☐ Third party report of client change
- ☐ Other, please specify

Q18, Can you comment on any client responses you may have noticed (positive, negative or neutral) to the use of outcome measures? Limit of 150 words.

Q19 Are you familiar with the following evaluation measures? Please tick. Note - many of these

measures are less well known

- ☐ The Personal Questionnaire
- ☐ Evaluation of Therapy Form
- ☐ Post – Session Questionnaire-PSQ
- ☐ Psychlops – Psychological Outcome Profiles
- ☐ HAT – Helpful Aspects of Therapy form
- ☐ GAS – Goal Attainment Scale
- ☐ Client Assessment of Change- CAC
- ☐ Narrative Interviews
- ☐ Client Post Therapy Questionnaire - CPTQ
- ☐ Interpersonal Process Recall - IPR
- ☐ Critical Incidents Technique
- ☐ Client Evaluation of Treatment Questionnaire - CETQ
- ☐ Brief Structured Recall - BSR
- ☐ Client Change Interview
- ☐ Outcome Questionnaire. OQ45
- ☐ Cross-Contextual Qualitative Diaries

- [ ] Feedback Letter
- [ ] Outcome Rating Scale & Session Rating Scale (ORS &SRS)
- [ ] Significant Events Form -SEF
- [ ] Corrective Experiences Questionnaire- CEQ
- [ ] Role Analysis - RA
- [ ] IEQ – Important Events Questionnaire
- [ ] Self - Compassion Scale
- [ ] Working Alliance Questionnaire
- [ ] Personal Orientation Inventory (POI)
- [ ] Barrett- Lennard Relationship Inventory (BLRI)
- [ ] Relational Depth Inventory

Thank you for participating.

Appendix D – Ethics Approval

HUMAN RESEARCH ETHICS COMMITTEE

20 October 2020

Mrs Penelope Gardner

School of Social Sciences

Dear Penelope,

Project Title: "Counsellors and Outcome Measures: Usage Trends, Attitudes and Familiarity. A NSW Pilot Study"

HREC Approval Number: H14080

Risk Rating: Low

I am pleased to advise the above research project meets the requirements of the National Statement on Ethical Conduct in Human Research 2007 (Updated 2018).

Ethical approval for this project has been granted by the Western Sydney University Human Research Ethics Committee. This HREC is constituted and operates in accordance with the National Statement on Ethical Conduct in Human Research 2007 (Updated 2018).

Approval of this project is valid from 20 October 2020 until 20 July 2021.

This protocol covers the following researchers:

Penelope Gardner, Carmel Hamilton, Amanda Webb

Summary of Conditions of Approval

1. A progress report will be due annually on the anniversary of the approval date.

2. A final report will be due at the expiration of the approval period.

3. Any amendments to the project must be approved by the Human Research Ethics Committee prior to being implemented. Amendments must be requested using the HREC Amendment Request Form.

4. Any serious or unexpected adverse events on participants must be reported to the Human Research Ethics Committee via the Human Ethics Officer as a matter of priority.

5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the Committee as a matter of priority.
6. Consent forms are to be retained within the archives of the School or Research Institute and made available to the Committee upon request.
7. Approval is only valid while you hold a position or are enrolled at Western Sydney University. You will need to transfer your project or seek fresh ethics approval from your new institution if you leave Western Sydney University.
8. Project specific conditions:

There are no specific conditions applicable.

Please quote the registration number and title as indicated above in the subject line on all future correspondence related to this project. All correspondence should be sent to humanethics@westernsydney.edu.au as this email address is closely monitored. Yours sincerely

Professor Brett Bowden
Presiding Member,
Western Sydney University Human Research Ethics Committee

Appendix E

List of Outcome Measures

Adult Needs and Strengths Assessment (ANSA; Walton & Kim, 2109)

Australian Treatment Outcomes Profile (ATOP; Deacon et al., 2020)

Alcohol Use Disorders Identification Test (AUDI; Saunders et al., 1993)

Beck Inventory of Depression (BDI, Beck; 2009)

Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962*)*

Brief Structured Recall (BRS; Elliott & Shapiro, 1988)

Client Assessment of Change (CAC; Halstead, 2012).

Client Assessment of Treatment Questionnaire (Swift & Callahan; 2009)

Client Change Interview (CCI; Elliott et al., 2001)

Corrective Experiences Questionnaire (CEQ; Friedlander et al.,2011)

Critical Incident Technique (CIT; Greenberg et al, 1988)

Cross Contextual Diaries (CCD; Mackrill, 2007)

Depression, Anxiety & Stress Scales (DASS; Lovibond & Lovibond, 1995)

Edinburgh Depression Scales (EDS; Cox et al., 1996)

Evaluation of Therapy Form (ETF; Gershefski et al., 1996)

Feedback Letter (FL; Sales & Alves, 2013)

Generalized Anxiety Disorder Assessment (GAD-7; Spitzer et al., 2006)

Goal Attainment Scale (GAS; Kiresuk & Sherman, 1968)

Global Assessment of Functioning (GAF; Endicott et al., 1976)

Hamilton Rating Scale for Depression (HRSD; Worboys, 2013)

Harvard Trauma Questionnaire (HTQ; Mollica et al.,1992)

Helpful Aspects of Therapy (HAT; Elliott, 1993)

Health of the Nation Outcome Scales (HoNOS; Wing et al., 1998)

Hopkins Symptoms Checklist, (HSC; Bech et al., 2014)

Important Event Questionnaire (IEQ; Cummings et al., 1992)

Interpersonal Process Recall (IPR; Elliott, 1986)

Kessler Psychological Distress Scale (K10; Andrews & Slade,2001)

Life Skills Profile-16 (LSP-16; Rosen et al., 1989)

Middlesex Hospital Questionnaire 14 (MHQ14; Crown & Crisp, 1966)

Outcome Questionnaire-45 (OQ-45; Lambert et al.,1996)

Outcome Star (OS; Mackeith, 2014)

Patient Health Questionnaire (PHQ; Kroenke et al, 2001)

Partners for Change Outcome Management System (PCOMS; Miller & Duncan 2004)

(Includes the *Session Rating Scale* and *Outcome Rating Scale*)

Personal Questionnaire (PQ; Elliott et al.,1999)

Post Therapy Questionnaire (PTQ; Strupp et al., 1964)

PTSD Checklist for DSM-5 (PCL-5; Weathers et al.,2013)

Psychological Outcomes Profile (PSYCLOPS; Ashworth et al.,2004)

Quality of Life Questionnaire (QLQ; Cohen et al., 1995)

Readiness for Change Questionnaire (RCQ; Rollnick et al., 1992)

Relational Depth Inventory (RDI; Di Malta, Evans & Cooper, 2019)

Role Analysis (RA; Clayton & Black, 1992)

Self Compassion Scale (SCS; Neff, 2003)

Severity of Dependence Scale (SDS; Gosop et al., 1997)

Significant Events Form (SEF; Moreno et al., 1995)

Single Units of Distress Scale (SUDS; Sperry, 2016)

The Relationship Inventory (RI; Barrett- Lennard, 2015)

Therapist -Client Interaction Analysis (TCIA; Wiseman & Rice, 1989)

Values Bullseye (VB; Villatte et al., 2016)

World Health Organization Disability Assessment Schedule (WHODAS; WHO,2000)