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HOW ROUTINE PATIENT-CENTERED MONITORING RELATES TO THERAPEUTIC GAINS IN FAMILY THERAPY: A SINGLE-CASE STUDY

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As routine outcome monitoring systems develop, questions emerge about how therapists incorporate feedback into their practice, and how this relates to therapeutic gains. A case of covert grief was monitored in each session with the Personal Questionnaire and the Helpful Aspects of Therapy instruments. At 4 months follow-up, the Change Interview was administered. Individualized items facilitated access to the private views and needs of each member, which was useful for case formulation and ongoing personalization of the intervention. Qualitative feedback of treatment experiences helped therapists confirm the impacts of interventions, monitor therapeutic alliance, reformulate clinical hypothesis, and plan sessions. Therapists followed a critical triangulation process to decide the clinical meaning of feedback, according to his/her intervention model, expertise, and case-specific context.

One of the major goals of the practice-based evidence approach is basing routine clinical work on strong evidence by monitoring every case, and giving practitioners feedback about treatment response to support clinical decision making (Barkham, Hardy, & Mellor-Clark, 2010; Halford, Pepping, & Petch, 2016). As tracking systems are created and evidence of their effects on outcome start to be documented, questions emerge about how therapists incorporate monitoring information into their practice and how this relates to the therapeutic gains of patients. This article aims to shed light on the process of routine monitoring and feedback of individualized outcomes and treatment experiences in family therapy. We present a successful intervention in a case of covert grief, and provide a detailed description of how clinical decision-making was shaped by the family session-to-session feedback, leading to outcomes enhancement.

The idea of limiting clinical practice to treatments with experimental evidence of positive effects (i.e., evidence-based practice) has given rise to a counter movement toward broadening of the concept of evidence, in order to consider knowledge derived from real practice (e.g., Gordon, Pell, & Pell, 2003; Halford et al., 2016). A strategy for gathering practice-based evidence of the real

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effects of talking therapies consists of evaluating outcomes in each and every patient, and using technological platforms for treating and archiving the large scale resulting databases. While aggregating data to inform about service performance and benchmarking (e.g., Barkham et al., 2001) these systems also make available to clinicians systematic feedback about treatment response (Johnson, Miller, Bradford, & Anderson, 2017; Lambert & Shimokawa, 2011; Lappan, Shamoon, & Blow, 2017). In the field of couple and family therapy, the American Association for Marriage and Family Therapy has recommended the routine use of family feedback as a core competency for practice (Nelson et al., 2007) and five systems have been launched support therapists in this task: the *Contextualized Feedback System* (CFS; Bickman, Kelley, Breda, De Andrade, & Riemer, 2011); the *Individualized Patient-Progress System* (IPPS; Sales, Alves, Evans, & Elliott, 2014; the *Partners for Change Outcome Management System* (PCOMS; Anker, Duncan, & Sparks, 2009); the *Marriage and Family Therapy Practice Research Network* (MFT-PRN; Johnson et al., 2017); and the *Systemic Therapy Inventory of Change* (STIC; Pinsof et al., 2015).

A meta-analysis of 12 controlled studies (Knaup, Koesters, Shoefer, Becker, & Puschner, 2009) showed that feedback of outcome over the course of the treatment had a small, albeit statistically significant short-term effect on improving mental health outcomes ($d = 0.10$, 95% CI 0.01–0.19). This suggests that besides informing about outcomes, routine outcome monitoring (ROM) systems could also be used as clinical adjuvant tools, enhancing the quality of care. However, Knaup et al. (2009) also found that the positive effect of feedback on patient outcomes did not persist in the long run after termination of treatment. More recently, contradictory results were found. A number of studies (e.g., Amble, Gude, Ulvenes, Stubdal, & Wampold, 2016; Janse et al., 2017; Kendrick et al., 2016; Probst, Lambert, Dahlbender, Loew, & Tritt, 2014) showed that ongoing feedback about outcome progress and therapeutic alliance does not result in a better treatment outcome in CBT, except in the treatment of depression (Janse et al., 2017). On the other hand, outcomes were enhanced by providing treatment progress and alliance information to both clients and therapists in couple therapy (Anker et al., 2009; Reese, Toland, Slone, & Norsworthy, 2010) and in family therapy (Bickman et al., 2011; Cooper, Stewart, Sparks, & Bunting, 2012). Interpretation of these inconsistent findings is difficult due to the diversity of explanatory factors. Inconsistency can be caused by plausible heterogeneity on how therapists actually use ROM systems, by differences on the type of measures included in the system, or by the algorithms and formats of feedback it provides, the type of therapy, among many other factors. Research is needed that unveils how feedback is used and the mechanisms by which feedback influences outcomes (Amble et al., 2016; Janse et al., 2017; Moltu et al., 2018). Greenhalgh, Long, and Flynn (2005) hypothesized that the lack of consistent impact of outcome feedback into practice may be due to the nomothetic nature of the assessment tools used, which provide too general information, whereas therapeutic processes are individualized. ROM systems follow a nomothetic approach using gold standard outcome measures appropriated for repeated administration over the course of the treatment (Lutz, Stulz, Martinovich, Leon, & Saunders, 2009; Overington & Ionita, 2012). Although excellent measurement tools, standardized pre-set measures are limited when it comes to capturing the uniqueness of each patient reality. In contrast, patient-generated measures (PGM) give patients the possibility of proposing items that reflect their personal areas of concern (see Sales & Alves, 2016 for a review), hence favoring a patient-centered assessment that reflects patient values and needs (Barkham, 2016; Green, 2016; Sales, 2017). Therapists have expressed their preference for integrating PGM in progress tracking systems, not only to monitor individualized outcomes but also to monitor patient experiences (Haber, Carlson, & Braga, 2014; Jensen-Doss et al., 2017; McLeod, 2017; Sales & Alves, 2012; Sales et al., 2014). A personalized monitoring approach, combining nomothetic ROM and qualitative PGM, was implemented, the IPPS System (Sales et al., 2014), which is tailored for individual, group, couple and family therapy and is integrated on the CORE-Net System (Barkham, Mellor-Clark, & Stiles, 2015); as well as in the MFT-PRN (Johnson et al., 2017), an internet-based portal designed to support a professional community of couple and family therapists on progress monitoring. However, it is unknown what feedback data therapists choose to integrate in their practice, and how PGM enhance outcomes.

This article explores these questions in a case study of a family in therapy dealing with covert grief. A single-case design adds to the existing evidence on the benefits and value of monitoring progress systems, which has been mainly derived from survey studies. While surveys to the

therapists provide an overall view of acceptance and feasibility of routine formal monitoring, the analysis of clinical cases offers a step-by-step contextualized picture of how feedback is selected by therapists and influences therapeutic work during the course of therapeutic sessions. Case studies have been used to explore feedback monitoring mechanisms (e.g., psychodynamic therapy, Winkeljohn Black et al., 2017) but to our knowledge it has never been used in family therapy. We present a case of a family suffering from covert grief, which was monitored on a session-by-session basis with PGM. Our aim was to gather a close perspective of how feedback of this data was used by therapists and how it related to therapeutic gains.

In order to frame the case, we briefly present key aspects of our family therapy intervention in covert grief. When families face the death of a close member, resources are mobilized toward reestablishing equilibrium, which helps members to mourn and at the same time to adapt to new patterns of connecting to each other and reaching a new family identity (Shapiro, 2008). However, some families face difficulties in restoring this developmental movement and the discontinuity brought by death keeps them in relational patterns that do not facilitate grief and growth. One way that prevents families from grieving their loved ones is when their members are not able to recognize the meaning of their loss, nor express or share their feelings. Some families adopt unconsciously a closed communication system that protects them against the anxiety aroused by an open communication stance (Bowen, 1976). The tension between the individual and the collective tasks of mourning may hinder the expression of grief, sometimes leading to more superficial and less genuine interactions between family members (Moos, 1995; Walsh, 2003). Complicated grief may manifest in different ways (Boerner, Mancini, & Bonanno, 2013; Fulmer, 1983). Families often present themselves for family therapy with an explicit request concerning symptoms related to the reaction to death. But bereavement in covert grief cases is not perceived as the key issue and another presenting problem is brought to therapy. The family does not recognize (and often refuses to acknowledge) the link between the presenting problem and the impact of a prior death/loss in the family (Montesinos, Garcia, & Beviá, 2002; Walsh, 2003). Bloch (1991) refers to the symptom carrier (typically a child) as serving the function of attracting concern and attention to allow the family to avoid facing the suffering of loss, hence maintaining homeostasis and preventing the emergence of transformational mechanisms for the adaptation. Family therapy is an effective therapeutic approach in covert grief, as it facilitates open communication and strengthens interpersonal family relationships (e.g., Abeles, Victor, & Delano-Wood, 2004; Bloch, 1991; Carr, 2009).

METHOD

Participants, Clinical Setting, and Ethical Considerations

Clients were a Portuguese single parent middle class family consisting of the mother (39 years old), and two full genetic sibling daughters (D1—13 years, and D2—9 years). Father had died 2 years before, at the age of 37.

The therapy was provided by two female therapists (both aged 27 years), clinical psychologists with approximately 4 years of experience and post-graduate training in systemic family therapy. They worked together in all the sessions as co-therapists. The case was supervised session-by-session in group meetings led by a certified supervisor with 15 years of clinical experience, female and aged 40 (CMDS, the first author). The supervision group was also attended by senior therapists and clinical psychologists enrolled in the family therapy post-graduation program at the Centre for Research and Family Support, Autonomous University of Lisbon (CIAF-UAL), described later. The number of participants in the supervision meetings varied between six and ten and their sociodemographic data were not collected.

The research team was composed of the supervisor and first author, CMDS, a practitioner-researcher with main interest in routine personalized assessment of outcomes and processes; SF, a licensed clinical psychologist who was engaged on the CIAF-UAL post-graduate training in family therapy but who did not take part in the treatment or in the case supervision process; SF holds a Master on Clinical Psychology and is a fulltime practitioner; and PMM, a Professor in Clinical and Health Psychology, psychotherapist and researcher in the fields of attachment, family and psychotherapy, who joined the team for the preparation of the article. The team members shared a

commitment to conduct research in naturalistic settings and their preexisting expectations were positive but critical in tone toward ROM systems and PGM. The group as a whole can be seen as having potential biases but this did not come forth as a major issue in the study.

Treatment took place at CIAF-UAL, a university-based clinic in Lisbon (Portugal), led by therapists from the Portuguese Association of Family and Community Therapy, which served as the clinical internship placement of family therapy post-graduation trainees. CIAF-UAL was partner of an international Practice Research Network aiming to explore formats of personalized feedback-informed therapy (IPHA, Sales et al., 2014). According to the CIAF-UAL practice research protocol, all family members were independently assessed on a session-by-session basis, as described later in this article. At intake, families were informed of the protocol and asked for their informed consent to use data for research and teaching purposes. The family agreed and gave consent. Written informed consent was obtained from the mother for publication of this case report. The study was approved by the research ethics committee of the Universidade Autónoma de Lisboa.

Instruments

Simplified Personal Questionnaire (PQ) (Elliott, Mack, & Shapiro, 1999; Portuguese adaptation for family therapy by Sales, Gonçalves, Fragoeiro, Noronha, & Elliott, 2007; Sales, Gonçalves, Fragoeiro, Silva et al., 2007) is a patient-generated outcome measure, listing approximately 10 "problems" that the patient would like to work on in therapy. The list is constructed in a semi-structured standardized 45-min interview. Complaints are rank ordered and the patient is asked to rate each problem on the list "according to how much it has bothered you during the past 7 days, including today" using a seven-point scale (where 1 is *not at all*, and 7 is *maximum possible*). Over the course of treatment, the PQ form is administered at the start of each session. Patients are allowed to enter new problems or to delete previous items if they wish. Elliott et al. (2016) recommend a minimum of 1.50 points (based on 1.67 points for pre-post change, and 1.4 points for week-to-week change at $p < .05$), as a reliable change index (RCI) interval (Jacobson & Truax, 1991), and a caseness threshold of 3.25. In this study, each interviewer summarized the clinical information provided during the interview, which was added to the PQ form, to inform therapy, since clinical relevance of these interview reports was previously stated (Sales, 2005).

Helpful Aspects of Therapy (HAT) (Llewelyn, 1988; Portuguese version by Sales, Gonçalves, Fragoeiro, 2007; Sales, Gonçalves, Fragoeiro, Silva et al., 2007) is a patient-generated process measure that asks patients to describe in their own words, the most helpful event in the session, and to rate how helpful it was. HAT also asks about other helpful or hindering events in the session. The HAT form is usually administered immediately after each session, and sometimes after the inter-session period (i.e., immediately before the next session).

Change Interview (CI) (Elliott, Slatick, & Urman, 2001; Portuguese adaptation for follow-up assessment by Sales, Gonçalves, Fragoeiro, 2007; Sales, Gonçalves, Fragoeiro, Silva et al., 2007) is also a patient-generated process measure, in the format of semi-structured interview to be administered after therapy has been completed. It is designed to obtain a rich qualitative account of the patients' understanding of what has changed in themselves and their families and how those changes have come about; what aspects of change were due to the therapy; and what were the helpful and hindering aspects of therapy.

Notes of the clinical sessions and of the supervision meetings, and a final case report written by the therapists after the follow-up were used as additional data sources.

Procedure

Data collection. The family was assessed and monitored according to the CIAF-UAL practice research protocol. The major steps of the protocol are as follows: In a first intake meeting, all family members (>10 years) are separately interviewed for the PQ construction and scoring (the interviews are conducted by trainees of the family therapy post-graduation with prior training on PQ administration procedures, who are not in the therapeutic team of the case). The family is given an appointment for the first family therapy session, and before this first session the PQ is administered in the waiting room by the co-therapist, in order to monitor eventual changes between the intake interview and the beginning of the therapy. All PQ information is taken to the supervision

meeting and becomes part of the available data reviewed in the preparation of the session. At the end of the session, still in the therapy room, each member (>10 years) fills in the HAT and their answers are taken to the supervision post-session discussion meeting, where it can be used it to obtain an immediate feedback of the experiences. When the family comes for the second session, they are asked to fill in the PQ (to monitor change) and the HAT concerning the previous session (for a complementary feedback of their experiences) and these data are shared with the supervision group. After the session, the HAT is filled in and used in the post-session supervision meeting. This procedure is repeated over the course of the treatment until discharge. A follow-up session is conducted 4–6 months after discharge, where each family member is separately interviewed (Change interview) and are asked to score the PQ. Figure 1 displays the data collection and feedback design. The application of this protocol is flexible, according to the family preferences and the service contingencies: Family members are free not to fill in the measures, if they do not wish to; in addition, because of practical unexpected constraints of the service dynamics, some administrations may be missed. In this particular case, there were some deviations from the protocol that are described in Figure 1.

Data analysis. We started by analyzing the outcomes, following the initial step of analysis of the Hermeneutic Single Case Efficacy Design (HSCED, Elliott, 2002). This method was chosen because it evaluates clinical change by bringing together both quantitative outcome (clinically significant change on mean PQ scores) and the qualitative patient perceived changes (HAT and CI results), in order to answer the question *Was there therapeutic change?*

In a second step, we performed a detailed session-to-session therapeutic process description, in order to identify *what feedback information was used by clinicians* and to understand *how the feedback integrated in the therapy contributed to therapeutic change*. After an initial reading of all the available data, SF made a preliminary description, based on the session and supervision notes and all available data. CMDS read this preliminary description, discussed it with SF, and re-wrote the analysis accordingly until a final consensual analysis was reached.

RESULTS

Intake and Treatment Overview

The mother initiated contact by telephone, and she cited her concerns with her eldest daughter as the reason for requesting family therapy: poor school performance ("four negative grades last semester") and truancy ("reached the limit of absences allowed in school"). In the individual

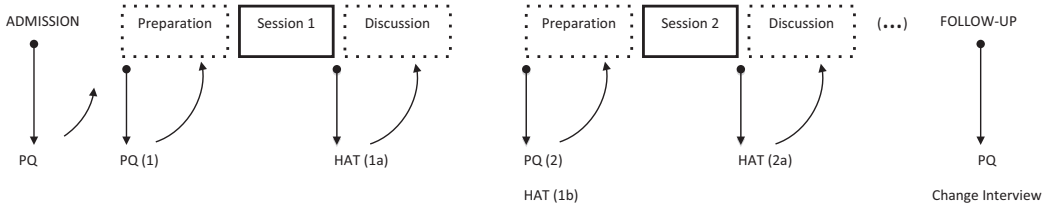

Figure 1. CIAF-UAL protocol for session-to-session monitoring and feedback.
PQ (#)—Personal Questionnaire administered before session #.
HAT (#a)—Helpful Aspects of Therapy administered immediately after session #.
HAT (#b)—HAT regarding session # administered immediately before the next session.
Preparation—Supervision meeting that revises the case and planes the session that is about to start.
Discussion—Supervision meeting that discusses the session that just ended.
Deviations from protocol (data missing in the case):
Mother: Left HAT (1b) in blank; PQ was not administered on follow-up
D1: PQ was built up at PQ (2); D1 did not attend the follow-up session
D2: The protocol was not applied, due to her young age
Due to service constrains, HAT (3b) and (4b) were not delivered to the family

interview for the construction of the PQ, the mother again presented D1 as the identified patient (IP), and indicated the main problems she wished to solve in therapy as being the rebelliousness of D1 and the mother-daughter conflicts caused by the daughter's disruptive behavior. In addition, the mother referred to relationship problems between her and her husband's families of origin. She said she felt torn between the families, caught in the middle of a "conflict of loyalties." The problems indicated by D1 in the PQ interview concerned difficulties in the relationship with the mother; problems with school performance and integration with classmates; and also concerns about the well-being of the younger sister (see list of complaints on Table 1). At start of family therapy mother was receiving psychotropic medication (*Lexotan*, *Dumyrox*, and *Xanax*), which had been prescribed following the death of her husband, and she was also receiving individual psychological

Table 1
PQ Items of the Mother (M) and the Oldest Daughter (D1) and Respective Session-to-Session Intensity of Distress, on a 1–7 Likert Scale

PQ items	Pre-treat 30.5.08	Session 1 20.6.08	Session 2 18.7.08	Session 3 25.7.08	Session 4 21.11.08	Session 5 12.12.08	Session 6 9.1.09
M							
1. My daughter (D1) is rebellious	6		2	5	6	6	5
2. I do not get along with my two families	5		3	4	4	3	2
3. My daughter (D1) is not loyal to me						6	4
D1							
1. Lack of confidence on the part of the mother			2	4	3	4	2
2. Lack of tolerance by the mother			3	3	4	3	2
3. Lack of firmness by mother			3	3	4	4	2
4. Being a model for the sister (because of imitating also the negative aspects)			4	3	2	1	_
5. Indiscretion of sister			3	4	1	3	3
6. School performance (weak)			3	3	2	3	_
7. Lack of acceptance by the class to which I belong			3	1	1	1	_
8. Friends are "chungas"*			2	2	2	1	_

Note. *Slang Portuguese term that refers to young people who do not behave, have low educational attainment and are rude.

therapy. D1 had been offered individual psychological treatment after father's death, however, she expressed little interest in the process and only attended one session. Family therapy consisted of six sessions over 7 months. Termination was decided by both parts, in face of the observed recovery, and the shared perception that the family could manage the persisting difficulties without professional help. The follow-up was carried out 4 months after discharge.

Therapy Outcomes

Quantitative change. Pre-post quantitative change was only computed for the mother because pre-treatment PQ ratings were available only for her. As displayed in Figures 1 and 2, mean PQ scores decreased from a mean of 5.5 points to 3.5 at discharge, which corresponds to a significant clinical improvement (RCI > 1.67) in the mothers' priority problems indicated before starting treatment. This improvement almost reached the functional intensity of distress levels of PQ (caseness threshold of 3.25 points). The progress of the mother on PQ mean scores was not linear: After a clinically significant improvement from intake to pre-session 2 (RCI > 1.4 points), she returned to the initial level of distress and improved significantly before the last session. The daughter was not clinically distressed by session 2 and she continued to display reliable improvement across therapy.

Qualitative change. At 4 months follow-up, the mother identified several positive changes that she attributed directly to family therapy: "The therapy has united the three of us more" [mother and daughters]; "therapy taught us to communicate better"; "therapy changed D1, she left the bad phase, has regained academic performance and acknowledged that she was troubled"; "therapy changed my ability to relate to my daughters, less angry." However, the mother reported that D1 "remains oppositional and stubborn" although she acknowledged that this was age appropriate. This relates to the PQ complaint "My daughter is rebellious" which was still present at discharge (5 points) and was a complaint that showed no change. Finally the mother reported that since the end of the therapy, relational problems with both families of origin had worsened ("more conflicts with families were generated").

Since D1 did not come to the follow-up interview, and she did not rate the PQ items in the pre-treatment appointment, the analysis of change concerned to the PQ evolution from sessions 2–6. Her complaints were mostly related to the mother, the sister and the school. The highest rated concern was assigned to the worry of being a bad model to the sister ('moderate discomfort', 4 points). In the end, the complaints were no longer disturbing and those related to school were withdrawn by her request because they did not exist anymore.

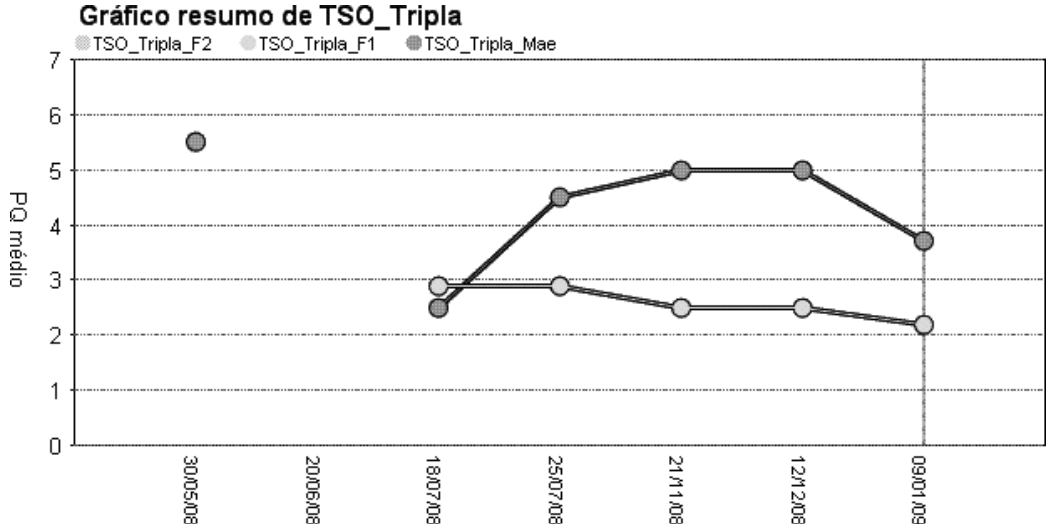

Figure 2. Session-to-session mean PQ progress for M and D1 (print out from the IPPS system). Gráfico resumo de TSO_Tripla—Graphical summary of case code TSO_Tripla; PQ médio—Mean PQ; Abcisses represent session dates.

Session-to-Session Therapeutic Process

In the preparatory meeting of the first session, the therapeutic team reviewed the telephone request for treatment, the family history and the PQ items identified by the mother at intake. The therapists noted that during the PQ generation interview the mother demonstrated emotional distress and lability when referring to her husband, and she described disturbing feelings of "guilt and dismay" after his death. However, she did not indicate any PQ items regarding the father, as complaints were centered on D1. The interviewer who conducted the PQ item-generation session wrote, "mother does not know how to handle the situation, she feels very insecure and disoriented, she has commented 'I do not recognize myself!'"(PQ interview notes). Using this data the therapeutic team formulated the systemic hypothesis that there was an unresolved grief and explored this hypothesis in the first session.

Session 1. The first session aimed to formulate a diagnosis of the family system in the presence of the three members. The themes identified in the interviews of PQ were explored. At the end of the session, in response to the initial complaint about conflictual relations between mother and daughter, a specific homework task was suggested: they should exchange roles, each putting herself in the place of the other, while the youngest daughter was to act as observer and provide feedback afterwards. However, it was clear to the team that mourning "seems to be, right now, the real problem of this family. The mother cannot talk about the death of the father, and refers to it as, 'after what happened. . .'. The children also do not speak about it" (first session notes).

Family feedback—D1 confirmed this interpretation of the therapists in her HAT forms. She identified the most difficult point of the session for her as: "I think it was the fact that I talked about my father. As it was still recent, it cost me a bit" (HAT post session 1). At the meeting of supervision after the first session, the hypothesis was consolidated that the disturbed behavior of D1 would have the function of maintaining a forced homeostasis within the family system in view of the unresolved grief of the father. Strong difficult feelings (anger, hurt, distress) were located in D1's behavior and her relationship with the mother rather than as feelings related to the loss of the father. The resolution of grief was defined as the general therapeutic goal.

Session 2. The aim of the second session was to facilitate and legitimize the expression of feelings related to grief. "We addressed the positive moments with father; and a layout of the family house as it was before the death and as it is now was drawn" with the children, in order to prompt the identification of relational changes and emotional expression. The mother talked about the two earlier heart attacks of her husband and his eventual death after the third. "The whole process was quick and unexpected, and the mother is visibly disturbed and moved when talking about this, but she tries to hold back her tears and feelings" (therapist notes of the second session). The intervention focused on the following changes in family functioning: "emphasizing positive aspects of cohesion in the mother-daughters triangle, and acknowledging and normalizing that it must be very hard to deal with this loss" (. . .) and; "acknowledging that it is hard to raise two daughters without the support of the second parent. (. . .) The difficulty of the mother in addressing this painful aspect was validated, but the team stressed the importance of talking about the past in order to cope and moving forward" (notes of the second session and summary report at the end of the therapeutic process).

Family feedback—The impact of the expression of emotions associated with bereavement was particularly evidenced by D1: "What cost me the most was perhaps having spoken of my father and how our life was with him (. . .) we haven't talked about this for a long time (. . .) perhaps because I do not want to accept the idea that my father's death is really true" (D1 most difficult event in HAT2). The most positive aspect of the session was the sharing of memories, "it was how all of us talked in the family about our life before" because "it served to show us what each of us is thinking, and to know what each of us thought when my father still was present, and to help me see the feelings of my mother and my sister" (D1 most helpful events).

The supervision meeting at the end of the second session examined the family feedback given in the HATs, together with notes and impressions of therapists. Some signs of poor therapeutic alliance with the mother were noted: not having completed the first homework assignment (role exchange), showing "some relational avoidance during this session and the poor adherence to the HAT" (second session notes), responses to which were evasive and incomplete. One of the therapists stated that "it gave me the impression of a person in deep mourning, very focused on her own

pain, which she prefers not to talk about. With reduced optimism about life, about the success of therapy and about her relation with D1." Following the premise that it is impossible not to communicate, the avoidance of reporting the experiences (on HAT) regarding this session devoted to explore grief was interpreted as signal of suppression of this emotion, as well as a signal of nonagreement with this task. On the other hand, the therapists also considered the possibility that "the daughters' presence could be inhibiting to the mother, who may have hesitated to show emotions, possibly because she did not want her daughters to see her vulnerable" (second session notes).

Based on these data, it was decided to use the next session to strengthen the therapeutic alliance with the mother and to facilitate the expression of emotions in an individual space format, respecting her privacy and circumventing the emotional suppression that in the mother's view could be protective of daughters. "It was thought that it would help set up *recorte*[1] meetings to provide separate spaces to facilitate the expression of emotions. For the mother it was meant to allow her talking of her husband's death, without the daughters" (summary report of the therapeutic process). For the daughters, and following an issue that emerged in the PQ, the aim was to strengthen their relationship, and to "enhance the role of D1 as older sister, as she herself acknowledges that she is a model for her sister, but admits she often does not know how to be in that role the best way." By emphasizing the role of D1 as a model sister she could be helped to realize that "her conduct does not impact only the mother but also the younger sister, thus leading to a reflection on how to become a positive role model for sister" (second session notes).

Session 3. The third session followed two therapeutic strategies: (a) redefining the request ("reframing the problem of the family as a case of mourning, which is natural given the death of the father, and not as a serious problem of D1 rebellion") (summary report of the therapeutic process); and (b) facilitating the emotional expression in face of father's death. It was proposed to talk separately and in parallel with the mother in another room, according to the technique of *recorte*.

In the *recorte* with daughters, "drawings of the family before and after father's death were made to facilitate speaking about the death. The union of the sisterhood and the role of D1 as a model sister was stressed. Both sisters spoke about the revolt of D1 and about the mother's complaint "that every time someone talks about the father, D1 changes the subject or tells a joke." The therapist reframed this behavior as an attempt of protect her mother and sister. D1 agreed and was visibly moved. She said it cost her to see her mother in a low mood, because she would not know how to help" (summary report of the therapeutic process).

In the *recorte* with the mother, besides supporting emotional disclosure concerning the husband's death in a private context not exposing her vulnerability to children, the same positive reframing of D1 behavior as protective was stressed: "D1 reacts to the most emotional moments with laughter in an attempt to ease the tension that is generated. Poor behavior in school serves as an attempt to draw the attention of the mother, as if to say 'Mom I'm here and I need you' as well as being typical teenage rebellion. The real problem of the mother and the whole family is not D1's poor behavior but the fact that father passed away 2 years ago." The mother accepted this reframing (third session notes).

Family feedback—For D1 the most significant aspect of the session was "talking about the past, how and when my father died, (. . .) I feel upset talking about it", but then, "it is important to know that all we suffer, although differently, (. . .) to know what each of us thinks" (HAT the end of the third session). Correspondingly, the mother revealed that the most difficult aspects of sessions 2 and 3 were "talking about the past" (. . .) because "remembering our past is very difficult" (HAT from second and third sessions). However, "talking about the past in order to face reality" was the most helpful event for the mother during session 3.

Sessions 4 to 6. The fourth session took place after 4 months. This time gap took account both of the summer holiday break and also a postponement of a session for administrative reasons. Given the large time interval, the team decided that the session would have the aim of reevaluating the family system. The mother reported improvements in the relationship with the older daughter, with fewer difficult discussions and more good times shared during the holidays. Still, from the mother's point of view, D1 continued to give insufficient help with housework. This and the following sessions did not focus the theme of grief directly, but rather focused on the initial request made by the mother concerning the difficult relationship with D1. The session explored what each person expected from the other and how negotiation about these tasks took place. Again, the theme of the

father's death emerged and D1 referred to it as a difficult aspect of session 4: "Perhaps telling how there was an equilibrium (in negotiation concerning the household activities) when my father was alive".

In the fifth session, the "rebellion" of D1 was reframed as a normative behavior to be expected at her age, even though the therapeutic team recognized that it upsets the mother. In the 6th and final session, the therapeutic work returned to the issues of communication and negotiation. A roleplay of a conflict situation was conducted. The situation was explored from various angles to find the best way for mother and daughter to make requests of one another and to reach agreement. A reflection was made on how to apply these principles in future situations, noting the best way to make requests and how to improve non-verbal communication. In order to conclude the therapeutic process, an account of the family progress was made. The family was given discharge from therapy and given a follow-up session to take place after 4 months.

In the sixth session HAT, D1 pointed the most difficult event as "talking about Christmas" because "we end up thinking about Christmas as it was before, when my father was alive", showing that the theme of mourning remains present throughout the therapeutic process even when not directly covered in the session.

Follow-up. At the follow-up the mother attributed important changes to family therapy: "What was most important was that the relationship with my oldest daughter was resolved" (. . .) "what helped most were the dialogues with my daughters and the fact that while talking it was possible to talk about their father's death" (CI). When asked about the hindering aspects of family therapy, the mother stated that in the "first sessions she had difficulty talking about the death of her husband and particularly to talk with her daughters about it. However, at the same time as being very painful it was also positive since 'it allowed us to address this matter'" (CI).

DISCUSSION

This case aimed to gather a close understanding of how family therapists use patient-centered monitoring data resulting from an individualized outcome measure and the reporting of patient perceived in-session experiences, and to disclosure paths by which this feedback related to the positive changes observed in the family system.

Although PQ provides quantitative feedback of clinical progress, therapists mostly relied on its qualitative information, not necessarily for monitoring the progress of outcomes but rather for case formulation and the identification of themes to explore in the sessions. Family therapists had previously stated that PQ was useful for case formulation and treatment planning (Antunes, Sales, & Elliott, 2018; Sales, Gonçalves, Fragoeiro, 2007; Sales, Gonçalves, Fragoeiro, Silva et al., 2007) and our results provide clues to understand how. The individual PQ interview facilitated the quick access to the private views and needs of each member, which could be difficult to emerge in sessions with the entire family (e.g., the suffering and guilt of the mother regarding the death of father). The contrast between what was said in the PQ interview and what was chosen as PQ item was also clinically informative (e.g., neither the mother nor D1 indicated grief issues). In the particular setting of family therapy, with a different PQ for each family member, the range of problems indicated by each person provided valuable information for case formulation. Due to the nature of the case itself, grief was not indicated as a PQ item. However, it was the discrepancy between the impact of father's death and its absence in PQ that led therapists to explore the hypothesis of covert grief. Moreover, therapists faced PQ items as individual priority areas of intervention and tailored therapeutic tasks accordingly (e.g., focusing the role model as older sister in the *recorte* with the sisters). Hence, it is plausible that PQ items helped to tailor treatment planning, which facilitates agreement in therapeutic tasks and enhances alliance and outcomes (Friedlander, Escudero, Heatherington, & Diamond, 2011).

In summary, therapists combined the information collected during the PQ interviews and the content of PQ items to draw diagnostic hypothesis, and relied on the individual priorities of members to personalize intervention. This is in line with recent claims of the clinical utility of integrating individualized outcome measures in routine practice and monitoring (Antunes et al., 2018), and the used of multiple views from family members to gain a contextualized picture of the system dynamics (Bickman, Douglas, & Athay, 2012).

PQ helped to identify themes to address in therapy but the clinical agenda was not restricted or dictated by the problems indicated by the family. For instance, the mother mentioned problems with the families of origin but this aspect was not explored or included in the therapeutic aims. Therapists critically contrasted PQ data with clinical observation and with further information emerged from clinical encounters. Interpretation of PQ (either contents or scores) followed a process of data triangulation to assist therapists thinking about the case, a process that was also described in the Children and Young People Improving Access to Psychological Therapies program (CYI IAPT) (Norman, Dean, Hansford, & Ford, 2014). For instance, CY IAPT therapists observed that parents' fear of discharge could drive them to inflate their scores in nomothetic outcome measures, and therefore a poor outcome indicated by measures could not reflect a real deterioration (Norman et al., 2014). Also in our case, PQ scores reported before session 4 did not revealed significant changes, while during the session, important improvements were recognized both by the family and the therapist. In sum, therapists followed a critical triangulation process to interpret the clinical meaning of responses, weighting information from multiple sources and having into consideration the clinical history and the therapeutic relational dynamics. This triangulation process for incorporating feedback into practice is not exclusive for PGM, as it was also reported with nomothetic ROM in real-world settings. Independently of its nature (individualized or nomothetic) outcome feedback is an additional source of data whose meaning and usefulness is to be decided by the therapist, according to his/her intervention model, expertise and case-specific context.

A closer view of how therapists used PQ feedback showed that instead of relying on overall change scores therapists examined change in specific problematic areas, related to the particular aspects of family life. Such preference for case-specific feedback is in consonance with therapists' criticisms of depersonalization of nomothetic ROM, seen as over-focused on quantitative and simplistic representations of clinical outcomes, overseeing the complexities of clinical change occurring in unique cases (e.g., Evans, 2012; Greenhalgh et al., 2005; Norman et al., 2014). As a therapist put it, "each patient is individual. Have to look individually" (Norman et al., 2014, p. 586). By including items indicated by patients themselves, PQ and other outcome PGM allow monitoring progress on case-specific issues that are not captured by their nomothetic counterparts they introduce novelty (Ashworth et al., 2007; Sales, Neves, Alves, & Ashworth, 2017) that is valued and used by therapists (Antunes et al., 2018; Barkham, 2016), while also perceived by patients as useful for promoting self-reflection (Alves, Sales, & Ashworth, 2016; Guerra, Sales, & Pereira, 2018). Besides IPPS, which uses PQ, the MFT-PRN (Johnson et al., 2017) also offers this possibility, by including in the intake questionnaire the top three presenting problems indicated by each family member, which are scored for intensity on a weekly basis.

Finally, therapists extensively guided their practice listening to patients' feedback regarding their treatment experiences reported in HAT. As indicated by therapists in previous surveys (e.g., Haber et al., 2014; Sales, Gonçalves, Fragoeiro, 2007; Sales, Gonçalves, Fragoeiro, Silva et al., 2007), the therapeutic team used the HAT for confirm the impacts of interventions, monitoring therapeutic alliance, testing and reformulating clinical hypothesis, adjusting treatment plans and as a basis for session planning. This result points to the introduction of process PGM in tracking systems, and the provision of systematic qualitative feedback on patient experiences that includes their narratives. As far as we know, IPPS is the only system offering such functionality.

Limitations

This study was based on the data available in the clinical records and notes. However, it was not possible to ascertain if these materials provided an exact description of the way therapists used PGM. For instance, there was less information regarding the use of PQ scores than qualitative inputs of HAT and PQ. Was it because therapists did not rely on PQ scores, or because it was not reported on their notes? Although the first author was present on the meetings as supervisor, her memories can be biased and therefore her first hand testimony was not considered. Our results are not representative of the integration of idiographic feedback into routine practice, and should be interpreted accordingly. In the future it would

interesting to include the collection of the users' experiences (i.e., therapists and, if possible, patients) in routine monitoring protocols, since it allows a more accurate understanding involved in feedback-informed therapies in real settings.

We described the use of feedback in a successful clinical intervention. We relied on the HSCED approach to determine success, showing that there were positive outcomes (i.e., there were quantitative and qualitative evidence of positive changes in the family). However, we would have had a must stronger case, if we had showed that the intervention was effective (i.e., that changes were due to the intervention and could not be explained by alternative causes); we would then have gathered evidence of the link between idiographic feedback and efficacy. HSCED, in its full version, is a valid method to establish causal relations between intervention and outcomes in non-experimental cases studies derived from everyday real practice (Elliott, 2002). It proposes a set of steps for the systematic analysis of evidence in favor and against the effect of intervention, and it is adapted to family therapy (Sales, 2005; Sales, Fragoeiro, Noronha, Faísca, & Ortega Beviá, 2003). However, we did not perform the full efficacy analysis for two reasons. First, because we did not have enough data to conduct the analysis. Second, and more important, because using HSCED to show that family therapy was effective in a case of covert grief would in itself be an objective for another article. Still, and despite these limitations, our study identified innovative paths of routine use feedback that supported case formulation and intervention.

CONCLUSION

This case showed that routine monitoring using PGM provides clinical data that is relevant for case formulation and treatment adjustment in family therapy. Therapists rely essentially on qualitative case-specific data, which they filter and critically triangulate with further clinical data, in order to redesign creative and unique therapeutic paths. Three major recommendations can be derived for tracking systems: (a) to personalize feedback, by combining PGM and nomothetic monitoring tools; (b) to include feedback on patient experiences, and not only on outcome measures; (c) to provide descriptive feedback that facilitates/organizes access to the patient views and qualitative inputs; in family therapy, such feedback will be particularly useful if it displays the contrast of members views, since the total system response pattern is clinically informative. This case also raises an important question regarding the use of ROM systems data in quality management, for therapists and services performance evaluation. It clearly shows that a direct and uncritical data aggregation decontextualizes outcome scores and may lead to inaccurate conclusions regarding clinical achievements and performance.

NOTE

[1]*Recorte* is a Portuguese phrase coined by Prof. Pina Prata. It literally translates as "cut-out" and refers to parallel meetings of sub-groups of the family, but it invokes something of the figure-ground relationship used in gestalt psychology to mark the relationship between different parts of the system depending on ones perspective. Recorte technique consists of two parallel interviews within the session: At the beginning of the session, separate conversations are proposed; a part of the family talks with one therapist, and the other members with the co-therapist in another room. Recorte can be used to address individual issues, or subsystems issues (e.g., facets of conjugal life, interviewing the couple separately from the children) or to help reframing (Pina Prata, Sales, & Gonçalves, 2008).

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