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Outcome Measures in Transactional Analysis Clinical Practice

Abstract

This article presents a review of the literature on the use of Outcome Measures (OMs) in counselling and psychotherapy, done by the author as part of her research (to be reported later) into how transactional analysis practitioners use OMs in TA contracting, diagnosis and treatment planning. A wide range of non-TA literature is presented, various OMs are described, practitioners' positive and negative perceptions of them are described as well what they tend to do instead of using OMs. It is reported how few counsellors and psychotherapists utilise OMs as part of their clinical practice. This article explores the issues and give more depth and detail into the 'pros and cons' of OM use within TA practice and is intended to initiate discussions of the topic alongside the research study.

Key Words

transactional analysis, outcome measures, outcome rating scale, session rating scale, clinical supervision

Introduction to a Research Study

This article is the first to appear about a research study that is being conducted as part of doctoral research. The author is a Certified Transactional Analyst (Psychotherapy) researching how TA practitioners (practitioners) use outcome measures (OMs) as part of their TA diagnosis, contracting and treatment planning process. There is a gap within the TA and wider research output, on how practitioners use the OM information from each therapeutic session, in their clinical decision making, to inform their client case formulation, and to adjust session by session components of the diagnosis, contract, or treatment planning in response to OM data. The research study has 12 participants who are qualified TA psychotherapists using OMs in their private practice. They have completed 60-minute semi-structured interviews that are being analysed using Interpretative Phenomenological Analysis (Smith, Flowers and Larkin, 2022), a hermeneutic, phenomenological and idiographic methodology well suited to the phenomenological basis of TA as it explores the intrapersonal and intrapsychic realm of the participants and their cognitive and affective lived experience in the clinical decision-making process.

As a trainee and then a qualified psychotherapist, the author has used OMs with clients for over 15 years to track clients' psychotherapeutic treatment trajectories to monitor their progress and intervene when there are indications of plateauing or deterioration and to adjust or ameliorate a client's TA diagnosis, contract or treatment plan. As such, OMs are a rich source of intrapersonal, interpersonal and extrapersonal information, immediately available to the practitioner at the start of the session. The client and therapist together can, in a few minutes, review levels of anxiety, depression, panic, somatic issues, interpersonal relationships, general health and well-being, trauma-related symptoms, mood disorders, and risk factors for self-harm and suicide. The OM scores and tracking data can then be utilised in session to inform TA counselling and psychotherapy. This author is therefore potentially biased – hence a research study to find out more about the process.

This means that OMs are a supportive tool for establishing the working alliance and holding the therapeutic container for the work together (Bordin, 1994; Bachelor and Horvath, 1999; Horvath, 2018). The use of OMs can help the client to gain a meta perspective of their therapeutic journey as they can track their progress over time and make informed decisions on the contract and goals for therapy. This is a partnership approach where the OM data is shared between client and therapist, promoting an OK-OK therapeutic relationship (Berne, 1975) and helps to focus the TA contract as exploratory, clarifying, behavioural or growth and discovery (Sills, 2006), using the OM data to inform this process. The use of OMs aids the development of the client's self-awareness of their intrapsychic dialogue through reflection on how Parent to Child messages impact on their anxiety, depression, self-esteem and self-confidence, and how changes in the intrapsychic

dialogue show up as improvements in their OM scores and aid in strengthening the Adult ego state (Berne, 1961, 1966). The OMs may also provide a framework for TA psychoeducation, in introducing the client to concepts and models by utilising the client's OM responses to address self-regulation, open communication and various TA concepts.

When clients fill in an outcome questionnaire at each appointment this positively affects the result of their therapy (van Rijn, Wild and Moran, 2011). Clients have used outcome measures to let therapists know how they experience the therapeutic relationship, and this can affect positively the client's outcome of therapy, meeting their goals and improving attendance (Miller, Duncan, Brown, Sorrel, and Chalk, 2006).

Finally, modern technology allows for OMs to be attached to email and sent ahead of the client's appointment, for completion and return prior to the session. This enables the OM to be reviewed, scored, charted and any improvement, plateauing or deterioration noted, and the trajectory of previous weeks OMs compared. This can take less than 5 minutes for the counsellor or psychotherapist to complete and after saying hello to the client the week's OM can be reviewed, discussed, and explored together with what emerges during the session.

The use of OMs in TA has begun to gain some traction among TA researchers and the wider TA community in recent years. This journal, *IJTARP*, has highlighted a plethora of research, primarily case studies, where OMs have been utilised in evaluating client's response to focussed interventions, such as anxiety and depression (van Rijn and Wild, 2013; Harford, 2013; Harford and Widdowson, 2014). Case study researches using OMs to track client responses to TA treatment have also made important contributions to the sound evidence base of TA clinical practice and effective treatment of mood disorders (Gentelet and Widdowson, 2016; Widdowson, 2011, 2012, 2013; Benelli, Revello, Piccirillo, Mazzetti, Calvo, Palmieri, Sambin, and Widdowson. 2016; Benelli, Scotta, Barreca, Palmieri, Calvo, de Renoche, Colussi, Sambin, and Widdowson, 2016; Benelli, Boschetti, Piccirillo, Quagliotti, Calvo, Palmieri, Sambin, and Widdowson, 2016; Benelli, Moretti, Cavallero, Greco, Calvo, Mannarini, Palmieri, and Widdowson, 2017; Benelli, Filanti, Musso, Calvo, Mannarini, Palmieri and Widdowson, 2017; Benelli, Procacci, Fornaro, Calvo, Mannarini, Palmieri, and Zanchetta, 2018; Zanchetta, Farina, Moreno and Benelli, 2019; Zanchetta, Picco, Revello, Piccirillo and Benelli, 2019).

Other articles have appeared in the *Transactional Analysis Journal* – such as Gentelet and Widdowson (2016) describing a case study in which they found TA psychotherapy to be "... an effective therapeutic approach for people with long-term health conditions, depression, and emetophobia …*" (*p.192). Recent research with 25 mild-to-moderate substance users who attended a 12-session TA programme and used validated OMs found strengthened Adult ego states, changed stroking patterns and life positions (Williams and Glarino, 2023). TA has also developed several concept-specific screening tools or psychometric TA instruments for use by therapists with their clients, and Vos and van Rijn (2021) completed a comprehensive search and review of 56 psychometric TA instruments, evaluated with Consensus-Based Standards for the selection of health Measurement Instruments (COSMIN). However, of these 56 instruments, only 5 were found to have met fair-to-good COSMIN standard: the Life Position Scale (Boholst, 2002), Schema Mode Inventory (Edwards and Arntz, 2012), Tokyo University Egogram (Oshima, Horie, Yoshiuchi, Shimura, Nomura, Wada, Tawara, Nakao, Kuboki and Suematsu, 1996), Adjective Checklist-TA Scales (Gough and Heilbron, 2007), and ANINT-A36 Questionnaire (Scilligo, 2000). These psychometric instruments are a more qualitative approach specific to TA whilst OMs can be seen as a generic quantitative method in measuring clients' symptoms and responses to counselling and psychotherapeutic treatment. Vos and van Rijn concluded *"*These findings may motivate psychotherapists to use the instruments … in their clinical practice to identify client's main problems and their root causes. Where they are used as sources of feedback and engagement with therapy, they strengthen the working alliance and prevent poor outcomes" (p.150-151).

Outcome Measures

For the purposes of this article, I will use the term Outcome Measures although other terms are used by various authors. The overarching aspect and key principles of OMs is to ask clients to self-report on how they experience their mental health and daily functioning, both at the first intake session, and throughout their therapeutic treatment. These frequent measurements detect progress and improvement as well as any levelling-off or plateauing, and the likelihood of early drop out from treatment when the client is not feeling any improvement in their mental health. When therapists use OM feedback systems, they can respond to any deterioration and work collaboratively with the client to improve their symptoms (Lambert and Harmon, 2018).

Note that there are OMs that are free to use whilst others require subscription payments. These may be aligned to a business model to generate income, to negatively evaluate existing competitors' OMs, or use a meta-analysis approach to test out the reliability and validity of OMs in routine use. There may be the issue of bias so care may need to be taken when choosing, especially as OMs become assimilated into daily use and their reliability and validity unquestioned and accepted.

Typical examples of OMs include:

- Clinical Outcomes in Routine Evaluation-Outcome Measure known as CORE-OM (Evans, Mellor-Clark, Margison, Barkham, Audin, Connell and McGrath, 2000) which measures global distress.
- Generalized Anxiety Disorder version 7 (Spitzer, Kroenke Williams and Lowe, 2006) known as GAD-7 which measures levels of anxiety.
- Patient Health Questionnaire, known as the PHQ-9 (Kroenke, Spitzer and Williams, 1999) which monitors levels of depression, and the Hospital Anxiety and Depression Scale or HADS (Zigmond and Snaith, 1983).
- Outcome Rating Scale (ORS) (Miller, Duncan, Brown, Sparks and Claud, 2003) measures the client's perspective on change or improvement.
- Session Rating Scale (SRS) (Miller, Duncan, and Johnson, 2002; Duncan, Miller, Sparks, Claud, Reynolds, Brown and Johnson, 2003) monitors the practitioner and client working alliance parameters.

These OMs are free to use once registered on their website as a licenced user and have handbooks or instructions on how to present these to the client for their completion, how to score client responses, the score ranges (from within normal limits, moderate and severe impairment) and how to interpret and track the trajectories. The reader may be aware of or use other OMs which are not mentioned in this article.

There are also:

- Measurement-Based Care (MBC) is defined by Scott and Lewis (2015) as "the practice of basing clinical care on client data collected throughout treatment. MBC is considered a core component of numerous evidence-based practices" (p.49).
- Symptom Rating Scales are defined by Baer and Blais (2010) as "... designed to quantify the severity of a disorder ... the severity of depressive symptoms ... can inform treatment planning and monitor patient progress" (p.2).
- Routine Outcome Monitoring (ROM) is defined by Barkham, De Jong, Delgadillo and Lutz (2023) as "... a method that integrates data into the process of therapy and enables adjustments when patients are not on track ... thus enhancing the overall effectiveness of psychotherapy" (p. 841).
- Patient Reported Outcome Measures (PROMs) according to Roe, Slade and Jones (2022) *" ...* directly assess the lived experiences of service users, capturing their perspectives on their health status and essential subjective constructs such as goal attainment, quality of life and social inclusion" (p.56).
- Progress Monitoring (PM) is defined by Ionita, Ciquer and Fitpatrick (2020) as *" ...* measures which help ensure evidence-based practice, allow the tracking of client progress in psychotherapy treatment and even predict which clients will have negative outcomes" (p.245).

The use of handbooks, manuals, national and international standards, and guidelines for mental health practitioners have come into widespread use, as an attempt to make the delivery and measurement of mental health services formulaic. The Improving Access to Psychological Therapies (IAPT) (Holland, 2009) sets out case-identification tools for anxiety and depression and moves onto recommending 12 specific OMs for routine use in IAPT services, for 14 mental health problems. The National Institute for Health and Clinical Excellence (NICE) (2011), recommends that General Practitioners (GPs) ask the two Whooley (Whooley, Avins, Miranda and Browner, 1997) questions to screen for depression: "During the past month, have you often been bothered by feeling down, depressed, or hopeless? During the last month, have you often been bothered by having little interest or pleasure in doing things?" These are intended to incentivise GPs to measure the severity of depression to target antidepressant prescribing in line with NICE (2009) guidelines and to follow the UK GP contract (National Quality and Outcomes Framework, 2006/2007). GPs are then recommended to assess their patients with the PHQ-9 (Kroenke et al, 1999), the HADS (Zigmond and Snaith, 1983) or the BDI-II (Beck, Steer and Brown, 1996). The use of OMs as a reliable and valid measure of how unwell is the client, contrasts with a GP's clinical judgement alone, which may be flawed, and they may offer inappropriate medical treatment or mistake mild for severe cases (NICE, 2011).

This author finds the Session Rating Scale (SRS) useful as a framework that gives ample space and opportunity for the exploration of transferential and countertransferential factors in the therapeutic

relationship. This relates to the transference and countertransference matrix (Berne, 1964; Hargaden and Sills, 2002; Little, 2011) and in early intervention with therapeutic rupture and repair (Erskine, 1993). The SRS asks the client to rate the session (from 0-10) in how they experience: the therapeutic relationship, in feeling heard, understood and respected (Horvath, 2018); the sessional contract working on and talking about their topics and goals (Sills, 2006); the therapist's approach or method being a good enough fit for the client; and finally overall asks if there was something missing in the session.

The author has found that clients quickly become familiar with OMs and are able to identify how their OM scores show the impact of script limiting factors in their intrapersonal, interpersonal and extrapersonal aspects of their lives. This allows them to recover awareness, intimacy and spontaneity, resulting in their autonomy (Berne, 1968; Stewart and Joines, 1987). Moving next into specific areas of treatment planning which may be helpful in supporting counsellors and psychotherapists in clinical practice, I also consider the use of OMs in the exploration of the client's risk of harm to themself or others as being a key aspect of safeguarding the client and managing risk in psychotherapy and counselling. OMs such as CORE-OM, GAD 7 and PHQ 9, include statements or questions on thoughts of self-harm, suicidal ideation, and suicide planning. The risk factors listed in the outcome measures offer the client inherent permission to disclose, as well as safeguarding, proffering protection (Crossman, 1966) to the client, normalising the client's experience to enable them to explore their thoughts, feelings and behaviours involving self-harm and suicidality. Without the use of CORE, issues such as feelings of shame may well inhibit self-disclosure of such key information. Therapists have such a limited time with their clients each week and CORE can quickly show where and when clients are experiencing a decline in their mental health or an increase in their level of risk (van Rijn and Wild, 2016). A key question might be how does the TA practitioner then use the outcome data to manage risk in decision-making? The psychotherapist or counsellor may then consider concepts such as escape hatches (Haiberg, Sefness and Berne, 1963) with the client and assess if the client is at low, moderate or elevated risk of self-harm (and/or risk to others) and either monitor and track their responses or refer onto primary- or secondary-care providers. OMs offer a sliding scale or continuum of risk assessment to practitioners to support their decisions whether to refer on, and OMs can communicate to colleagues and fellow professionals areas of risk and the rationale for referral.

What do practitioners do instead of using OMs

Most practitioners use 'clinical judgement' rather than evidence-based sources in their treatment of clients (Bower and Gilbody, 2010). Counsellors and psychotherapists find it difficult to implement clinically relevant research in their decision-making. There has been important literature appearing from small, accumulated studies which explain this phenomenon, finding that psychologists ignore the research evidence, preferring to use clinical judgement and experience in making clinical decisions (Stewart, Stirman and Chambless 2012); Gyani, Shafran, Myles and Rose, 2014; due to time pressures and costs associated with training, rather than negativity towards research evidence (Stewart, Chambless and Baron, 2012).

Clinical judgements, based on 'gut feelings' or hunches without a robust evidence-base are prone to cognitive biases and heuristics. Heuristics are essentially shortcuts, a reductive, rapid, prioritising process in the clinical setting in response to time pressure and limitations within the professional environment (Bate, Hutchison, Maskrey and Underhill, 2012). Heuristics are outside the practitioner's direct awareness, held determinedly whilst adversely impacting on their clinical decision making and increasing risk to their clients (Tarescavage and Ben-Porath, 2017).

The three types of bias relevant to clinical decision making are those of confirmation, overconfidence, and blind spot (Lilienfeld and Lynn, 2015). Confirmation bias involves looking for information that fits the clinician's first impressions whilst simultaneously ignoring information that does not fit (Tarescavage and Ben-Porath, 2017). Over-confidence bias occurs when practitioners trust their clinical judgement when it is inaccurate. Blind spot bias occurs when they see other clinicians' decision-making bias and not their own (Tarescavage and Ben-Porath, 2017). These cognitive biases are important considerations, particularly confirmation bias which can be improved using OMs which are free of cognitive bias and invaluable as part of the evidence-based assessment process (Lilienfeld and Lynn, 2015; Tarescavage and Ben-Porath, 2017)).

Heuristics, or 'hunches' or 'gut feelings', can be useful to practitioners if applied with care and caution (Lilienfeld and Lynn, 2015) and rooted firmly in Evidence Based Practice (EBP). This may be likened to the Somatic Child response we experience in our bodies to a client talking about what has happened to them, our 'Little Professor' makes an interpretation or assumption, and if we check this out from Adult ego state by getting more information, asking questions or 'thinking Martian' (Berne, 1963) we can hone the heuristic and limit biases.

The Evidence Based movement originated in Paris in the mid 1800s but did not gain momentum until the 1990's (Rycroft-Malone, Seers, Titchen, Harvey, Kitson and McCormack, 2004), and can be seen as the original forerunner of EBP, initiated by medical practitioners and described as being the rigorous, precise, and considered use of the most recent evidence in the clinical decision-making of individualised client care (Sackett , Rosenberg, Gray, Haynes, and Richardson, 1996). These authors encourage practitioners to integrate and use their clinical expertise in how they apply the objective evidence, as one without the other may lead to inappropriate, obsolete, or inhumane clinical care.

The epistemological sources of evidence which can be used in clinical practice, known as the 'three-legged stool' (Figure 1) are sourced from research, clinical expertise, clients, and carers being involved in shared decision making about care and considering the culture and local environment (Rycroft-Malone et al., 2004; Stewart et al, 2012). There is rarely ontological certainty with even the gold standards of a Systematic Review or Randomised Controlled Trial (RCT), as research evidence shifts, changes and is updated as new knowledge emerges. As Rycroft-Malone et al (2004) point out, the axiological implications of the evidence base when focussed to specific aspects of treatment can hold diverse, competing sources of evidence open to a variety of explanations. The clinician's decision-making is always contextual and embedded in their organisation's attitudes and beliefs, priorities for the work, workload, management systems and what EBP senior professionals may have alighted upon. Private practice psychotherapists have other pressures and priorities, particularly financial; their incomes are dependent on attracting and retaining clients, advertising, paying practice-based utilities whilst complying with their professional organisations and insurers, managing their accountancy systems, and keeping abreast of the rules and regulations surrounding private practice. For counsellors and psychotherapists, the time pressures are acute. For those in organisations, access to Continuous Professional Development (CPD), necessitates time away from their clients, arranging cover for their caseload, and certain CPD may be mandatory and in line with short term/long term goals and priorities. This may leave practitioners with little choice in how they might widen and deepen their individual learning needs or interests. Private counsellors and psychotherapists experience barriers to accessing CPD or up-to-date research and this may impose limitations on how they might integrate new theory into practice. Professional journals have subscriptions and CPD courses cost time and financial resources, and are often 'fitted into' the working day or annual leave. There is also a plethora of new research on clinical practice coming on-stream and counsellors and psychotherapists can feel overwhelmed on where to look, what to choose, how and when to implement and integrate this new knowledge into clinical practice. This may be further complicated by modality specific publications which offer a particular philosophical perspective or stance on practice and leave the practitioner unsure on how to interpret and then implement EBP. The gap between research and clinical practice persists, and despite huge investment to promote EBP from organisations, clinicians appear to prefer their clinical judgement rather than the evidence gleaned from the research (Gabbay and Le May, 2011).

Practitioners may find it challenging to objectively assess the efficacy of their practice, and studies have shown they overestimate their effectiveness by up to 65% (Miller, Hubble, and Duncan, 2007). Therapists believed in one large scale survey that they helped 80% of their clients, whilst almost 25% of therapists felt confident that 90% of their clients, or more, improved, with very few deteriorating (Walfish, McAlister, O'Donnell and Lambert, 2012). Bickman (2005) conducted a study asking therapists to rate their performance from A+ to F, and 66% rated themselves A and above whilst no-one scored themselves below average. When it comes to keeping track of a client's trajectory in treatment, Hannan, Lambert, Harmon, Nielsen, Smart, Shimokawa and Sutton (2005) studied 550 clients seen by therapists who judged their deterioration in treatment, noting that on average 8% of clients show deterioration; sadly, in their study the therapists could only judge deterioration in one client out of 550 cases and were unable to detect the 39 clients who did deteriorate. A review of a meta-analysis in the research literature on the effectiveness of OMs in therapy has found them to be reliably consistent (Wampold and Imel, 2015) and yet psychotherapy outcomes have failed to improve in over 40 years (Prochaska, Norcross, and Saul, 2020; Thomas, 2013; Wampold and Imel, 2015). This has been despite the exponential growth in the number of psychotherapy modalities since the 1960s; an estimation of the number of actual modalities and techniques is well into several hundred (Lambert, 2013).

There is a belief amongst therapists that they improve and develop with professional training and working experience. Goussakovski and Sizikova's (2017) quantitative research tested the hypothesis that therapists became more empathic with experience; their research with more than 100 practitioners with experience ranging from 1 month to 15 years did not support this hypothesis. Instead,

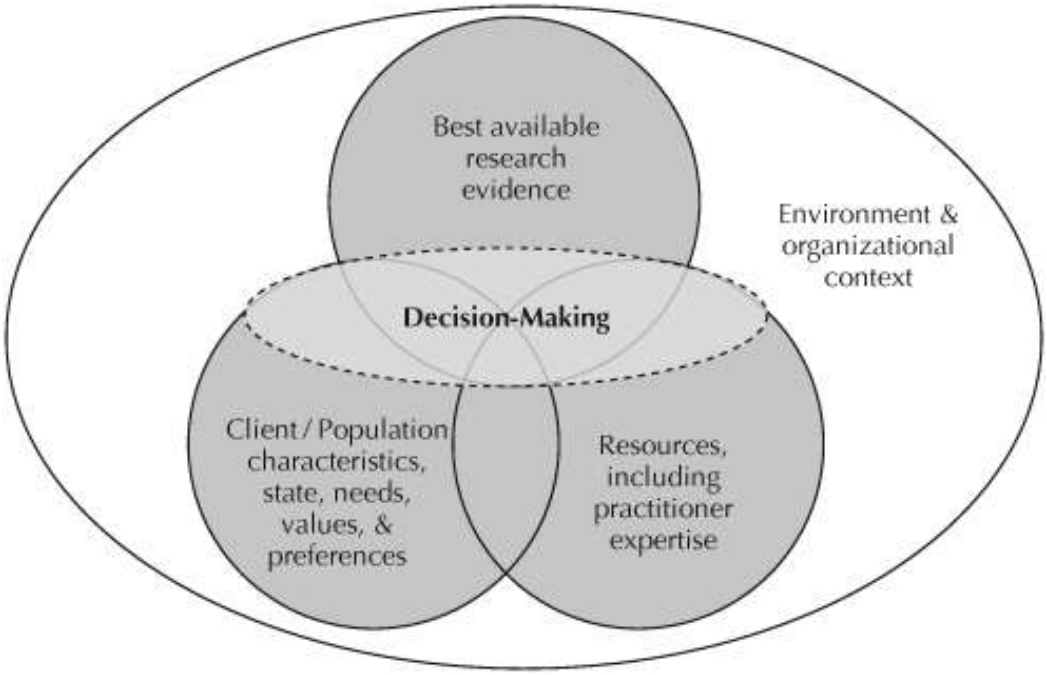

Figure 1: Elements that need to be integrated into EBP (Council for Evidence-Based Practice. (Spring and Hitchcock, 2010, online)

their findings showed that the TA therapist's level of empathy declined with experience, which led them to suggest that therapists develop 'professional empathy' as a tool, rather than use personal empathy, to protect against burnout. The assumptions made by practitioners as key in their professional growth and success in client work leading to positive outcomes includes the gender of the therapist, and the therapist's personal therapy (Duncan, 2010; Geller, Norcross and Orlinsky, 2005). Research has shown that counsellors and psychotherapists theoretical approach or professional discipline are found to be weak predictors of positive therapeutic outcomes with clients (Beutler, Malik, Alimohamed, Harwood, Talebi, Noble and Wong, 2004; Duncan, Miller, Wampold and Hubble, 2010). The research has shown that despite years of experience, qualified therapists perform no better than trainees in terms of positive, successful outcomes to therapy (Goldberg, Babins-Wagner, Rousmaniere, Berzins, Hoyt, Whipple, Miller and Lampold, 2016; Wampold and Brown, 2005; Boswell, Castonguay and Wasserman, 2010).

Positive and negative perceptions of OMs

There is currently much recent research supporting the use of OMs, and yet scepticism remains within the TA and wider counselling and psychotherapy community. Therapists continue to perceive that the use of OMs in some way interferes with or interrupts the therapeutic relationship and working alliance (Youn, Kraus and Castonguay, 2012).They also perceive that administering an OM delays or eats into the session time, or that OMs are not acceptable to clients (Hatfield and Ogles, 2004; Cooper, 2012; Tryon, Blackwell and Hammel, 2007; Green and Latchford, 2012; Boisvert and Faust, 2006; Macdonald and Mellor-Clark, 2014; McLeod, 2017). Researchers Miller, Duncan, Sorrel and Brown (2005) suggest that OMs with only four items, such as the Partners for Change Outcome Management System (PCOMS) take clients two minutes, five minutes for each of GAD 7 and PHQ9, and up to 10 minutes for CORE-OM; can be completed online sent ahead of the planned appointment time; and takes the counsellor or psychotherapist a few moments to calculate the score and then share this with the client.

Van Wert, Malik, Memel, Moore, Buccino, Hackerman and Narrow (2020) surveyed 138 practitioners on their attitudes towards OMs and identified the following barriers to implementation: time pressures (50%); uncertainty around which OMs to use (35%); OM findings being difficult to locate (34%); insufficient training on understanding the data (29%); workplaces being unsupportive of OMs (19%); the use of OMs not seen as important (14%); incorrect selection of OMs (18%); and incompatibilities with the therapeutic work (18%) . Practitioners may feel a sense of control from managers or organisations who have the power to affect and determine their professional judgement

and clinical decision making (Rousmaniere, Goodyear, Miller and Wampold, 2017). For those practitioners in private practice there may be other considerations.

There is a sense of 'big brother' overseeing psychotherapists' work with clients, and a threat that they will be compared to their peers and colleagues and found lacking in some way (Hatfield and Ogles, 2004; Youn et al., 2012). Practitioners may believe that clinical work is under such time pressures that to squeeze in another task, that they believe is of dubious therapeutic value, would be wasteful. (McLeod, 2017). Practitioners can rely on their 'clinical judgement' to monitor the client's response to therapeutic work even though the research suggests this intuiting method can be an unreliable method to find how well their client is responding to therapy (Hatfield and Ogles, 2004; Hatfield, McCullough, Frantz, and Krieger, 2010; Hall, Taylor, Moldavsky, Marriott, Pass, Newell and Hollis, 2014;). Practitioners have competing demands on their time and added administration to fill in more forms is added pressure (Chapman, Winklejohn Black, Drinane, Bach, Kuo and Owen, 2017). Research has shown that a five minute time slot, at the start of the session, can be allocated to complete OMs. Research has shown that a five minute time slot, at the start of the session, can be allocated to complete OMs (Meier, 2008).

A recent estimation, from data provided from the UK Association for Transactional Analysis) (UKATA) (A. Davey, personal communication, February 2nd, 2021) and the UK Council for Psychotherapy (UKCP) (E. Dunn, personal communication, February 25, 2021), of TA practitioners using OMs who are registered in the UK is between 7% to 36%. This figure does need to be viewed with caution as TA therapists may be registered with other professional bodies, not included in the estimation, or may be counted twice as therapists can hold membership of more than one registering organisation. A search of the wider research literature from the USA shows a range of results for therapists who use outcome measures: 37% (Hatfield and Ogles, 2004); 29% (Phelps, Eisman and Kohout, 1998); 23% (Bickman, Rosof-Williams, Salzer, Summerfelt, Noser, Wilson and Karver, 2000); under 20% (Lewis, Boyd, Puspitasari, Navarro, Howard, Kassab and Kroenke, 2019); and 13.9% (Jensen-Doss, Haimes, Smith, Lyon, Lewis, Stanick and Hawley, 2018). Across the USA border, only 12% of Canadian psychotherapists use OMs (Ionita and Fitzpatrick, 2014; Tasca, Angus, Bonli, Drapeau, Fitpatrick, Hunsley and Knoll, 2019). The low uptake of OMs by counsellors and psychotherapists seems to be a widespread phenomenon not confined to the UK.

Hatfield and Ogles (2007), in their survey of therapists, found similar issues about the adverse practicalities of administering OMs: more paperwork, time taken, burdening clients, OMs not being supportive of the therapeutic process and a negative effect on client treatment. Garland, Hurlbert and Hawley (2006) concurred, with their research on why therapists do not use OMs, showing: 90% of respondents cited time issues; 55% felt OMs were not of use with their clients; and 15% found the interpretation of OMs scores to be challenging. Ionita and Fitzpatrick (2014) add that 67% of practitioners were not aware that OMs existed, and the 33% who did know about OMs felt they did not have enough knowledge or training and that OMs intruded into time with and they felt this burdened the client. Boswell, Kraus, Miller and Lambert (2013) summarised the obstacles and challenges to OM uptake into practical obstacles such as financial and time burden, multiple stakeholders with diverse needs and staff turnover. The philosophical obstacles relate to the belief that OM is different from other assessments; fear and mistrust over who has access to the data and therapist performance; and finally privacy and ethical issues around confidentiality and information sharing. Ionita et al (2020) reported on the results of an online survey of 533 psychologists in Canada about the barriers to using outcomes measures, citing a lack of understanding, training, impact on clients, an increase in workload and time spent administering the OMs.

The facilitative factors on the use of OMs reported by psychotherapists included: that OMs are convenient (Hall et al., 2014; Perry, Barkham and Evans, 2013); improve the treatment process (Perry et al, 2013); enable clients to see their progress (Omer, Golden and Priebe, 2016); express themselves (Omer et al., 2016; Perry et al., 2013); and support the development of service provision (Wolpert, Curtis-Tyler, and Edbrooke-Childs 2016). Therapists did find them useful when they felt they had adequate training and could use OMs in a flexible and creative way with their clients (Unsworth, Cowie and Green, 2012). Hatfield and Ogles (2004) survey of therapists found that 37% used some form of OM to track their clients' progress, to watch treatment trajectories, to implement ethical practice and to discover the clients' strengths and vulnerabilities. Hatfield and Ogles reported that the most useful clinical information for practitioners was being able to check the clients progress since work began, the client's global ability to function at work, support close long-term relationships, and name indicators of difficulty for the client.

Rye, Rognmo, Aarons and Skre (2019) discovered that therapists who were in stable employment situations utilised OMs more often and recognised the importance of the information as a standard of their expertise and ability as a therapist. Van Wert et al (2020) recent research on the barriers and facilitators to OM use found: most clinicians (86%), of the 138 surveyed, would increase their use of OMs if there was ease of access to OM data; 77% would be willing to spend 3-5 minutes of the session in the client completion of the OM; therapists felt OMs would increase their accountability; they needed training and support to implement OMs; 74% responded affirmatively that OMs would supply meaningful and accurate measurements of their work.

Ionita et al (2020) make differentiation between OMs and Progress Monitoring (PM), the former being used towards aiming to work towards a successful termination of treatment in short term therapy, and the latter to continuously assess the client's progress by using the PM data to inform the clinical case management process and monitor the client response to therapeutic treatment. They suggest that the PM measures which perform this integrative function are the Outcome Questionnaire-45 (OQ-45; Lambert, Burlingame and Hansen, 1996), the Partners for Change Outcome Management System (PCOMS; Miller et al., 2005) and the Treatment Outcome Package (TOP; Kraus, Seligman and Jordan, 2005). There may be a useful discussion to be had about whether there is a need to differentiate between PMs and OMs and whether this difference is significant. Is this discussion less about either OMs or PMs or more about how these measures are used in the clinical decision-making process by therapists?

What next?

The positive outcomes of treatment that clients receive in therapy and the research in the literature indicate that it is the working alliance and developing therapeutic relationship which make the difference (Prusinski, 2022; Bordin, 1994). In today's climate of value for money and evidence-based psychotherapeutic practice, professionals can no longer rely completely on established 'custom-and-practice' ways of delivering mental health services. The drive to supply evidence and research-based interventions has become clear, as is the need to shed light on what happens in the therapy room between client and therapist. This is where OMs, such as the Session Rating Scale (SRS), can offer direct client feedback on their experience of counselling and psychotherapy (Miller, Duncan, and Johnson, 2002). Practitioners need clients to give session-based feedback on the therapeutic alliance to improve treatment and recovery trajectories and reduce client drop-out rates. Duncan (2010) recommends the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) for psychotherapy practice. Two independent Randomised Controlled Trials (RCTs) found that clients who completed feedback about their experience were up to four times more likely to improve clinically than those who were not asked for feedback (Reese, Norsworthy and Rowlands, 2009; Reese, Toland, Slone and Norsworthy, 2010). Feedback Informed Treatment (FIT), using ORS and SRS, improved client's outcomes by 27% and reduced deterioration rates by 50% (Miller, Duncan, Brown, and Sorrel, 2005; Lambert and Shimokawa, 2011).

Clients are becoming more aware of what they want from therapy in terms of outcomes and are likely to drop-out from therapy if they do not feel connected to the therapist or the therapy process. Medicine and other health professions have seen the rise of the 'expert patient' who has gained 'expertise-by-experience' through living with a mental illness (Swift and Parkin, 2017; Noorani, 2013). These expert seekers of services, who do their research increasingly via the internet (Kaluzeviciute, 2020; Knox, Connelly, Rochlen, Clinton, Butler and Lineback, 2020), know a lot about their psychological issue or mental health problem. Clients looking for a psychotherapist can be attracted by specific details, such as their professional experience, area of specialisation, and where they are situated geographically (Pomerantz and Dever, 2021). The Covid-19 pandemic has enabled the delivery of counselling and psychotherapy via online platforms so clients can choose from much further afield. The expert client, armed with this level of detail, can discuss with their mental health professional what treatment options might be available to them. If we gaze into the horizon of psychotherapy's future, we may expect to see clients who want much more in the way of involvement and consultation in their psychological care (Swift and Parkin, 2017; Black, Owen, Chapman, Lavin, Drinane and Kuo, 2017). Clients are less likely to accept that the psychotherapist knows best (Swift and Parkin, 2017). Clients will also look for individual tailoring of their needs "characteristics, culture, and preferences" (American Psychological Association, 2006, p.273), and a therapist who is able to synthesise and apply outcome data to inform their TA diagnosis, treatment plan and together formulate a mutual contract for the work. Clients will also want to be able to give the therapist feedback on how they are responding to their needs for contact, connection, relationship building, personalised treatment methods and approach to working in partnership (Black et al, 2017).

Psychotherapists and counsellors care passionately about the future of practice and the retention of

clients in therapy, and a reduction in drop-out and no-show rates, whether this is for short- or long-term work (Whipple, Lambert, Vermeersch, Smart, Nielsen and Hawkins, 2003). The use of OMs helps the treatment planning process, the beginning stages of building the working alliance, and paying attention to the client's day-to-day functioning. The therapist can offer psychoeducational support with issues such as sleep hygiene, nutritional needs, and aspects of physical health and wellbeing, which tend to be the most disruptive aspects of clients' lives; they can offer social control and symptomatic relief. This integrated approach builds the therapeutic relationship and the client's confidence in the therapist's ability and interest in their lives. Clients may also begin to develop insight and reflection on what brought them to therapy, and the therapist can gauge their psychological awareness and understanding. OMs give both an objectivity of what is measured, and the client and therapist can notice the subjective elements and the impact on their daily life, internal world, and relationships.

Clinical supervision is an important part of all TA practice and OMs may be a useful adjunct. There are several studies which support the use of OMs to enable supervisors and supervisees to have discussions based on the client's clinical data rather than solely upon the supervisee's assessment of the client (Swift. Callahan, Rousmaniere, Whipple, Dexter and Wrape, 2014). The client OMs can support a supervisee's decision-making as to which clients to bring to supervision, making more use of supervision sessions (Reese, Usher, Bowman, Norsworthy, Halstead, Rowlands and Chisholm, 2009), and for supervisors to see any emerging patterns with clients over time or suggest specific OMs to add into the client work (Swift et al. 2014). OMs in supervision can also help in the identification of the client's presenting problem or issue, level of risk to themselves or others, Adult ego state functioning, interpersonal relationships, psych-ological awareness, and the tracking of the client's treatment response trajectory. The supervisor and supervisee can monitor together the client's improvement, plateauing, deterioration, ruptures in the therapeutic relationship, unplanned ending of treatment (Lambert, 2010; Swift et al., 2014) and therefore focus on and prioritise areas of difficulty encountered by the client and supervisee. The OMs in supervision would not replace the other important aspects of clinical supervision but offer an enhanced dimension to the process of both qualitative and quantitative data. The OMs offer the supervisee opportunities to assimilate data into the TA diagnosis, contracting and treatment planning process. This is an area of research the author is exploring in the forthcoming research.

Conclusion

This article seeks to begin a conversation with counsellors and psychotherapists who may be considering using OMs in their clinical practice to improve treatment outcomes and client retention, and reduce drop-out rates and no-show appointments (Lambert, Whipple, Hawkins, Vermeersch, Nielsen and Smart, 2003; Bohanske and Franczak, 2010; Ionita, Fitzpatrick, Tomaro, Chen and Overington, 2016). This discussion will offer the practitioner the current and available research and evidence and practice-based data on both the positive benefits and challenges to using OMs in private practice.

Research continues to show that OMs have high validity and reliability and can be used across different modalities as a rapid assessment tool supplying data on a client's progress, plateauing and deterioration. OM data supplements clinical judgment and provides an opportunity for the counsellor or psychotherapist to intervene and review the client's treatment plan and direction. The use of OMs, such as CORE, PHQ 9 and GAD 7 in private practice and beyond show utility in ongoing client risk assessment and screening for self-harm. Finally, supervisors and supervisees using OMs as an adjunct to clinical judgment in supervision may offer clinical data which supplements the early client assessment process, presenting issues, TA diagnosis, contracting and treatment planning approaches.

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