

ROUTINE OUTCOME MONITORING AND FEEDBACK IN PSYCHOTHERAPY

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En el campo de la investigación en psicoterapia existe una intensa dialéctica entre el enfoque centrado en los resultados y el enfoque centrado en el proceso psicoterapéutico. La Práctica Basada en la Evidencia integra ambas posturas junto a las características del paciente y la pericia de los clínicos. De este modo, las variables de proceso tienen una mayor visibilidad en la última década. En este trabajo se aborda una de ellas: la monitorización sistemática de resultados y el uso del feedback del paciente en psicoterapia. Se realiza una presentación del tema en nuestro entorno y se ilustra mediante la exposición de 5 casos clínicos. Se revisa el estatus empírico de la cuestión, sus principales virtudes y algunos inconvenientes para su generalización en la práctica clínica.

Palabras Clave: Monitorización Sistemática de Resultados, Feedback, Pericia, PCOMS, Psicología Clínica.

There is a passionate dialectic between outcome-based and process-based psychotherapeutic approaches in the field of psychotherapy research. Evidence-based practice integrates both positions with patient characteristics and clinical expertise. Thus, process factors have had increased visibility over the past decade. This paper examines one of them: routine outcome monitoring and collecting patient feedback. The topic is presented in our context and it is illustrated by exposing five clinical cases. We review the empirical status on the topic and the main strengths and barriers for its generalization in clinical practice are discussed.

Key Words: Routine outcome monitoring, Collecting Feedback, Expertise, PCOMS, Clinical psychology.

Although currently the efficacy of psychotherapy is well established (American Psychological Association [APA], 2013), between 40% and 60% of people who come to treatment do not benefit from it, either because they give up prematurely, they do not improve during treatment or they deteriorate (Lambert, 2010; Lampropoulos, 2011; Shimokawa, Lambert, & Smart, 2010; Swift & Greenberg, 2014). The literature also shows that this finding is repeated through different models and psychotherapeutic approaches (Imel, Laska, Jakupcak, & Simpson, 2013; Wampold & Imel, 2015). Other noteworthy findings of the last 15 years of research in psychotherapy include the decisive role of the patient, which is the variable that explains the most percentage of variance of the outcome of psychotherapy (APA, 2013; Bohart & Wade, 2013; Wampold & Imel, 2015), and the existence of supershrinks, psychotherapists and clinical psychologists who systematically obtain better results than most of their peers (Castonguay & Hill, 2017; Chow, 2014; Okiishi, Lambert, Nielsen, & Ogles, 2003; Prado-Abril, Sánchez-Reales, & Inchausti, 2017). The common factors movement in psychotherapy, despite certain criticisms (González-Blanch & Carral-Fernández, 2017), continues to be a consistent, fruitful and stimulating line of empirical research

(Norcross, 2011). Some variables of the psychotherapeutic process are more determinant of the outcome of psychological treatments than the techniques used or the model of theoretical ascription (Flückiger, Del Re, Wampold, & Horvath, 2018; Gimeno-Peón, Barrio-Nespereira, & Álvarez-Casariago, 2018). Among the process variables that have greater empirical support are the therapeutic alliance, both in psychotherapy with adults and with adolescents, and both in individual format and in family-systemic format, cohesion in group therapy, empathy of the therapist perceived by the patient and collecting feedback from patients (Norcross & Wampold, 2011).

In this article, the variable related to the importance of collecting and using the feedback of patients about the progress of psychotherapeutic treatment is analyzed in a preliminary way in our context. Furthermore, it is analyzed by presenting a specific assessment and monitoring system, the Partners for Change Outcome Management System (PCOMS; Duncan & Miller, 2008; Miller, Duncan, Sorrell, & Brown, 2005; Rodrigo-Holgado, Hernández-Gómez, Díaz-Trejo, Fernández-Rozas, Andrade-González, & Fernández-Liria, 2018). Although there are other instruments for systematic monitoring (see Table 1), the topic is illustrated using PCOMS because it is the shortest, it is not a list of symptoms and it is simple to fill out and correct. These characteristics, in our opinion, facilitate the harmonious fitting of the assessment within the therapeutic relationship without establishing such a clear gap between what is involved

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in an evaluation session (completing a questionnaire) and in a psychotherapy session (relational and technical procedures guided through conversation). Consequently, PCOMS is an assessment system designed for talking with patients, from one consultation to the next, about the possible difficulties in the therapeutic alliance and on the evolution of the treatment outcome, in order to monitor systematically the psychotherapeutic process and adjust the treatment to the needs and preferences of the patient from moment to moment. It is a method that has proven to be effective in English-speaking communities (Lambert & Shimokawa, 2011) and its use in clinical practice will be illustrated by the presentation of a series of clinical cases. Although an analysis of these characteristics is not intended to test theories, it is valuable in the construction of heuristic theories since the exhaustive analysis of a series of clinical cases allows the formulation of specific hypotheses about the mechanisms of change in psychotherapy (Prado-Abril, García-Campayo, & Sánchez-Reales, 2013). Finally, the implications, limitations and obstacles associated with the use of systematic monitoring and collecting patient feedback in clinical practice will be discussed.

ROUTINE OUTCOME MONITORING AND FEEDBACK: BRIEF STATE OF THE QUESTION

Routine outcome monitoring (ROM) in psychotherapy consists of the periodic and immediate assessment, using standardized instruments, of progress, or its absence, throughout the course of psychological treatment (Lambert, 2010). This practice has been shown to be effective in reducing the number of premature dropouts and in improving the treatment outcome, especially in cases of stagnation or deterioration during treatment (Lambert & Shimokawa, 2011; Shimokawa; et al., 2010). There are several feedback systems for use in psychotherapy (see Table 1), their main function being to provide the clinician with an indication of the patient's clinical state in order to facilitate the flexibility

and adaptation of the treatment to the changing needs of patients and their psychotherapeutic processes.

The meta-analyses of Shimokawa et al. (2010) and Lambert and Shimokawa (2011) studied two standardized methods that obtained favorable and promising results: the *Outcome Questionnaire Psychotherapy Quality Management System* (Lambert, 2010; Lambert et al., 2004) and the aforementioned PCOMS (Duncan & Miller, 2008; Miller et al., 2005). The meta-analysis performed by Shimokawa et al. (2010) covers a sample of 6,151 patients evaluated with the Outcome Questionnaire [OQ-45.2] (Lambert et al, 2004; von Bergen & de la Parra, 2002) as a measure of routine outcome monitoring and compares the usual treatment conditions with and without feedback. In the feedback group, in contrast to the group without feedback, the probability that patients experience deterioration is reduced by about 50% and the probability of obtaining a clinically significant improvement is increased up to 2.6 times. The meta-analysis of Lambert and Shimokawa (2011) shows similar results when a PCOMS routine outcome monitoring and feedback system was used. Patients in the group with feedback were 3.5 times more likely to improve and half as likely to suffer deterioration during treatment. PCOMS has also shown consistent performance in couples therapy (Anker, Duncan, & Sparks, 2009), group therapy in substance abuse (Schuman, Slone, Reese, & Duncan, 2015), in palliative care (Etkind et al., 2015) and in children and adolescents (Cooper, Stewart, Sparks, & Bunting, 2013).

Due to its particularity, it is appropriate to mention also the meta-analysis of Sapyta (2004, unpublished manuscript, cited in Sapyta, Riemer, & Bickman, 2005). In this study, the results were analyzed of 30 controlled clinical trials in community settings on the effectiveness of feedback on the clinical status of patients. Although a small effect size was obtained (0.21), the average results at the end of the treatment show better results in the feedback condition than in the control condition. However,

TABLE 1
CHARACTERISTICS AND PSYCHOMETRIC PROPERTIES OF THE MAIN ROUTINE OUTCOME MONITORING INSTRUMENTS OF THE PSYCHOTHERAPEUTIC PROCESS

Instrument	Abbreviation	Dimensions	Nº items	Reliability (Cronbach's α)	Spanish validation
Outcome Questionnaire-45.2 (Lambert et al., 2004)	OQ-45.2	Symptoms Distress, Interpersonal relationships, Social role	45	.93	Translation and validation in the Chilean population (von Bergen & de la Parra, 2002)
Clinical Outcomes in Routine Evaluation - Outcome Measure (Evans et al., 2002)	CORE-OM	Subjective well-being, Problems/Symptoms, Life Functioning, Risk	34	.94	Translation and validation in the Spanish population (Feixas et al., 2012; Trujillo et al., 2016)
Partners for Change Outcome Management System (Miller et al., 2005)	PCOMS	Outcome Rating Scale, Session Rating Scale	8	.93	Translation and preliminary validation in Spanish population (Rodrigo-Holgado et al., 2018)



the most interesting aspect of the study by Sapyta (2004) is that it verifies that the effectiveness varies according to the degree of discrepancy between the therapist's view of the evolution of the psychotherapeutic process and the feedback reported by the patient (Sapyta et al., 2005). That is, the greater the disparity of criteria between the professional and the patient, the more important the obtaining and use of feedback in the results at the end of the treatment. This supports the hypothesis that the mechanism that mediates the effectiveness of using the patient's feedback is the subsequent adjustment of the therapist and treatment to their needs. In the same way, the results of Chow (2014) show that the number of times a clinician is surprised by the feedback of his or her patient turns out to be a good predictor of the outcome of psychotherapy.

Consequently, routine outcome monitoring and the use of feedback can help clinicians improve their ability to detect, in their patients, patterns of deterioration, stagnation, impasses and/or episodes sensitive to special risk of abandonment of treatment (Prado-Abril, Sánchez-Reales, & García-Campayo, 2016). In this way, the flexibility of the clinician's procedures is facilitated and the treatments adjusted to the needs of the patients in order to try to increase their effectiveness. Obtaining objective data on these frequent episodes of psychotherapies is especially timely based on the available knowledge about the notable lack of skill shown by most psychotherapists to reliably report both the deterioration of their patients (Hannan et al., 2005) and their own perceived effectiveness (Walfish, McAllister, O'Donnell, & Lambert, 2012).

THE PARTNERS FOR CHANGE OUTCOME MANAGEMENT SYSTEM (PCOMS)

PCOMS (Duncan & Miller, 2008; Miller et al., 2005; Rodrigo-Holgado et al., 2018) is a feedback system composed of two brief four-item scales, the Outcome Rating Scale (ORS; Miller & Duncan, 2000) and the Session Rating Scale (SRS; Miller, Duncan, & Johnson, 2002). The ORS is a clinical measure of the patient's status that is administered at the beginning of the sessions and, although it has a very short format, it is based on the same philosophy as other routine outcome monitoring instruments such as OQ-45.2 (Lambert et al., 2004) and the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM; Evans et al., 2002; Feixas et al., 2012; Trujillo et al., 2016). The four items are presented in analog visual scale format and measure dimensions referring to individual, interpersonal, social, and global discomfort. The SRS is a measure of the therapeutic alliance based on the Bordin model (1979) and it is administered at the end of the sessions. The four items measure the quality dimensions of the therapeutic bond, the objectives and topics of the session, the approach and method of the therapist, and a global scale on the usefulness of the session. There are adapted versions for working with

children, adolescents, and their main caregivers (Duncan & Miller, 2008; Duncan, Sparks, Miller, Bohanske, & Claud, 2006). All the scales included in PCOMS have a score range between 0 and 40, where the higher score, the better the result: less distress on the ORS and better therapist-patient fit on the SRS. Its brevity facilitates the acceptance of both clinicians and patients, only minimally invading the psychotherapeutic setting, and its good psychometric properties enable the obtaining of reliable information (Duncan & Miller, 2008; Duncan et al., 2006; Miller & Duncan, 2000; Miller et al., 2002; 2003; Rodrigo-Holgado et al., 2018). The translation of the ORS and SRS scales, as well as their psychometric characteristics in the preliminary Spanish validation, can be consulted in Rodrigo-Holgado et al. (2018).

It is an instrument that works as a thermometer of the evolution of the patient and the state of the quality of the therapeutic alliance, allowing the clinician to quickly detect the deterioration or stagnation of the process, or threats to the rupture of the alliance and, consequently, the risk that patients will leave the treatment prematurely. In other words, its effectiveness as a measure of the psychotherapeutic process lies in its ability to retain the patient, improve their adherence to treatment and contribute to the persistence in the work on their personal goals. One of the peculiarities of psychological treatments, in contrast to other health interventions, is that in order to be effective they require an implication and an agency on the part of patients that is not necessary, for example, in a surgical operation. Therefore, instruments that collect patient feedback and focus on collaboration problems are useful in clinical practice. Monitoring variables such as the therapeutic alliance help the patient move from a position of object to another as an active agent of the change process, and helps the clinician to consider the characteristics, preferences and culture of the patient, which is a fundamental part of evidence-based practice (APA Presidential Task Force on Evidence-Based Practice, 2006, Prado-Abril et al., 2017).

FROM THEORY TO ACTION: PCOMS IN CLINICAL PRACTICE

Next, we present a series of clinical cases in which different ways of collecting and using the feedback of patients in psychotherapy can be observed. The clinical sample corresponds to the private consultancy of the first of the authors and the exhibition focuses on exemplifying the use and contributions of PCOMS. Any information that may facilitate the identification of patients has been omitted and some data have been modified for the same reason.

When instruments for monitoring outcome and collecting feedback from patients in psychotherapy are used, it is appropriate to opt for a standard and explicit instructions. In this paper the following adaptation of the instructions proposed by Prescott, Maeschalck and Miller (2017) was



used: "At the beginning of each of our sessions, I am going to ask you to fill out a scale. It's very short and it will not take you more than a minute to complete it. We will use it to check if the work that we are doing together is useful and to monitor your progress. Similarly, at the end of each session, I will ask you to answer another scale that is just as brief but, on this occasion, it will serve to assess the session and check whether we should adjust the treatment plan in order to better meet your needs. For me it is essential to capture your needs and to be able to provide a treatment that is specific to your needs. So your opinion is critical for me and, in fact, it is known that using these measures helps the treatments to be more successful. OK? It will be like a thermometer to show how we are doing in the treatment."

Case 1

This is a 29-year-old man who attended the clinic suffering from low mood, lack of motivation, and low self-esteem. He was "blocked" when dealing with a job to which he did not manage to devote all the time he would have liked and his main objective was focused on increasing his motivation to stay "active". The treatment was developed over five sessions, using PCOMS in all of them (see Figure 1).

In the second session a score of 26.5 was obtained on the SRS (scores lower than 36 are indicative that the session has not been as good as would be desirable, Duncan & Miller, 2008). The lowest point of the scale was found in the section of objectives and themes of the session (four points) and time was spent at the end of the session exploring this aspect together. During the whole hour, the clinical psychologist had focused on reviewing the patient's life history trying to complete the assessment of the first session. The patient, however, said he had hoped they would spend it talking about his current problem and how to solve it. The clinician was empathetic and understanding and they both agreed to address it in the next session. As can be seen in Figure 1, this produced changes in the patient. In the following session, the third one, the patient was feeling worse (see score on ORS) but the SRS score improved, especially in the objectives dimension, since this time the clinical work focused on the aspects that were important for the patient. In the fourth session there was an increase of almost 12 points on the ORS, thanks to the work between sessions that facilitated the third session, and the SRS increased to reach acceptable scores. Good scores were maintained in the next session.

Case 2

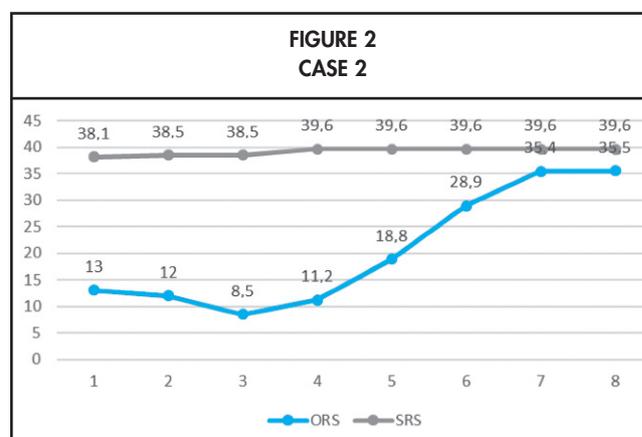
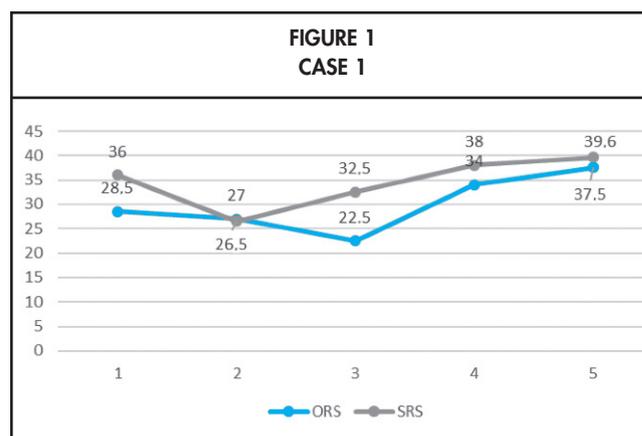
A 31-year-old man who went to psychotherapy with the aim of "breaking out of a vicious circle" that he was caught in, affected by a depressive episode of several months of evolution. He was treated with psychotherapy over eight sessions, in which

PCOMS was used. The results obtained can be seen in Figure 2.

In this case, contrary to the previous one, the data obtained on the SRS indicated that the therapeutic alliance was quite solid, although despite this, some time was still spent, at the end of each session, on trying to assess how useful it had been for the patient. The type of feedback that was important was that provided by the scores obtained on the ORS. Until the third session, the clinical status worsened progressively, warning of a possible case of deterioration. The observation of this evolution in the data motivated the clinician to consider a change in therapeutic strategy which served to modify the trend of the results, as can be seen in Figure 2.

Case 3

This case is presented not so much from the point of view of the use of PCOMS, but to illustrate another relevant situation in the prevention of dropouts in psychotherapy: *falling in love with the psychotherapist's hypothesis* (a type of deficit in decentering in which clinicians sometimes incur) at the expense of the patient's reason for coming to consultation. This is the case of an 18-year-old girl whose reason for the consultation was, according to her own words, a "lack of self-esteem". Her academic results



were declining, her social life had deteriorated and her mood was notably down. The treatment was carried out over eight sessions and its results were monitored with PCOMS (Figure 3).

The determining information in this case was that provided by the patient in the first session. A few months before, she had gone to the office of another professional who had developed the hypothesis that her problem was related to her difficulty in becoming independent and separate from her family of origin. The young woman had not been too satisfied with the therapy being focused in that way and, as she expressed it, for her the central problem was her lack of self-esteem. It was considered that for the patient this was the main focus of the work and the sessions focused on this aspect. This served to make her feel that the work carried out made sense with respect to her objectives. Despite this, it can be seen that the scores on the SRS were not high enough during the first sessions. We would like to pause at this point to comment on an aspect that seems very important to us. The therapist who attended this person, initially, came to the same conclusion as the previous professional who had attended her: there was a dependency problem with her family of origin. However, seen in perspective, we believe that a plausible hypothesis that may explain the abandonment of the first treatment is that what was at that time essential to the patient was not considered. As a result, there were tensions in the

alliance, the collaboration was undermined, the therapist and patient became progressively distanced and, finally, the treatment was finished (Prado-Abril et al., 2013; Safran & Muran, 2000).

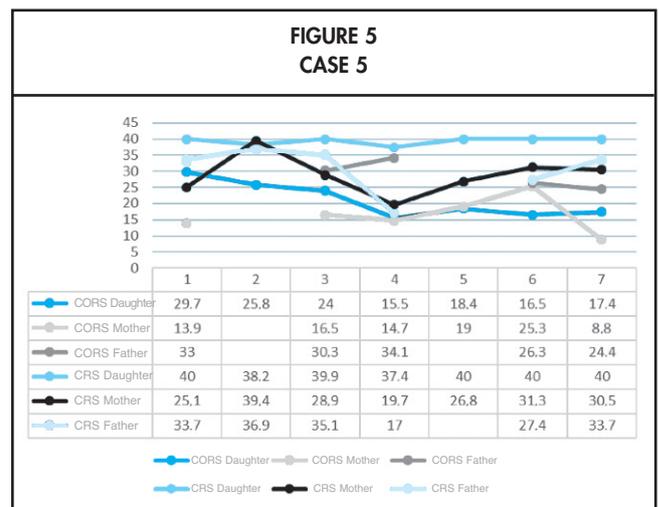
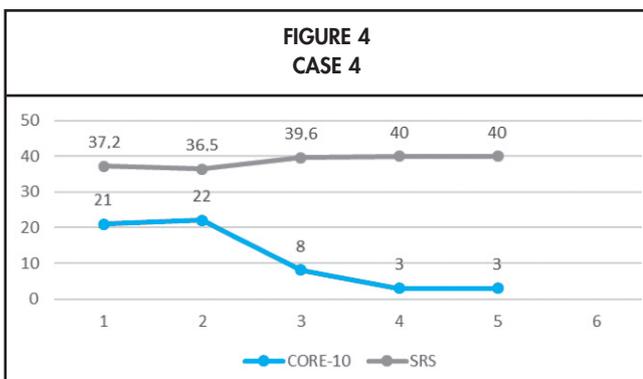
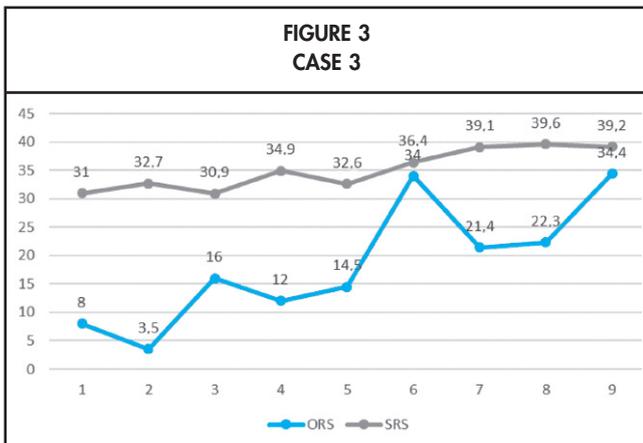
Case 4

The following case exemplifies the use of other measuring instruments that also allow us to obtain feedback and can be integrated into PCOMS according to the clinical needs of the case. Again, the SRS scale was used to evaluate the therapeutic alliance. The results of the treatment were monitored with the 10-item reduced version of CORE-OM (Feixas et al., 2012). The patient was a 39-year-old man who presented various symptoms of anxiety (insomnia, muscle tension, uneasiness, and rumination) that affected his personal and family life. The problems had begun in the wake of a major change in his company and resulted in a considerable increase in his workload. A brief psychotherapy focused on the development of stress coping strategies was carried out over five sessions. The results obtained can be seen in Figure 4.

It was decided to use the CORE-OM because, as it is an inventory of symptoms, it seemed that it could fit better with the patient's needs, which were rather focused on the symptoms. In addition, the 10-item version, due to its brevity and ease of correction, allows us, at the beginning of each session, to give direct visual feedback on the progress obtained. When reviewing Figure 4, please note that, unlike the ORS scale, on the CORE-OM improvement is reflected in lower scores, so the inclination of the line is indicating a positive result.

Case 5

The monitoring of the results is complicated in cases in which there are several people involved in the therapy, as in this example of an 8-year-old girl who was taken to consultation by





her parents for behavior problems at home. PCOMS, in its version for children and adolescents, was applied to both the parents and the daughter. The results are shown in Figure 5.

This therapy ended with the abandonment of the treatment. As can be seen in Figure 5, both the outcome and relationship measures were not good. The attending clinician accepts responsibility for the outcome since, despite having devoted time to the feedback received during all the sessions, he or she recognizes that he or she did not really take their opinions into account. For example, without being exhaustive, in the last consultation they attended, the father reported that he thought that the treatment should have focused more on the girl and not so much on the family. However, the time dedicated to the parents or the whole family was much greater than that dedicated to the girl.

DISCUSSION

Previously, a series of cases have been presented as clinical vignettes to illustrate how clinicians can collect and obtain feedback from their patients. The illustration emphasizes the central role that feedback has played in the outcome of treatments. However, although the analysis that has been carried out does not allow us to be conclusive, it shows that, at the least, in the absence of feedback, the results would have been different. As with most of the components that constitute clinical expertise (APA Presidential Task Force on Evidence-Based Practice, 2006, Prado-Abril et al., 2017), and the use of feedback is one of them, versatility and flexibility in making the best clinical decisions ends up making psychotherapy an inevitable amalgam of science and art. It is in this sense where it should be noted that the feedback will have greater or lesser relevance depending on the particular needs of each case.

For example, it is possible that Case 4, in the absence of monitoring the results, would have followed the same course. In general, in cases in which the patient improves progressively, there is a good emotional bond and there are no tensions in the relationship, psychotherapy progresses normally and the use of monitoring systems and standardized feedback does not seem to be decisive for the results. On the other hand, where the object of this work shows all its therapeutic potential is in cases that do not improve, ones that stagnate and have problems in the therapeutic relationship. In Case 1, had the SRS not been used, it is possible that the clinician would not have noticed the threat to the alliance (disagreement in the objectives of the session) and an impasse or rupture of the alliance would have been precipitated in future sessions. Instead, the therapist was able to detect the threat, address it with the patient and facilitate an episode of change in the successive sessions. Paraphrasing Safran and Muran (2000), managing to detect and repair a situation of tension is, in itself, a particularly powerful factor of change. On the other hand, in Cases 2 and 3, at the end of the

psychotherapeutic process, graphs similar to those presented here (Figures 2 and 3) were presented as feedback from the therapist about the process. The therapeutic effect had to do with facilitating the recapitulation of the treatment itself. Both patients were able to identify, by observing the trends on the ORS, what had happened in the sessions in which their process of symptomatic change began, facilitating reflexivity and affirming the aspects worked on.

The present work has several limitations that must be pointed out. The first belongs to the analysis of clinical cases (Prado-Abril et al., 2013), although the objective here was to outline and exemplify the use of routine outcome monitoring and patient feedback in daily clinical practice. Second, it is important to underline that PCOMS, like any system that includes self-report measures, is subject to sources of error such as simulation, social desirability, response trends, and the influence of individual differences on personality variables. (Austin, Deary, Gibson, McGregor, & Dent, 1998). In addition, the proximity that it promotes between the clinician and patient can accentuate some of these biases. It is a very brief and perhaps simplified measure of the clinical evolution and the quality of the status of the alliance and it requires, at the present time, more studies and research focused on heterogeneous clinical populations that would enable us to determine when it is the most appropriate measure with respect to other alternatives. Finally, there is still no standardized validation in Spanish and although the preliminary data are positive they come from a small sample and we should still consider them to be a first approximation (Holgado-Rodrigo et al., 2018).

Regarding the obstacles to the generalization of this evidence-based practice, from the beginning, the resistance of the professionals themselves has been noted. This practice implies self-doubt about the efficacy of one's own performance, and fosters the self-criticism and internal scrutiny of the therapist, and although the research of Nissen-Lie et al. (2015) relates these doubts with better results at the end of the treatment, it is also true that it is an uncomfortable experience that leads many therapists to reject the measure. In this sense, the findings of Goldberg et al. (2016) are particularly illustrative. Their paper describes the case of a health agency where an improvement project was carried out and presents various results after eight years since the implementation of quality measures. The project, in short, consisted of the agency's clinicians developing the culture of monitoring their results, obtaining feedback on their effectiveness and level of performance. The project was not intended to be punitive and, in fact, it included specific monitoring and training measures for feedback with the aim of improving the results of the professionals and the health agency. The measurement, with the passage of the years, proved to be effective in improving the results of the treatments and the satisfaction of the users. However, one of the most striking pieces



of data was that four months after the start of the project, 40% of the workforce had left the organization. It seems that as a collective we are, still, somewhat wary when it comes to being held accountable for our performance. However, it should also be noted, especially in the field of the Spanish National Health System, where the authors have mainly done their training and practice, healthcare pressure, the lack of incentives and job insecurity do not facilitate the implementation of such systematic work measures. In any case, we think that trying to understand where we are at with our level of performance, with more or fewer situational and structural constraints, and focusing on learning from our mistakes is what helps us improve in our clinical practice. At the same time, our patients deserve to see how we work, our effectiveness (or lack thereof), and the best clinical practices available.

The second major obstacle is conditioned by what in the field is known as loyalty to the therapeutic model of ascription. While one cannot work without a model, these are heuristic rather than strict routes to be adhered to inflexibly. For example, going back to Case 3, the two professionals who attended the patient concluded on a clinical formulation of a systemic nature. However, we hypothesize that one forced his or her work model and the other put it on suspension and worked with the patient's motives. Similarly, in Case 5, the best evidence recommends that it is ideal to work with parents (e.g., Scott, 2008), however, this clinical decision did not produce the best results. Sometimes, models, when adopted without nuances, make us forget that psychotherapy is an interpersonal act and that although evidence-based treatments are efficacious, the conditions that allow them to be efficacious are not less so. We must adapt to the needs of patients, prepare them, mature the therapeutic relationships, monitor the process variables that are key for each case and then proceed as appropriate. Both in Case 3 and in Case 5, as in most psychotherapies of a certain duration, family relationships would have ended up being appropriate as the object of the sessions. In short, forgetting the broad context surrounding the application of evidence-based treatments within the framework of a therapeutic relationship can precipitate the clinician's decisions and lead to therapeutic failure.

In conclusion, monitoring the evolution of the results and attending to the feedback of the patients, in very varied clinical situations, is useful and influences the results of the treatments. For this purpose, PCOMS is a standardized system that offers several advantages. It is brief, its application and correction do not require more than two minutes, it presents adequate psychometric properties and it is in the process of validation in Spanish with promising preliminary results. Furthermore, it facilitates the development of other therapeutic ingredients that have proven to be common factors based on evidence and that

are related to a quality therapeutic alliance (Norcross, 2011). Taking time to discuss the results of the scales with the patient encourages collaboration, emphasizes the objectives of the patients, promoting their agency, helps them to establish consensus and shared goals, contrasts the perspectives of the clinician and the patient, facilitating the empathic capacity of the clinician and, finally, minimizes ruptures in the alliance or, if this does occur, leads towards work on its repair.

ETHICAL RESPONSIBILITIES

The authors declare that the procedures followed for the presentation of this paper followed the ethical guidelines of the Declaration of Helsinki. All patients were thoroughly informed about the nature of the present work, signed the relevant informed consent and yielded the use of their clinical data.

CONFLICT OF INTEREST

The authors declare no conflicts of interest.

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We would like to pay tribute with this humble paper to the memory of Professor Jeremy D. Safran, traumatically lost to our field during the writing of this manuscript. His ideas and innovations will remain with the psychotherapists focused on the therapeutic relationship.

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