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'One step up, but not there yet': using client feedback to optimise the therapeutic alliance in family therapy

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As research suggests that there is a strong link between the quality of the therapeutic alliance and the effectiveness of psychotherapy, family therapists should reflect on ways to improve the quality of the alliance. The systematic use of client feedback can be a rich resource as a response to the complexity of the alliance in the family therapy setting. In this paper the focus is on ways in which the client's systematic feedback can contribute to an optimisation of the therapeutic alliance. We present the Dialogical Feedback Tool (DFT), a simple feedback instrument to be used especially in family therapy sessions in which young children are involved. A case study illustrates how the feedback of clients on their experiences in therapy can help therapists to better attune to family members' experiences and expectations about therapy.

Practitioner points

- The therapeutic alliance in family therapy is complex, especially when children are involved
- Using a simple feedback instrument can help deal with the complexity of the therapeutic alliance
- The most important challenge for therapists using feedback instruments is how to integrate the feedback in a constructive way in the therapeutic process

Keywords: family therapy with children; feedback orientation; therapeutic alliance

Introduction

The Smits family is in family therapy because the parents are worried about their 8-year-old daughter Emma. She is described as being aggressive and difficult. At

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the end of the second session, invited to give feedback on the session, the 11-year-old son Fred says, 'we are one step up, but we are not there yet'. This remark puzzles the therapist, and he asks Fred with curiosity to help him understand the meaning of his words …

Based on years of psychotherapy research with randomised controlled trials (RCTs), we can conclude that psychotherapy works (e.g. Lambert, 2013): '… psychotherapy stands up to empirical scrutiny with the best of health-care interventions' (Norcross and Lambert, 2018, p. 306). The question can then be posed, what accounts for psychotherapy success? What exactly works in psychotherapy? There is a lot of controversy around this question (e.g. Norcross, Beutler and Levant, 2006). Still, there seems to be substantial evidence suggesting that non-specific factors are important in explaining the efficacy of psychotherapy (e.g. Duncan, Miller, Wampold and Hubble, 2010; Lambert, 2013). In particular, it seems that the quality of the therapeutic alliance is the most robust predictor of therapeutic change (e.g. Norcross and Lambert, 2011, 2018; Wampold and Imel, 2015), especially if the quality as experienced by the clients is taken into account (Bachelor and Horvath, 1999). The most important advice for practising therapists seems to be: be flexible and avoid one-size-fits-all therapies (Norcross and Lambert, 2011; Norcross and Wampold, 2019). The therapist must be prepared to be open to the feedback of the client and to tailor the therapeutic relationship to the needs and preferences of the specific client (Norcross and Wampold, 2019).

Several authors have recommended that practitioners should routinely monitor patients' feedback about their experiences of the therapy relationship and ongoing treatment, as this can lead to increased opportunities to reestablish collaboration and improve the relationship (e.g. Duncan, Miller, Wampold and Hubble, 2010; Norcross and Wampold, 2019). In feedback-oriented therapy, session-by-session feedback from the clients is gathered with the use of simple, valid and reliable instruments. This feedback is immediately delivered to therapist and client(s) in order to fine-tune the therapy when necessary. This perspective of feedback-oriented therapy represents an important development in the field of psychotherapy (e.g. Lambert, 2010). While RCT research provides information on average group effects and does not help clinicians to answer the question 'How should I treat this unique client sitting in front of me?', feedback-oriented therapy is focused on the specific unique client. In that way, research based on systematically gathered client feedback in therapy contributes to bridging the gap between research and clinical practice (e.g. Pinsof, Goldsmith and Latta, 2012).

Furthermore, although there are a lot of complexities (Wampold, 2015), research suggests that feedback-oriented practice is associated with better outcomes (e.g. Anker, Duncan and Sparks, 2009; Sapyta, Riemer and Bickman, 2005). Furthermore, it leads to dropout reduction and a better dose/effect ratio (e.g. Shimokawa, Lambert and Smart, 2010). These good effects of using client feedback can probably best be attributed to the optimisation of the therapeutic alliance. For instance, research suggests that it increases motivation and empowerment of clients (De Jong *et al.*, 2014). Because of the early detection of problems in the alliance, it facilitates a better working alliance (e.g. Shimokawa *et al.*, 2010).

The challenge of the alliance in family therapy

While the therapeutic alliance is important in all forms of psychotherapy, in a family therapy setting therapeutic alliance is particularly complex (e.g. Friedlander, Escudero, Welmers-van de Poll and Heatherington, 2019; Pinsof and Catherall, 1986). It could be said that the setting of family therapy demands a unique conceptualisation of the therapeutic alliance (e.g. Sprenkle, Davis and Lebow, 2009). Research shows that in family therapy parents and children develop different alliances with the therapist (Friedlander, Escudero and Heatherington, 2006). While children and especially adolescents tend to be attuned to their own reactions to the therapist, parents also monitor their children's reactions to the therapeutic process and assess the child's alliance with the therapist in an attempt to evaluate the child's improvement (Friedlander *et al.*, 2006). Furthermore, in family therapy the therapeutic alliance is more than the sum of the alliances between the different family members and the therapist, because of the additional existence of within-systems alliances. Friedlander *et al.* (2006) speak about a *shared sense of purpose* (p. 125). This refers to the family members' history together and their allegiance that precedes the development of the alliance with the therapist. Research shows that in successful therapies the within-systems alliance tends to gradually strengthen (Friedlander *et al.*, 2019). As the alliance with the therapist develops, it is the therapist's goal to also enhance the family's *shared sense of purpose*.

In the first family therapy session, the family's *shared sense of purpose* is not visible, as often the family members do not agree on the existence of a problem, or on the definition of the problem or on the necessity of family therapy to address the problem.

A lot has been written about the difficulty of mobilising the voices of children in family therapy (e.g. Rober, 1998, 2008; Sori, 2006). Forming an alliance with children or youngsters is often difficult for family therapists. Qualitative psychotherapy research shows that children experience therapy as a challenge and that being heard is very important to them (Strickland-Clark, Campbell and Dallos, 2000). Furthermore, research suggests that, if the therapist does not specifically attempt to engage with children, children do not succeed in taking the conversational floor from an adult in a family therapy session (O'Reilly, 2008).

Feedback-orientation in family therapy

Given the complexity of the therapeutic alliance in family therapy, the feedback-orientation of the therapist is of paramount importance (e.g. Lappan, Shamoon and Blow, 2018). However, working as family therapists in a feedback-oriented way is a challenge, as a lot of the traditional feedback instruments were – notwithstanding the empirical support for their reliability and validity – actually not developed with the complexity of the therapeutic alliance in family therapy in mind, nor the complexity of working with young children in family therapy. With one notable exception (Haber, Carlson and Braga, 2014), we did not find any publications on feedback-oriented psychotherapy in which the specificity of the family therapy session was taken into account. That is why we developed our own simple instrument, the Dialogical Feedback Tool (DFT), to be used in family therapy sessions with young children. In this paper we will present this instrument and show how we use it in family therapy.

In order to illustrate the use of this instrument, we will describe part of the therapy with the Smits family in Context, a small outpatient family therapy team that is part of the University Hospital of Leuven (UPC KU Leuven), Belgium. The first (PR) and the second (KvT) authors were the therapists. The first two sessions of the therapy will be discussed in detail. RS, the third author, working at the Norwegian Ambulant Family Section (AFS), commented on this work from a distance and had the role of supervisor of the project. His expertise on the usefulness of feedback instruments as conversational tools (e.g. Sundet, 2014) inspired the first two authors from the very beginning of their project on feedback-oriented family therapy.

Case: The Smits family (1)

Father wanted to go into therapy with his family. He talked to his wife and she agreed that something needed to be done. Then he talked to the children: 11-year-old Fred listened but he didn't say much – 'OK' was all he said; 8-year-old Emma protested: 'There is nothing wrong with me. Why should I go to the therapist?' Father responded by explaining: 'We will go to the therapist together, because we fight too much, and we want us all to be happy instead of angry and sad'.

This illustrates the typical complexity of the motivation to come to family therapy that Friedlander *et al.* (2006) described. Some family members (most often the parents) are worried and they think that family therapy might be useful for them. Other family members may be less worried, or are reluctant to go to family therapy for other reasons. It is clear that this multiplicity in expectations and motivations is a challenge for the family therapist who wants to develop a strong therapeutic alliance with all family members.

Developing a feedback culture

One of the first things we learned when we started to work in a feedback-oriented way is that choosing the right instruments is just one aspect of the challenge. The biggest challenge, however, is the development of a culture of feedback (Duncan, Miller and Hubble, 2007): an atmosphere in which the family members are invited to give feedback and to contribute to the therapeutic process. In our way of working, the development of a feedback culture in the therapy starts from the very first moment of contact between the therapist and the client. Often this first contact is by telephone, when the person seeking help is offered an appointment for a first session. Already in such a telephone conversation the feedback orientation of the therapist should be briefly introduced as an important part of the standard care that the family can expect.

Case: The Smits family (2): father's telephone call

Father called us to make an appointment and asked how he could introduce family therapy to his daughter. I (KvT) talked to him and I offered him our definition of family therapy: 'A family therapist is someone who talks with family members when someone in the family is worried about something. And then we talk and listen to what everybody has to say'.

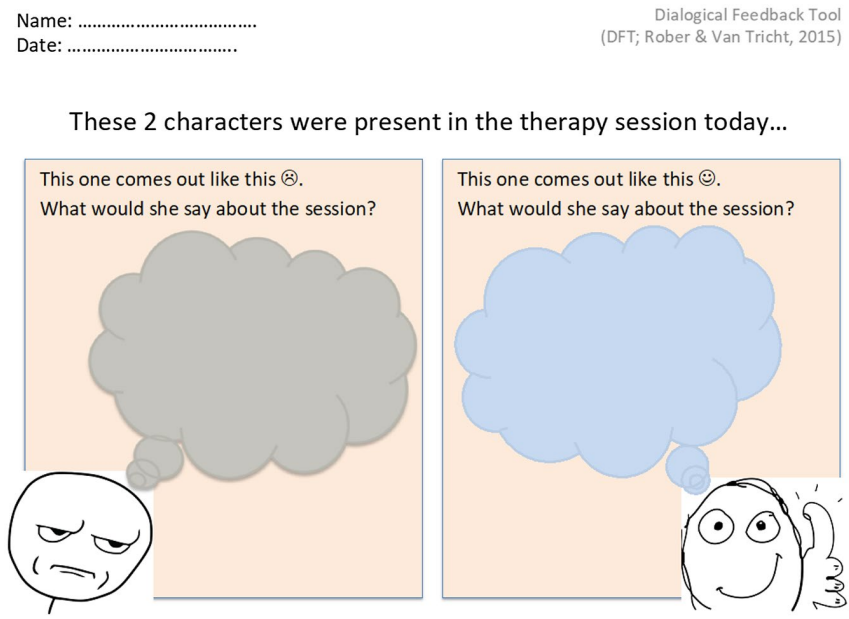

Figure 1. The Dialogical Feedback Tool (DFT). Free to download at https://www.intherapytogether.com/.

This description of family therapy is respectful to the family members who hesitate to come to therapy, as the main idea is not that the focus is on an objective problem in the family or in one of its members, but rather that the worries of someone are the starting point for therapy (Rober, 2017). While we validate the ones who are worried in the family (usually the parents), we also leave room for other perspectives, as we make it clear that therapy does not start from an official diagnosis or a clearly defined problem.

Dialogical feedback insturments as conversational tools

The Dialogical Feedback Tool[1] (DFT) (Figure 1) is mainly developed to be used in therapies with families with young children, but the

[1]Free to download at https://www.intherapytogether.com/.

instrument can also be used for adolescents, young adults and adults (Rober, 2017). It is a simple instrument.

Towards the end of each session (approximately ten minutes before the end of the session), all family members are invited to fill out the DFT: to write in the speech bubbles of both characters what, in their view, they might think or say about the session. By means of the pictures of a smiling and an unhappy face we make room for ambivalent thoughts and feelings. Furthermore, giving clients the opportunity to explicitly mention what they appreciated often allows them room to also mention things that were less than optimal or that were displeasing. The family members are allowed to fill in the DFT however they want. Parents often write some words or short sentences. Children may prefer to not only use words but to also add colours, symbols and drawings to provide feedback in their own way. Whatever family members fill out, it is appreciated by us as therapists and welcomed with curiosity and enthusiasm. When the DFTs of the different family members are completed towards the end of the session, the therapist takes a moment to review them briefly. In a friendly and curious way she promises the family members that in the next session issues that are raised in the DFTs will be addressed. Adopting such a warm and accepting attitude – especially when the feedback is critical – contributes to the development of a feedback culture.

Case: The Smits family (3): the DFT at the end of the first session

At the end of the session we invited mother, father, Fred and Emma to fill out the DFT. Emma playfully accepted the invitation to share with us, with her parents and her brother how she had experienced the session.

Predictably, in her DFT (Figure 2) Emma repeated that therapy was not a good idea. But on the other hand she wrote it was a 'super idea'. The most important thing was not the content of her feedback, but rather the fact that she had accepted our invitation to give feedback. We saw it as a first hesitant step towards participating in the therapy.

Fred's DFT after the first session (Figure 3) taught us that Fred was grateful and that hope was growing for him that therapy might lead to meaningful change in the family. Furthermore, we learned that positive change for Fred would be change in the direction of being more like friends in the family. What struck us in Fred's feedback was that he wrote that he had not had the chance to say what he wanted to say: 'It was never my turn'. It seemed that he had been waiting during the session until it was his turn to speak, but in the end had never had an opportunity to speak.

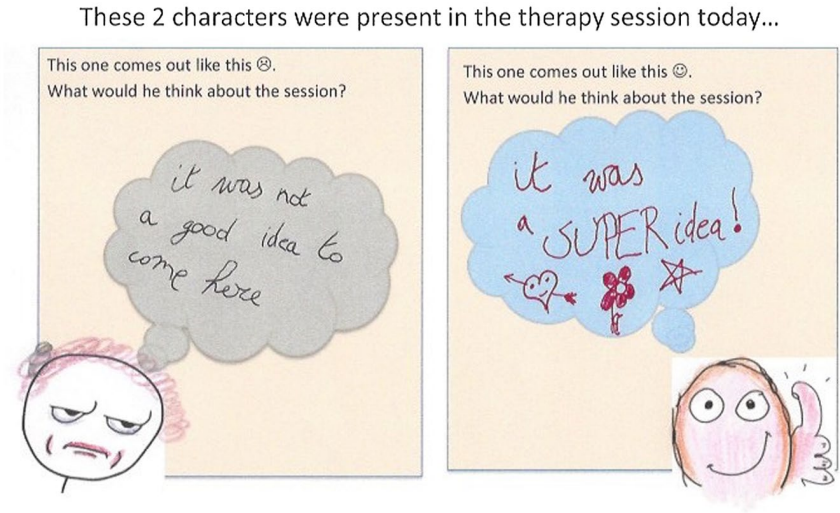

Figure 2. Emma's DFT (first session).

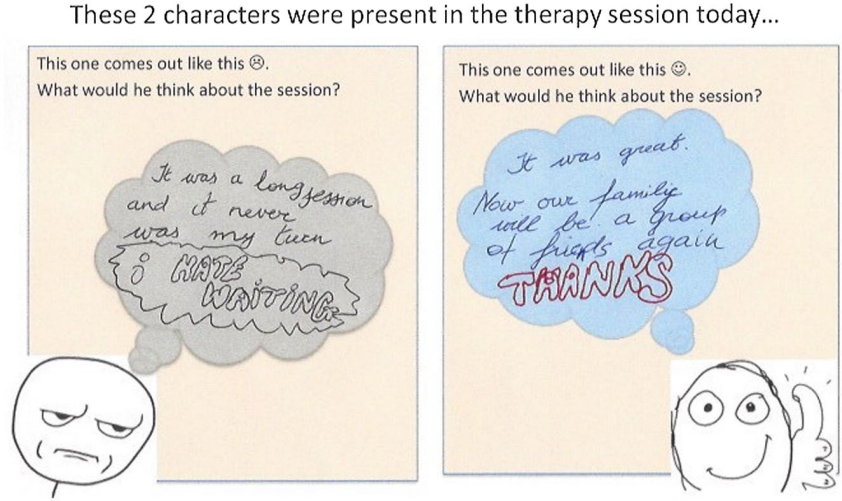

Figure 3. Fred's DFT (first session).

This was surprising for us; we had tried so hard to make room for everybody's voice, and now it seemed that we had not succeeded. Of course this was important feedback and we decided to talk with the family about it in the second session.

The parents also filled out a DFT. While the mother was positive and hopeful about the session, her remark about Fred's not feeling part of the conversation struck us especially. For one thing, it reiterated Fred's feedback of not having had the chance to participate in the session. This emphasised the importance of our resolution to talk about it with the family. Furthermore, it struck us that the mother said that Emma maybe was too much the focus of the session. This was surprising in the sense that Emma was the so-called identified patient and the main source of the parents' worries. Father's feedback on the DFT was brief. Two words. Still, both words were important. The smiling face said 'Finally', and the grim face 'Too short'. We understood 'finally' as expressing hope and relief; while we thought that 'Too short' conveyed that there is more work to be done and that the family will need time because there is so much going on.

In our way of working, before the beginning of the next session we review the DFTs that the clients completed in the previous session. We reflect on the way the family members' feedback might be helpful to orient the therapy in new directions. In preparing the next session, while we try to understand as best as we can all the feedback from the family, usually we choose one or two themes from the feedback as a potential starting point for the next session. In particular, we often choose the most critical or surprising feedback to start the session with. Such feedback can help us to orient the process in a direction that is useful for the family. Furthermore, our focusing on critical feedback shows the family that we welcome and value such feedback.

Case: The Smits family (4): the start of the second session

We presented the filled out DFTs to the family and asked them to comment: 'What do you notice?' or 'What surprises you?' This way of starting the session links the new session to the previous one and helps the family members to focus on what is most meaningful for them, in terms of process (e.g. the therapeutic alliance) and in terms of content (e.g. themes to talk about in the family).

'For us, it seems the growing hope was the most important feedback we can give', father said

We said we appreciated their feedback. Then we addressed Fred and thanked him especially for his feedback about not having had enough space to say what he had to say. We apologised to him and we promised that we would take care to give him enough room to speak this session.

In the session the family members mainly talked about anger and sadness; and how sometimes one can lose control over one's feelings. The family members talked about conflicts in the family and how they dealt with it. The parents talked in a very engaged and animated way, and so did the children. Both children made several drawings that helped them to explain some of the things they wanted to talk about. Everybody seemed to enjoy the pleasant and playful atmosphere in the session. At the end of the session the family members once more filled out the DFT.

In their DFTs the parents showed a continuing preoccupation about the participation of the children: 'Emma needed time to defrost', 'Fred participated more' … Both were pleased with the way the session had been going. Father wrote 'Today a lot of things surfaced' and mother wrote 'interesting ideas about conflict strategy'.

The DFTs of the children were especially interesting. Emma added long hair to the smiling character on the right and she said 'That's me. That is how I really think about the session'. She had written 'It was top, top, top' in the speech bubble.

Fred's feedback was also positive (Figure 4). While after the first session he had written 'I hate waiting', this time he wrote 'Time went by very quickly'

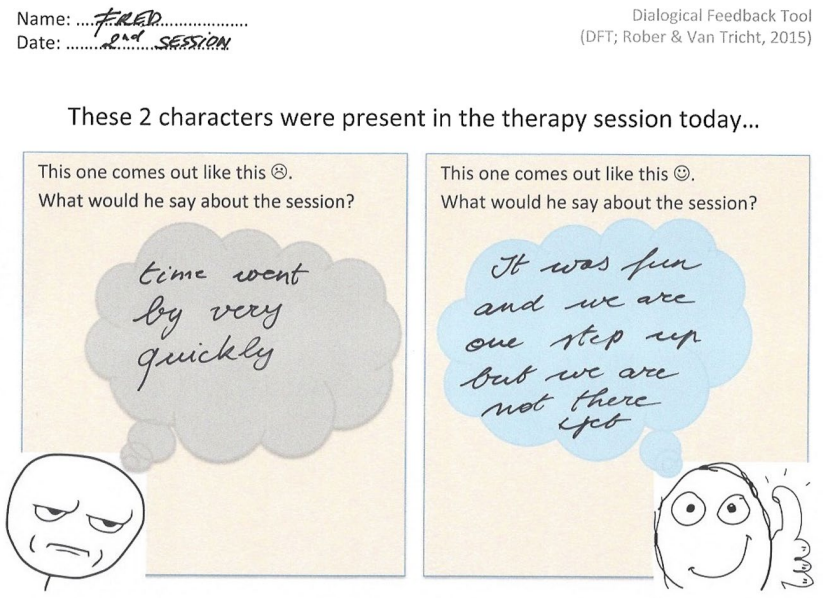

Figure 4. Fred's DFT (second session).

We were especially intrigued by Fred's words '… we are one step up, but we are not there yet'. I (PR) asked him: 'Can you tell us a bit more about what you mean?' Fred said 'Look', and he showed us a drawing he made in the course of the session. It was the drawing of a house (Figure 5).

Fred explained that his house has several floors. The bottom floor is called the 'boos verdieping' (trans. anger-floor). That is the floor where they have been for a long time, he said. The second floor is the 'Hulpzaam verdieping' (trans. helpfulness-floor), the third floor is the 'Vriendelijke verdieping' (trans. friendly-floor) and all the way up there is the 'Lief verdieping' (trans. sweet/love-floor).

Now we understood what Fred meant when he wrote on his DFT '… we are one step up, but we are not there yet'. Also in later sessions he would refer to the house with the floors as a metaphor for the family's connection and the progress of the therapy. For instance at the end of the third session in his DFT he noted: 'Through our talks we have made good progress. We are on the next floor!'

Discussion

Family therapy practice is very complex, and writing about what happened in a therapy session is always a simplification. Some things are described while other things are neglected. In our description of the therapy with the Smits family we have focused on micro interactions between the family members and the therapist in order to illustrate that it is interesting to systematically make room for the different family members' feedback and that the DFT is a useful instrument to do this. While we think it is not possible to be a-theoretical, we think that an instrument like the DFT can be used across therapy theories as it is focused on a common therapy factor like the alliance.

Feedback instruments as conversational tools

Working as family therapists in a feedback-oriented way is a challenge, as a lot of the traditional feedback instruments are in fact instruments for individual therapy that can be used in family sessions: for instance, Duncan and Miller's well-known and in the family therapy field widely used SRS and ORS (Duncan *et al.*, 2003; Miller, Duncan, Sparks and Claud, 2003). There are instruments that are developed from a systemic perspective and that can be used as feedback instruments: the STIC (e.g. Pinsof, 2017) and the SCORE (Stratton, Bland, James and Lask, 2010), for instance. These are very good instruments that have been

Figure 5. Fred's drawing of a house (second session).

tested for their psychometric qualities, in terms of validity and reliability. Instruments like the STIC and the SCORE, however, are much more than feedback instruments. They were conceived to also function as research tools (to measure outcome, for instance, see Stratton *et al.*, 2010) and they are time-consuming and cumbersome instruments that are quite clumsy to routinely use within the complexity of the multi-actor setting of a family therapy session.

The Dialogical Feedback Tool (DFT) is completely different. For one thing, it is not a measuring instrument. A measuring instrument is directed at securing quantitative information about process and/or outcome. Its psychometric properties can be calculated. The information that a measuring instrument generates can be the basis of graphics and software applications. The DFT does not generate quantitative information. It is a conversational tool that is supposed to contribute to the creation of a dialogical space, in which the family members and the therapist can together reflect on the process of therapy and in particular on the therapeutic alliance in all the complexity of such an alliance in a family therapy session (Rober, 2017). So the DFT is not an instrument that is aimed at monitoring progress in therapy in terms of outcome. In that sense, strictly speaking, it does not fit the Routine Outcome Monitoring (ROM) perspective (Tilden and Wampold, 2017).

What characterises conversational tools is not only that they do not generate quantitative data, but also that they do not give answers. Rather, they offer opportunities for questions and for respectful curiosity. For example, the responses of the Smits family on the DFT were always explored through the therapists' questions and were never given any definite interpretation outside of the conversations with the family members. Furthermore, feedback instruments as conversational tools are focused on optimisation of the collaboration between the family and the therapists (Sundet, 2011, 2017). An instrument like the DFT can be used to open space for conversations about attunement in the therapeutic relationship and about the need to re-orient the therapy process (e.g. Rober, 2017).

The family members' agency

Being feedback-oriented as a therapist is first of all about making dialogical space for the feedback of clients. This feedback may be positive or it may be critical. However, for clients it is not easy to be critical (e.g. Hill, Thomson, Cogar and Denman, 1993; Rennie, 1994). Only if clients feel safe enough will they take the risk of presenting critical feedback to the therapist (Rhodes, Hill, Thompson and Elliott, 1994).

It is precisely this critical kind of feedback that the therapist should be interested in, as it can help her to orient the therapy in a direction that is more useful for the clients (Duncan, 2010). Therefore it is important that we as therapists invest in creating a culture of feedback (Duncan, Miller and Hubble, 2007): a safe space in which clients can be sure that their feedback is welcome and taken seriously.

Research shows that the patient's contribution to the process is a crucial factor in therapeutic change (Assay and Lambert, 1999; Duncan and Miller, 2000). Clients are active self-healers, rather than submissive recipients of an intervention (Bohart and Tallman, 2010). The agency of the family members is central from the start of the therapy. The therapist engages with the family members as active, committed and responsible persons focused on finding ways to better manage their lives together. The therapist assists them with her knowledge and professional expertise, but especially by encouraging and supporting them in their self-healing efforts (Bohart and Tallman, 2010).

Feedback-oriented therapy as a responsibility

Feedback-oriented therapy is often framed within an *ethic of accountability*. Then it is often called *Routine Outcome Management* (ROM), as therapists are expected to prove their effectiveness using hard data based on repeated measurements. They have to demonstrate that the psychotherapy services they offer actually work and that they contribute significantly to the quality of life of their clients.

Although in these times of constraints (Wilson, 2017) it is impossible not to be affected by the ethic of accountability that is so dominant in the field of mental health care, our practice of feedback-oriented family therapy (Rober, 2017) does not fit well within such an ethical frame. We prefer to frame it within an *ethic of responsibility*.

The distinction made between an ethic of accountability and one of responsibility may not be readily understood. What exactly is the difference between an ethic of accountability and an ethic of responsibility? In an ethic of accountability there is always a triangle: there is the service user (the client), the professional (the therapist) and the controlling agent (the manager, the politician …) to whom the professional is accountable. It is specifically within the interaction between the professional and the controlling agent that objective outcome measures are crucial: with objective measurements the professional can prove that she does a good job and that it is a good idea for the policymaker to invest in her services.

In an ethic of responsibility there is no such triangle. Instead of being accountable to a controlling agent, the dialogue between the family members and the therapist is crucial: the family members suffer and the therapist tries to be responsive. While accountability is etymologically connected to 'counting', responsibility is connected to 'responding' or to 'response' (Partridge, 1961). Haraway (2008) also talks about responsibility as being 'response-able' (p. 71). Indeed, our first responsibility is to be responsive to our clients (Larner, 2004) and be open to their feedback. General knowledge about the average client may be necessary in order to make the right policy decisions, but it is insufficient for the practitioner confronted with the particular suffering of the unique client who just told his or her story. In the face-to-face encounter with the client the therapist has to learn to speak the language of the other (Larner, 2016): it is only through the conversations and dialogues with that specific, unique client in front of us that we get a sense of what might be helpful in this single case. It is here that we find the use of feedback instruments handled as conversational tools clinically relevant and indispensable. While measurements with valid and reliable instruments do make sense within an ethic of accountability, in the perspective of responsibility reliable measurements are less important, as the focus is on the client rather than on the controlling agent. If within an ethic of responsibility the therapist is accountable to someone, it is to the client, not to an outside controlling agent.

While there are clear differences between the *ethics of accountability* and the *ethics of responsibility*, both are necessary in a well functioning mental health system. Furthermore, these ethics are not necessarily mutually exclusive. It is possible, for instance, for a therapist to use quantitative measures in order to monitor progress and prove effectiveness, while also using qualitative measures to allow clients a voice about their experiences in therapy. Such complimentary use of feedback instruments, while risking being a burden on the clients who have to fill in a lot of questionnaires, offers a lot of opportunities for the therapist as well as for the family to make therapy an enriching experience.

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