FAMILY PROCESS

Feedback Informed Treatment: Evidence-Based Practice Meets Social Construction

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This article explores the challenges presented by the mandate for evidence-based practice for family therapists who identify with the philosophical stance of social construction. The history of psychotherapy outcome research is reviewed, as are current findings that provide empirical evidence for an engaged, dialogic practice. The authors suggest that the binary between empiricism and social construction may be unhinged by understanding empiricism as a particular discursive frame (i.e., a particular way of talking, acting, and being in the world), one of many available as a way of understanding and talking about our work. Through a case vignette, the authors introduce the evidence-based practice of Feedback Informed Treatment as an elaboration of social construction, and as an example of bridging the gap between the discursive frames of empiricism and social construction.

Keywords: Social Construction; Evidence-Based Practice; Feedback Informed Treatment; Outcome Measurement

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Evidence-based practice (EBP) poses a problem for family therapists who embrace the philosophical stance of social construction,[1] as the attempt to answer the call to be accountable, efficient, and outcome oriented is often heard as incompatible with the process orientation of discursive practices. This dichotomy between a focus on process and a focus on outcome is one of the central features that distinguish traditional, modernist orientations to therapy from what we will refer to in this article as "systemic/constructionist/dialogic" (SCD) family therapy. SCD is a term that embraces a long and important history in the family therapy world. This history started with the early systems models where focus on the family (as opposed to the individual) centered our attention on interactive patterns and properties of systems (Haley, 1971; Minuchin, 1974; Watzlawick, Beavin, & Jackson, 1967). This work evolved into what was, at the time, referred to as second-order cybernetics, where inclusion of the therapist/observer became central (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978). In turn, second-order cybernetic approaches to therapy served as the generative soil upon which current practices of family therapy, informed by a social constructionist philosophical stance, emerged. Therapy as social construction

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[1]We intentionally use the term *social construction* rather than *postmodern* because we are specifically talking about McNamee and Gergen's (1992) notion of *therapy as social construction.* We do not intend to label any particular model or practice as a "constructionist therapy." Thus, we understand any and all discursive frames (and therefore, methods of practice) as potentially meaningful and productive ways of engaging.

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focuses on the relational construction of meaning (McNamee & Gergen, 1992), as with the early systems models, but without the concomitant "properties of systems" (see von Bertalanffy, 1968) taking center stage as analytic tools.

The resistance to EBP by SCD-oriented family therapy reflects an understandable confusion between EBP and empirically supported treatments (EST), an important distinction that we will clarify in this article. Therapists often cite as concerns the focus on outcome rather than the unfolding process, and their belief that EBP is manufactured outside of the conversational moment, which is the very basis of SCD practice. Another concern frequently raised is based on the impression that EBP often relies on manualized approaches, thus silencing creativity in therapeutic practice, marginalizing relational inclinations (the heart and soul of SCD work), and restricting therapists' capacity to respond to clients' unique circumstances. By clarifying what constitutes EBP and presenting an EBP that centers on relational responsiveness, we believe there is a way to maintain the process orientation of SCD family therapy while simultaneously generating "evidence" that can inform effective practice.

What if there existed an EBP with the social poetics (i.e., an appreciation of the unfolding, dialogic process of meaning making) of a socially constructed and relationally engaged conversation? Would constructionists be willing to sign on to a practice endorsed as evidence-based if it empirically supported their being relationally responsive to their clients? If an EBP focused on being culturally relevant to clients, what significance might that have for constructionists? Would an EBP that unwaveringly acknowledges that the therapist him/herself is critical to what happens during the process of therapy be acceptable? What if there were an EBP that was explicitly organized around the idea that, together, therapist and clients create a unique way of being and moving on? Would these conditions answer the concerns about EBP commonly held by family therapists?

In this article, we discuss the communication gap that exists between constructionists[2] —who speak in the language of discursive production, multiple perspectives, and relational responsiveness—and the EBP mandate, perpetually and most important, erroneously practiced as technically scripted, rigidly prescriptive, and relationally aloof. We present the definition of EBP used by the National Registry of Evidence-Based Programs and Practices (NREPP) and demonstrate how the intended practice of EBP is actually quite coherent with the central tenets of social construction. We also review the history of the development of Feedback Informed Treatment (FIT), and suggest that FIT, recognized by The Substance Abuse and Mental Health Services Administration (SAMHSA)[3] as an EBP, is an elaboration of *therapy as social construction* (McNamee & Gergen, 1992). As such, it embodies the constructionist values of local and emergent meanings situated within an engaged and responsive therapeutic relationship. In the remainder of this article, we attempt to illustrate the ways in which FIT can help bridge the unnecessary gap between the institutional demand for EBP and the philosophical stance of social construction. Finally, we suggest that therapists who claim a constructionist sensibility are uniquely positioned to advocate for an EBP that puts into action core constructionist principles.

EBP OR EST?

Based on many of their experiences in the field, some family therapists rightfully entertain a number of concerns about EBP as they are often practiced. When conducting

[2]The term constructionist will be used as a "short hand" label for what we are referring to as the family of systemic/constructionist/dialogic therapies.

[3]SAMHSA is the government agency within the U.S. Department of Health and Human Services that focuses on behavioral health and grants EBP status. For information on this process, see www.nrepp.samhsa.gov. For SAMHSA's registry of interventions, see http://www.nrepp.samhsa.gov/ViewAll.aspx.

trainings for therapists on psychotherapy outcomes, it is not at all hard for us to elicit a white board full of well-articulated concerns.

Typically, what we hear from therapists is that they oppose EBP because they dictate how to work, and, more specifically, demand fidelity to a model that is chosen, typically, by matching a diagnosis (or presenting concern as defined by the professional community) with that particular model. This way of working is incompatible with constructionist sensibilities because it:

- Ignores local, client knowledges and privileges medicalized, expert ideas;
- Dictates the language of psychiatry/psychology as the language to use with clients;
- Is not contextual or culturally sensitive or responsive;
- Individualizes problems and offers universalized approaches (one size fits all);
- Ignores what the therapist brings and what the client and therapist create together. That is, it is a "product" approach and assumes anyone who is trained thoroughly in the product (model) and who administers it correctly will experience results (i.e., positive treatment outcomes).

Furthermore, many practitioners are disquieted by their impression that models endorsed as EBP typically do not reflect "real life" situations: The laboratory is not the family services agency. Therapists and clients are working together in conditions where there are an abundance of needs and scarcity of resources, not often the typical research scenario.

These are legitimate concerns . . . but *not* of EBP. These challenges that we typically hear from therapists in the field are actually critiques *of empirically supported treatments (ESTs)* or *evidence-based treatments (EBTs).* The distinction is an important one. According to the American Psychological Association Presidential Task Force on Evidence-Based Practice (2006), "ESTs start with a treatment and ask whether it works for a certain disorder or problem under specified circumstances" (p. 273), whereas EBP start with the client and focus on what will promote the best possible outcome. The confusion among practitioners is understandable given that the developers of treatment models frequently blur the distinction between ESTs and EBP themselves.

Evidence-Based Practice: Not What You Think It Is

The blurring of the distinction between ESTs/EBTs and EBP has led to an ongoing discrepancy between the idea of EBP, and how they have been implemented, practiced, and enforced. By *the idea* of EBP, we mean the definition (as asserted by NREPP, the governmental body in the United States that grants EBP status) and the values, purpose, and intentions implicit within the definition. Time and again, when conducting trainings with clinicians on outcomes in psychotherapy, there is a collective response of astonishment when we reveal the definition and criteria of EBP. Invariably, therapists say, "well, that's not so bad—in fact, that makes perfect sense."

Originally articulated by the Institute of Medicine, the following definition of EBP has been adopted (in various forms) by NREPP and the major professional organizations (e.g., AAMFT, APA, & NASW): *Evidence-based practice . . . is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.*

The Council for Training in Evidence-Based Practice (CTEBP) (2008) offers a rich description of what is involved in the *doing* of EBP. In the excerpt below from the document, *Definition and Competencies for Evidence-Based Behavioral Practice (EBBP)*, the council suggests that clinicians who provide EBP:

> . . .possess a curiosity and a sense of inquiry that defines them as life-long learners. They . . . continually learn ways to integrate research into practice and to critically evaluate the outcome of their behavioral interventions. . . . They recognize and understand the limits of science, their own knowledge, and their own skills. They are critically self-reflective and aware of the personal and cultural biases that each practitioner possesses. . . . They pay close attention to the environmental context and systems within which they work, and are sensitive to the many types of interpersonal and community-level differences that exist. They recognize and act upon the understanding that *decisions about health need to be made in collaboration with those most directly affected by the decisions*. . . . (pp. 2–3; emphasis added)

What is striking about this portrayal of EBP is how similar it is to our understanding and practice of social construction as a process of being relationally engaged. When we view therapy as social construction, we are not particularly interested in predetermining what sort of interactions will produce transformation. We are more concerned with adopting a *relationally engaged* stance with clients. Within such a stance, the ethic of psychotherapy is one of being relationally responsible (McNamee & Gergen, 1999). A relational, postmodern ethic is one of knowing *how* to be attentive to the *process* of opening viable possibilities and potentials for those with whom we work. This requires focus on what therapist and client do together in the therapeutic conversation because we can never "know" outside of any given context or, more specifically, outside of the interactive moment. The constructionist asks, "*What do we do, as therapists, once we propose that meaning emerges in the on-going flow of persons in situated activity? How do we know when clinical practice is responsible and ethical?*" Answering these questions requires attending to what people do together (McNamee, 2009).

The emphasis on curiosity and inquiry versus certitude and finality is a hallmark of a constructionist stance. Second, the implicit acknowledgment that *all ways of knowing* have limitations and benefits speaks to the notion that all discursive frames are resources to be considered. Third, this articulation of EBP highlights the constructionist emphasis on reflective practice and the recognition that therapists contribute to meaning making processes with their clients. The idea that practitioners should "evaluate the outcome" of their work resonates with the constructionist tenet that we are constantly negotiating meaning and crafting the effects of our engagements with those with whom we are in conversation. Finally, the assertion "that decisions about health need to be made in collaboration with those most directly affected by the decisions" is at the heart of relationally engaged ethics: We must be accountable to our clients.

Given the definition of EBP and the vision of its implementation and practice as described above, we suggest that constructionists are uniquely positioned to influence and shape both the understanding and practice of EBP in ways that can be helpful for clients and practitioners alike. Constructionists, with a focus on inquiry and reflection, a commitment to curiosity (Cecchin, 1987) and "not knowing" (Anderson, 1997), and the deftness of dialogue (Seikkula et al., 1995), have a unique opportunity to change the conversation about EBP.

As to why there is such a discrepancy between the idea and the practice of EBP, we can only speculate. One possibility is this: People do what they know and fold new practices into their ways of doing things—dialogically speaking they transpose practices into the language with which they are familiar. Thus, those who practice from a medicalized perspective, reliant on diagnosis, centering of professional knowledges, and organized by treatment planning, are likely to understand, approach, and execute EBP in a manner that is coherent with their philosophical stance and discursive frame. The idea of "evidence" is typically affiliated with traditional forms of research—forms that have emerged within a medicalized, essentialist understanding—thereby contributing to SCD resistance to EBP. Furthermore, funders and policy makers, who often make decisions about the

selection of EBP for specific, targeted groups, are likely to find the language of fidelity and precision (i.e., the language of traditional science) more comprehensible.

Rather than theorizing or speculating, however, from a constructionist standpoint, it may be more generative to ask questions, such as:

- In what ways might we be able to achieve the vision of EBP as articulated by the CTEBP?
- Who would be important to include in efforts to make this happen?
- How might we include the voices of clients in furthering our understanding of what counts as effective therapy, for whom, when, and in what context?
- What would be important to understand about the experiences of clients, clinicians, managers, and others?
- What have been some of the significant obstacles in translating research into practice that we need to consider? What has been most effective in doing this?
- How might we maintain a fluid dialogue between research and practice such that each informs the other?

Asking these questions is not necessarily a project in "getting to the right answers"; we are interested in bridging the existing gaps between the intentions and realities of EBP, and offering a dialogical link that unites purpose with practice, research, and application. There are, no doubt, many other questions that would serve us in this journey.

Our effort to build these bridges is part of a long history of researcher-practitioner attempts to reconcile the challenge of putting research to use. It is also part of more recent efforts to answer the call for accountability and focus on outcomes. Before we discuss how FIT provides a constructionist reply to these challenges, it is important to consider how it has emerged in response to previous understandings of and elaborations on psychotherapy outcome research.

Back to Babel? Reconsidering the Potential of a Multilingual Approach to Therapy

In *Escape from Babel: Toward a Unifying Language for Psychotherapy Practice* (Miller, Duncan, & Hubble, 1997), Scott Miller and colleagues argued that psychotherapy (broadly inclusive of individual, relationship, and family practices) is a fractured mess because of the proliferation of models populating the field (at the time of their writing, estimates ranged from 250 to 400 distinct models). The problem, the authors maintained, was that the existence of these many ways of explaining and intervening in people's problems failed to result in an increase in positive outcomes. In fact, the overall effectiveness of therapy had not changed after decades of outcome studies (Lambert & Bergin, 1994). Thus, they argued for a move away from the distinctive languages of multiple models (*I'll see your differentiation and raise you one parental sub-system*) toward a "unifying language" organized around and informed by the common factors (Lambert, 1992) as a way to save the field from the chaos (and stagnated outcomes) of Babel. It was time, they claimed, to surrender allegiance to the Model Builders and their multiple languages and instead focus on leveraging the common factors and speak in a universal tongue of psychotherapy.

The common factors identified by Lambert included: extratherapeutic factors, therapeutic alliance, placebo and expectancy factors, and model and technique. As common factors, they stand in contrast to *specific* components that are purported to be the "active ingredients" of a particular model.

The field of family therapy specifically has also taken a serious look at the common factors research. Several couples and family therapy (CFT) scholars (Lebow, 1997;

Sparks & Duncan, 2010; Sprenkle, 2002; Sprenkle & Blow, 2004; Sprenkle, Blow, & Dickey, 1999; Sprenkle, Davis, & Lebow, 2009) have invited family therapists to consider the common factors and their implications for the practice of couples and family therapy, actively challenging the insistence that models and techniques drive change. Consideration of the common factors reflects a broader effort in the CFT field to incorporate research into practice, and to develop research-informed practitioners. Gurman (1978, 2010, 2011) and Gurman and Kniskern (1978a,b,c) in particular have blazed the trail of research-informed CFT practice.

Attention to the common factors has stirred a generative and game-changing conversation about the practice of couples and family therapy. Yet, evidence of the role of common factors—while clearly one of the most significant (and robust) findings in the history of outcome research—does not tell the complete story about, nor does it offer explicit guidance for, effective practice. Facing the evidence that specific factors do not account for therapeutic change invites us to loosen our grasp on particular theories, models, and techniques, leading us to acknowledge that claims of superiority have no empirical footing. Yet, important questions remain: Does it help us know what to do? Is speaking a universal language of common factors the way forward to a practice of accountability and increasing effectiveness in the provision of therapy services?

We suggest that the answer to these questions is no: The common factors, by which we mean effective ingredients shared by all models of therapy (e.g., Lambert, 1992), alone do not provide a path forward. In addition, imposing universality effectively produces yet another model, the very thing that the research insists we reject (Hubble & Miller, 2004). Where then, do we look for guidance? Two factors have emerged as actually being *predictive* of positive or negative outcomes: (1) the strength of the alliance *from the client's perspective,* and (2) early change (Bachelor & Horvath, 1999; Haas, Hill, Lambert, & Morrell, 2002; Johnson, 1995; Lambert & Brown, 1996). In short, the client's experience of the alliance and their report of early change were found to be the best predictors of a positive outcome. Thus, while we cannot know "what to do" *before* meeting with clients (an inherent premise of assigning a particular EBP to a category of clientele), we *can* know if what we are doing is—or, more important is not—contributing to clinical progress and positive outcomes. When we know this, we can adjust the work in collaboration with our clients to increase the likelihood of progress.

Feedback Informed Treatment (FIT) is an effort to translate this research into a practice of continuous quality improvement (CQI). This practice is not intended to be another model, replete with its own language, explanatory interpretations of pathology, and specific techniques to be used universally with all clients. It is meant to make use of outcome and alliance feedback from clients to inform practice, regardless of the therapist's preferred way of practicing, and to engage therapists in an ongoing process of improving their effectiveness. By soliciting, monitoring, and responding to client feedback, therapists foster allegiance to clients, not models, and engage reflexively within the therapeutic encounter. This practice represents an active utilization of research by monitoring the alliance and outcome in an effort to respond to weaknesses in the delivery of service specific to a given therapist–client interaction.

From a relational constructionist perspective, this practice also reflects the heart of dialogical practice. We view this as an explicit invitation from empirical research to engage in a dialogical practice, one that responds to the multiple languages in which clients speak, rather than insisting on the singular voice of a particular model, or of the common factors. Indeed, the research is quite encouraging for CFTs who have resisted the mandate for rigid standards of adherence to a particular model, as the bottom line of outcome research tells us that what we need to adhere to is what is happening in our engagement with each client.

Research in Couples and Family Therapy

What about FIT in couples and family therapy contexts? In the largest study in the history of couples therapy, "couples in the feedback condition . . . achieved nearly four times the rate of clinically significant change, and maintained a significant advantage . . . at 6-month follow-up while attaining a significantly lower rate of separation or divorce" than couples in the treatment as usual (TAU) group (Anker, Duncan, & Sparks, 2009, p. 693). Reese, Toland, Slone, and Norsworthy (2010) reported similar findings in their study of using feedback with couples, noting that "four times as many couples in the feedback condition reported clinically significant change by the end of treatment" (p. 616). Furthermore, those couples in the feedback condition reported statistically greater improvement, and at a faster rate, than those receiving treatment as usual.

These two studies suggest the promise of incorporating feedback into practice. Other methods of obtaining client feedback, such as the Systemic Therapy Inventory of Change (Pinsof et al., 2009), are being developed, and are representative of the movement toward outcome monitoring in clinical practice.

The Language of Feedback and the Client's Voice: Resources for Listening

If current research is pointing to the use of client feedback and the need to monitor outcome while payers are demanding use of evidence-based practices, what options exist for the research-informed family therapist who wants to provide effective service? The most recent iteration in the effort to improve therapy outcomes by turning "evidence" produced through research into practice is *Feedback Informed Treatment (FIT)* (Bargmann & Robinson, 2012; Bertolino, Axsen, Maeschalck, Miller, & Babbins-Wagner, 2012; Bertolino, Bargmann, & Miller, 2012; Maeschalck, Bargmann, Miller, & Bertolino, 2012; Miller & Tilsen, 2011, 2014; Seidel & Miller, 2012; Tilsen, Maelchalck, Seidel, Robinson, & Miller, 2012). FIT attempts to position itself at the meta-level of abstraction and avoid prescriptions or directives with regard to specific models, methods, or techniques. FIT focuses on soliciting and responding to client feedback to inform the therapeutic process. As such, we see FIT as an *elaboration of social construction* in that it: (1) recognizes all models and methods of therapy as discursive options—all offer viable "languages" for engagement—based on the pragmatics of how well a particular practice allows us to go on (Wittgenstein, 1953); and (2) involves the reflexive practice of inviting feedback into the therapeutic relationship to co-construct emergent meaning with clients. Both FIT and social construction remind us that we cannot know how to engage with another *until* we enter that engagement and create together the most meaningful ways of "going on."

When teaching the principles and practices of FIT, we emphasize that we are *not* telling therapists *how to practice* or what theory or model to use; we are telling them to gather client feedback so that they can work out, together with clients, a way forward. This is the stance of social construction: All ways are possibilities, but you will not know until you have engaged—and responded—in the conversational moment which one(s) are helpful in any given context. Thus, rather than advocating for a path *away* from multiple languages to a single language, we suggest that the research supporting FIT provides empirical evidence that we are most helpful to more clients when we become fluent at responding to the multiple languages in which they speak.

However, this is *not* a license for a practice of "anything goes." Indeed, what FIT tells us is that we must respond to feedback about the alliance and outcome. Thus, by adjusting our practice for each client, we maximize the potential for accomplishing the clients' desired effects. Nor does it mean that we indiscriminately do whatever clients request of us, or that we have no limitations. Consideration of local ethics and the possible effects of what we do (or do not do) always guide our practice (McNamee, 2009). Finally, it does not

mean that we become expert or fluent in every way of working—that is not possible. It does mean that we recognize when our ways of working are not a generative fit for our clients—sooner rather than later—and we respond helpfully by facilitating a change to a service that is more in line with our clients' needs and preferences.

THE PRAGMATICS OF FIT

What does FIT look like in practice? Specifically, how is feedback solicited and integrated? FIT focuses on soliciting and responding to client feedback to inform the therapeutic process and function as process of CQI. Two ultra brief tools are used—one to monitor change, the *Outcome Rating Scale (ORS)* (Miller & Duncan, 2000), and the other to monitor the alliance, the *Session Rating Scale (SRS)* (Miller, Duncan, & Johnson, 2002).[4]

The ORS invites clients to describe their experience in four areas: individually (personal well-being); interpersonally (family, close relationships); socially (work, school, friendships); and overall (general sense of well-being). It provides a description of overall distress; however, it is important to note that the ORS is *not* an assessment or measure of psychopathology or illness. The SRS, on the other hand, seeks client feedback on the following aspects of the therapeutic meeting: relationship; goals and topics; approach or method; and overall. On both forms, each aspect is presented as one of four lines, 10 cm long. The ORS and SRS are presented as visual analogs, that is, blank lines with two end points without numbers.[5] The therapist measures the marks to the nearest millimeter and, together with the client, documents their marks on a simple graph.

While these scales generate "scores" that are compared against a normative clinical sample (aggregate data provide projected trajectories of change), the scores require that the client imbue them with meaning through the therapeutic conversation with the therapist. This is in sharp contrast to, for example, a GAF score with universally assigned meanings that are generated externally and interpreted by the clinician.

This practice requires the therapist's keen attunement to the relationship, deft conversational skills that elicit clients' local meanings and preferences, and the willingness and ability to move flexibly among many possible ways of proceeding in response to client feedback. This process also gives clients the opportunity to collaborate in the shaping of the ongoing and emergent nature of the therapeutic conversation. As such, we see it as a clear elaboration of *therapy as social construction* (McNamee, 2004), one that gives meaning to scientific discourse and lends support to the social poetics of meaning making. It is an invitation away from the univocality that an "escape from Babel" advocated in a complex world full of multiplicities.

A reasonable question could be asked, "How do you reconcile the apparent paradox of norms and social construction?" From a constructionist stance, all frames are viable options, including the frame of empiricism, which is simply one discursive frame. Also, norms are statistical constructions, ones that are situated within a particular context. And perhaps more important is the consideration that statistics is another "language game" (Wittgenstein, 1953)—no more "true" or "correct" than any other out of context.

Trying on for Size: FIT in Action

Therapists who practice feedback informed treatment focus on establishing a culture of feedback. It means that therapists actively and consistently, from the onset of service,

[4]The ORS and SRS are available free for downloading at http://scottdmiller.com/performance-metrics/

[5]For information on the psychometric properties of the ORS and SRS see Bertolino and Miller (2012) and Duncan, Miller, Wampold, and Hubble (2010).

communicate their sincere interest in and need for client feedback about the services provided. Cultivating and maintaining a culture of feedback requires that therapists embody an earnest need and desire for client feedback to inform and shape the conversational process. In particular, it means that therapists take responsibility for creating a conversational climate that allows clients to tell us what is *not* working well, when we are *not* being helpful, and when we need to make changes to keep the conversation going in meaningful ways (Bargmann & Robinson, 2012).

When first meeting with clients, we tell them that we are very serious about making sure that they get what they want from meeting with us, and to this end, we seek their feedback about the service they are receiving. We let them know that meeting together is supposed to make a difference—however they define that—and that is why we check in with them at each meeting. We explain the purpose of the ORS in tracking outcome and the SRS in tracking their experience of our work together. We emphasize the need to know what *is not* going well, what is missing, or what does not feel right. We briefly discuss why it is important to attend to outcome and client engagement, explaining that they are strong predictors of a good outcome, and that we pay close attention to these to make adjustments in treatment sooner rather than later.

What is important to highlight here is this: The purpose of the ORS and SRS are made visible to clients. They are recruited as active collaborators in the process of determining both the effectiveness and the process of therapy. The culture of feedback is just that, a culture, and as constructionists, we believe that language carries culture. As such, to create and sustain a culture of feedback, we must cultivate—and speak in—its language, from the beginning, and with earnestness.

Sustaining a culture of feedback also requires that therapists respond to and act on the feedback they receive. The integration of client feedback on outcome (from the ORS) and alliance (from the SRS) is critical in FIT, as it puts into practice the research on what works in therapy: insuring early change and a strong alliance. We cannot ask for client feedback in a tokenized way—we must take seriously what they tell us and respond accordingly. This includes engaging clients in the back-and-forth process of meaning making and forging preferred ways forward. In the culture and language of social construction, we are being relationally responsive, and discursively producing—*in the conversational moment*—the therapeutic conversation. It is this moment-by-moment responsive engagement that leads us to understand FIT as an elaboration of social construction.

Case Vignette

For example, Julie met with Jason and Ryan for relationship therapy. The forty-something couple said that they were experiencing "communication issues" that proved problematic for them in household planning and management decisions and in parenting their 10-year-old son, Scotty. At the first meeting, Julie asked the couple to mark the ORS for themselves, giving both partners their own separate form. Julie explained that their marks would be a description of how the problems that had brought them to therapy were affecting them. She then asked them to mark an ORS together; this time, they were to mark it from the relationship's perspective. "How would your relationship say things are going?" she asked. This practice is neither particular to nor required by FIT; rather, it reflects Julie's personal orientation toward the relational. While Jason's ORS was 18.5 and Ryan's was 16.9 (the average adult intake ORS score is between 18 and 19) the relationship reported an ORS of 14.8.

At the end of the session, Julie presented the couple with the SRS and underscored the importance of giving her any necessary "negative" feedback. "Negative feedback" means

feedback about things that clients find not helpful; it does not mean negative feedback in the systems sense of maintaining status quo.

Ryan scored the SRS above the cut-off mark on all four scales and expressed his satisfaction with the session's "take-aways"; however, Jason's mark on the "method or approach" scale was 8.3, below the cut-off of 9. Julie asked specifically what she might do differently to raise that score next time. Jason said that he would like "less questions and more time to talk about what's bothering me." Julie acknowledged that she does, indeed, ask lots of questions, and suggested that perhaps, she could check in to see if it was a good time to ask a question before doing so. Jason thought that this was a good compromise. When Julie checked with Ryan, however, he said that he thought the questions were "what helped make a difference for us" in the conversation.

Julie asked them to consider it from the relationship's perspective: Given the differences in their individual preferences, what did the relationship think would help the most? After thinking it over together, Jason said, "the relationship wants you to decide, Julie. The relationship thinks that Ryan and I have had our chances to tell it what to do, and it would really appreciate you taking over and putting us in the learner's seat."

Julie responded that it sounded as though they agreed with each other to listen to their relationship right now. She asked them if they (and their relationship) thought it made sense to keep our collective eye—and multiple perspectives—on the ORS and SRS to help determine how well she was doing and when they'd be ready to take over. They agreed.

Over the next three sessions, Ryan, Jason, and their relationship reported steady increases in the overall ORS scores as their marks climbed above the clinical cut-off of 25. SRS scores also rose and stabilized above the cut-off. Ryan and Jason described less frustration, fewer arguments, and expressed more hope for the direction of their relationship.

At the fifth session, Julie noticed that, while his overall ORS score was still on the rise, Ryan's score on the "individual" scale had gone down. She commented that it seemed that, perhaps, he was being buoyed by his relationships with Jason and others in his life, as his scores on the "interpersonal" and "social" scales had gone up significantly. Ryan agreed that all of his "relationship stuff and things out in the world are good—they do keep me afloat. Jason and I are doing so much better since we started trying some of the things we've talked about here. It's my back pain that brings me down."

Ryan explained that he had been living for the last 5 years with chronic back pain from a mountain biking injury. Jason commented that the pain was like a "third party in our relationship" as it demanded much of Ryan's energy and attention at times. Jason also explained that he was often torn about how to respond to the pain: "Ryan has been pretty clear that he doesn't want to talk about it because he feels like that gives it even more attention. I respect that, and, at the same time, it feels like something that comes between us."

We talked about the overall trajectory of the ORS scores—Ryan's, Jason's, and the relationship's—as well as the score of Ryan's individual scale. Julie asked their relationship what it thought would be best to do, noting that it seemed as though she did not need to be driving the decision bus anymore. The couple thought this over. As they talked with each other, Jason became teary and said, "I just feel so bad for him but I don't know what to do." Ryan took Jason's hand and said, "I think I've not paid attention to how the pain affects you and the relationship. . . . I think you've been trying to give the relationship a voice when you've wanted us to talk about it. Let's do that, OK?"

We spent the rest of the session exposing the effects of the physical pain on each of the men, their family, and their relationship. Julie asked them to use the ORS to describe the effects of Ryan's physical pain on their lives and the relationship. These marks were significantly lower than those on the ORS forms they completed when we started the session. At the end of the session, both men scored the SRS 40 and volunteered that they were

surprised how "involved with our lives" the pain had been. Jason, who had wanted for some time to talk about Ryan's injury, noted how "breaking it down on the ORS made it clearer how to talk about it."

We ended the session with Ryan accepting some referrals for a variety of complimentary medicine and bodywork services—something that he had apparently not been open to in the past, despite the urging of his parents, friends, and, Jason. We followed up 3 weeks later: The ORS scores (based on the impact of Ryan's physical pain) had risen significantly. The couple explained that, although Ryan was still experiencing pain, they now had ways of being in relationship with it that brought them together in conversation rather than dividing them with silence.

Is it likely that Jason, Ryan, and Julie would have identified the centrality of Ryan's experience with pain without using FIT? Of course, although there is no way to really know that. Could there be other practices that would have led to similar conversations about the effects of pain on their lives? Absolutely. The key point is that FIT supported the therapeutic conversations that Jason, Ryan, and Julie were creating together. Also, it helped orient the conversational compass in ways that led them to inquire about and attend to very specific considerations, such as the discussion on their different experiences in the first session (based on the SRS scores) and the exploration of Ryan's decreased score on the individual scale. By attending to these nuanced factors, the research on outcome and alliance suggests that Julie was able to adjust the course of treatment before the couple either left therapy dissatisfied or continued in an unhelpful direction. For therapists informed by constructionist philosophy and interested in finding useful questions that open up new areas of inquiry (and thus, possibility), the ORS and SRS provide more questions toward that end.

IMPLICATIONS FOR TRAINING AND PROFESSIONAL DEVELOPMENT

What are the implications of the research in support of organizing therapeutic practice around feedback for the training and development of effective therapists? From our perspective, the implications are significant. Historically, family therapy has focused a great deal of therapist preparation and continuing education on the study and mastery of various models of practice and the theories that inform them. Graduate programs continue to feature courses that emphasize theories and models, and they often require students to identify one or more specific model that they intend to practice. A large extent of ongoing professional development training is geared toward learning specific methods of practice.

With the current mandate for EBP, this has not changed: Therapists are often required to learn and execute methods of practice that bear the EBP endorsement. Consequently, therapists seek training in EBP. At the heart of all this professional education is the notion that learning the specific technical maneuvers of any particular model is what makes for an effective practitioner.

In addition to the nagging persistence of the research that refutes specificity in favor of common factors, the literature on tracking outcome and alliance and the importance of soliciting client feedback is a game-changer. Rather than spending our training time and dime on technical mastery of methodological fidelity, these findings implore us instead to develop expertise at *relationship building and feedback solicitation*. Such a focus is exemplified in the cultivation of a *deliberate and reflexive practice* (Maeschalck et al., 2012). Further support for shifting our training from a focus on models to a focus on feedback and deliberate practice is found in the literature on the study of excellent performance (Colvin, 2008; Ericsson, Charness, Feltovich, & Hoffman, 2006; Ericsson, Krampe, & Tesch-Romer, 1993; Miller, Duncan, & Hubble, 2007; Miller & Hubble, 2011; Shenk, 2010). From a constructionist perspective, we suggest that this shift is coherent with the

nurturing of a relationally responsive and reflexive practice that honors clients and acknowledges the importance of what we *do* together.

A Sheep in Wolves' Clothing: A Dialogic Practice Parading as Empiricism

Once, when giving a workshop on FIT to a group of skeptical family therapists at a youth-serving agency, a participant offered this observation near the end of the day: "FIT is like a sheep in wolves' clothing; it's scary because of how we're taught to feel about evidence-based practice, but when you get to know it, it's a really thoughtful approach."

Despite comments and reflections like this, there continues to be reluctance among many therapists to try on FIT. Family therapists *cri de coeur* can be summarized as a protestation against their fear of losing professional clinical autonomy in their practices. We would suggest that the notion of *autonomy* is misguided: We have never had complete independence from external controls. We practice under local laws and professional codes that articulate standards of practice, criteria of competence, and minimal expectations for ethical conduct that are reflective of local cultural norms. Our work is supervised and peer reviewed, ostensibly to monitor all of the above, as well as to ensure movement toward positive treatment outcomes and promote therapist development. For those who contract with insurance companies, there is another set of external influences that impacts autonomy. Thus, we have never really been fully autonomous in our practice, and while ceding our authority to some of the above external forces may indeed be a dubious enterprise, we do not think that *autonomy* should be a goal for practitioners—especially those who seek to engage in situated relational practices. Indeed, we argue that the very notion of *autonomy* is incoherent and at odds with relational practice. We also believe that it is *our clients*—through their feedback—who should occupy the critical position of influencing our practice (along with critically reflective peers and supervisors who help us reach to become the best therapists we can be).[6] This is what the research tells us. This is the empirical evidence for a relationally engaged practice of *therapy as social construction*.

We do agree that it is our clinical creativity, our professional judgment, and our clients' preferences, uniqueness, and voices that become erased by a rigid, often manualized approach to EBP. As a favorite mantra of FIT practitioners implores, "maintain fidelity to your clients, not your models." Nevertheless, that may be the sticking point for many family therapists: truly and sincerely being interested in soliciting *and acting on* client feedback, particularly when it suggests that what they are doing needs to be changed. Yet, we believe, and—within the discursive frame that is empiricism—the existing evidence supports us: To be effective we must be relationally responsive. Thus, there is "scientific evidence" for the social poetics of being conversationally responsive and relationally engaged; and it is only through relational engagement and conversational responsiveness that this evidence becomes legible. That is a discursive frame into which we are happy to speak.

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[6]See Ericsson et al. (2006) for a discussion of expert performance.

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