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How do mental health clincians using feedback informed treatment methods create a "cultural of feedback" with clients?

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ABSTRACT

This study was undertaken to explore how mental health clinicians using feedback informed treatment (FIT) interventions attempt to increase the likelihood of receiving genuine feedback from their clients. Furthermore, the study explores clinicians' perceptions about the ways in which interpersonal power dynamics, including race/ethnicity dynamics, influence the feedback process.

An anonymous online survey was posted on two Internet forums for FIT practitioners. A final sample of thirty licensed mental health clinicians completed the mixed methods survey, answering five demographics questions (age, gender, race/ethnicity, years using FIT methods, and nationality) and three open-ended questions. The open-ended questions asked respondents to discuss how they strove to evoke genuine feedback from clients as well as how they perceived power and race/ethnicity dynamics to interplay with the feedback process.

The findings showed that respondents used a variety of strategies to engender trust, comfort, and collaboration with clients in response to clients' reasonable skepticism about the process of feedback interventions. A majority of clinicians communicated sensitivity to ways in which power dynamics (in and outside of the therapy room) silence or inhibit clients, noting that FIT interventions helped some clients feel more empowered in the therapeutic relationship. At the same time, almost half of respondents (all white identified) denied the impact of race and ethnicity dynamics on the feedback process, raising questions about the degree to which white FIT practitioners are aware of their own participation in disempowering racial enactments.

HOW DO MENTAL HEALTH CLINICIANS USING FEEDBACK INFORMED TREATMENT

METHODS CREATE A "CULTURE OF FEEDBACK" WITH CLIENTS?

A project based upon an independent investigation, submitted in partial fulfillments of
the requirements for the degree of Master of Social Work.

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CHAPTER I

INTRODUCTION

Feedback-Informed Treatment (FIT) is a pantheoretical approach to evaluate and improve the effectiveness of therapy services. Originally conceived and developed in the first decade of the 21st century by a cohort of like-minded common factors researchers (e.g. Michael Lambert, Bruce Wampold, Scott Miller, Barry Duncan, and Mark Hubble among others), the approach involves therapists routinely and systematically asking clients to offer feedback about their perceptions of the quality of the therapeutic alliance and the extent of their therapeutic progress. Feedback is typically gathered in session using paper-and-pencil analogue scales such as the Outcome Rating Scale (ORS) and Session Rating Scale (SRS), developed with simplicity of use and real-world application in mind (Duncan et al., 2003; Miller et al., 2003). FIT is guided by common factors research showing that the client's perception of the strength of the therapeutic alliance is one of the most robust predictors of outcome (Baldwin, Wampold, & Imel, 2007) and that the average clinician lacks a consistently accurate ability to gauge his or her client's perception of the alliance (Tryon, Collins, & Felleman, 2006). As such, the approach assumes that therapists who use tools to directly learn about clients' experience of the alliance and make adjustments to treatment as necessary will help clients achieve better outcomes. Indeed, FIT has been extensively investigated in randomized controlled trials and shown to significantly improve outcomes among clients at risk for clinical deterioration or dropout (Anker, Duncan, & Sparks, 2009; Shimokawa, Lambert, & Smart, 2010; Harmon, Hawkins, Lambert, Slade, & Whipple, 2005). Some have called FIT methods a "revolution in progress" in the mental health field (Aveline, 2006, p. 233).

Despite the growing body of evidence that FIT methods could significantly increase the effectiveness of many helping professions, including social work, there remain significant limitations, biases, and unanswered questions in the current FIT literature. One major limitation is that almost all FIT studies rely on quantitative methodology and thus neglect to investigate in depth the complex interpersonal processes involved in the solicitation of feedback. In general, researchers have aimed to generate large-scale and horizontal data on the *effects* of feedback rather than seek out more nuanced and vertical narratives about the *process* of feedback. Indeed, in most research studies on FIT, researchers neglect to track the actual implementation of feedback interventions by clinicians, focusing instead on outcome results. As such, there has been limited exploration of the attitudes and behaviors that characterize clinicians' approaches to the feedback interaction; likewise, there is little understanding of how clients experience feedback-informed methods.

These limitations intertwine with a significant bias in the FIT literature, which is a widespread neglect to explicate the power dynamics inherent in clinician-client feedback interactions. For example, no study on FIT has explored how clinicians create enough trust with clients so they feel comfortable giving genuine feedback. As Miller and Bargman (2010) point out, clients may view the clinician as an 'expert' not to be questioned or feel uncomfortable offering criticism out of fears of producing a negative reaction in the clinician or causing harmful repercussions in the therapy relationship. Similarly, the effects of race and racism on the process of FIT interventions have not been explored. This poses considerable ethical concerns to the author of this proposal, particularly given the fact that an historical framework of Euro-American (white) cultural values has permeated the vast majority of research in the helping professions, resulting in the inculcation and replication of systemic racism among white

clinical practitioners (Hays, 2008). No FIT studies have posed the question: How do clinicians understand the manifestations of race and racism between themselves and their clients when they ask clients to offer feedback about the therapeutic alliance? Among the many dynamics at play in such a situation might be the client's desire to censor their feedback for reasons of self-protection, lack of cultural sensitivity or awareness of racism on the part of the clinician, or non-white cultural values which stress respect or deference for authority over egalitarian notions of building rapport (Abudabbeh, 1996; Falicov, 1996; Chang & Yoon, 2011).

In this exploratory study, two main questions are explored: 1) When soliciting feedback from clients about their experience of the alliance using the Session Rating Scale (SRS) form (Miller et al., 2003), how do clinicians increase their clients' comfort and increase the chance that clients will offer genuine feedback? 2) How do power dynamics between clinician and client help or hinder the solicitation of genuine feedback, from the clinician's perspective? Clinicians were asked to consider both the power dynamics inherent in the therapeutic relationship as well as power dynamics inherent in the interplay of the racial identities of themselves and their clients.

This investigation aligns with the professional goals of social work in two ways: it attempts to build upon our knowledge base about what clinicians do that might make treatment more effective (helping ameliorate social need) while also attempting to build upon our knowledge base about the extent to which clinicians incorporate their understanding of power and racism into their treatment methods (working to end social injustice).

In summary, while the pantheoretical intervention of FIT has been demonstrated to decrease deterioration and dropout among mental health clients in multiple settings, the complex interpersonal processes at play in the solicitation of feedback and the effect of power

dynamics on the implementation of such methods remain unexamined. This exploratory study aims to provide initial insights to clinical practitioners, supervisors, and researchers into this unexplored facet of feedback informed treatment methods.

CHAPTER II

LITERATURE REVIEW

The Case for the Common Factors

The following literature review will briefly summarize the common factors approach, a theoretical and research based paradigm that aims to understand which components of therapy seem to generate robust positive change across theoretical disciplines. The common factors paradigm is the primary focus of this literature review because it is the soil in which FIT was conceptualized, operationalized, and evaluated. Since FIT methodology does not require clinicians to adhere to particular treatment modalities or techniques, but rather is understood to improve therapy outcomes regardless of the identity of the clinician and their preferred clinical lens, it is a therapy intervention that stems directly from the common factors approach. This is significant, given the fact that a criticism of the common factors paradigm might be that it merely refutes the differences in claimed efficacy between various therapy models while neglecting to offer a behaviorally based approach to therapy based on its own findings. In short, common factors is a particularly useful place to start in exploring why and how FIT has come to be what it is today, including where FIT approaches may be headed in the future.

From a summary of Lambert's (1992) four common therapeutic factors, to a brief analysis of past and current understandings of the therapeutic working alliance, to an overview of the ways current FIT research gives therapists tools to improve therapy outcomes by strengthening the alliance, this review connects several threads of understanding about what works in therapy and what might make therapy work even better. It also explores limitations and biases in the current FIT literature, including a lack of vertical (as opposed to horizontal) data on

the process of feedback and racial bias in sampling methods and analysis of how feedback informs the treatment process. Finally, this literature review addresses the ways in which the author's proposed study aims to qualitatively investigate practicing clinicians' experience of FIT interventions, paying special attention to the issues of power and racial dynamics in the therapeutic dyad.

While a concrete definition of psychotherapy has been debated by many theorists over the years and remains ambiguous (Efran, Lukens, & Greene, 2007), a general understanding is that psychotherapy involves the formation of a formal relationship between a clinician and client with the mutual goal of helping the client cope with and perhaps transform ways of being that impair the client's functioning and fulfillment in life. Of primary consideration in this literature review and proposed qualitative study is the nature of the *relationship* in psychotherapy, which some theorists conceptualize as the "soil" in which therapeutic growth is made possible (Lazarus, 1993).

Historically, common factors theorists have been vocal advocates of the primacy of the therapeutic alliance in the realm of mental health treatment (Rogers, 1957; Beutler, Machado, & Allstetter Neufeldt, 1994). Such theorists take a *metaview* of therapy by looking across theoretical treatment models to find universal commonalities of effective therapy (Frank & Frank, 1991; Garfield, 1992). Using large-scale analysis of empirical studies on therapy outcomes, they have argued that the strength of the clinician-client working relationship is the most important factor predicting positive change in psychotherapy (Lambert, 1992; Hubble, Duncan, & Miller, 1999). As Lambert (1992) writes, cumulative data from research spanning decades, covering a range of adult disorders, and including a variety of research designs indicate that there are four primary therapeutic factors, including extratherapeutic (independent client

factors such as life events), common factors (e.g. elements of the alliance), expectancy factors (the placebo effect or client hope), and technique factors (differences in theoretical treatment models). As a bevy of meta-analyses show (e.g. Horvath & Symonds, 1991; Baldwin, Wampold, & Imel, 2007), the value of a strong therapeutic alliance consistently predicts therapy outcome better than any other factor (aside from extratherapeutic factors, which are by their nature out of the control of the therapist and often the client). For example, as Baldwin, Wampold, and Imel (2007) reported in a large-scale study of 80 therapists and 331 clients from 45 university counseling centers across the U.S., 97% of the difference in outcome between therapists was accounted for by differences in therapists' ability to form therapeutic relationships with a diverse array of clients; other therapist qualities were found to have little to no impact on outcome, including traditionally touted factors such as age, gender, years of experience, professional discipline, degree, training, licensure, theoretical orientation, amount of supervision or personal therapy, and use of evidence-based methods.

The assertion that common factors and the therapeutic alliance play a more significant role than theoretical technique in therapeutic outcome is controversial, especially given that the vast majority of clinical research (especially in the era of evidence-based practices and manualized treatments) focuses primarily on establishing the superiority of various therapy models, of which it is estimated there are now over 200 – an increase of 600% since the 1960s (Hubble, Duncan, & Miller, 1999). Indeed, many theorists (e.g. Eysenck, 1952; Skinner, 1985) challenge the notion that interpersonal aspects of therapy are more important than theoretical technique. Some researchers also argue that specific empirically supported treatments such as cognitive-behavioral therapy are efficacious due to their respective ingredients, presenting therapeutic techniques as analogous to specific medical treatments (Chambless & Hollon, 1998;

Wilson, 1996). In response, common factors researchers argue that such claims are the result of methodological artifacts derived from comparing active treatment groups with insufficient control groups. Indeed, when the outcome of the target treatment method is compared with the outcome of active control groups, differences in efficacy between theoretical techniques disappear (Lambert & Bergin, 1994).

The Working Alliance and Feedback Informed Treatment Methods

Common factors researchers have focused much time and energy towards understanding the dynamics of the therapeutic working alliance. As Bordin (1979) defines it, the alliance is a positive, reality-based component of the therapeutic relationship that is ubiquitous and universal in all successful helping endeavors. He further conceptualizes the alliance as consisting of three primary elements: the shared tasks, goals, and bond between client and clinician. Tasks are what the therapist and client agree need to be done to reach the client's goals, goals are the agreed on objectives of therapy that both parties must endorse and value, and the bond includes the positive interpersonal attachments between therapists and clients, shown by mutual trust, confidence, and acceptance (Bordin, 1979).

Pantheoretical research has consistently shown that the quality of the working alliance predicts therapy outcome more robustly than traditionally emphasized factors such as theoretical treatment model or therapist factors such as age, experience, gender, or professional training (Horvath & Symonds, 1991; Baldwin, Wampold, & Imel, 2007; Orlinsky, Rønnestad, & Willutzki, 2004). As cited above, in a randomized controlled trial involving 331 clients seen by eighty therapists, Baldwin, Wampold, and Imel (2007) found that 97% of the difference in outcome between therapists' clients was accounted for by differences in the quality of therapeutic relationship as rated by the client. Likewise, in Horvath and Symonds' (1991) meta-

analysis of research concerning the relationship between working alliance and outcome in psychotherapy, the client's rating of the therapeutic alliance was found to be the most significant predictor of outcome.

The distinction between client perception of the alliance and therapist perception of the alliance is especially significant. As empirical research has consistently demonstrated, therapists are relatively poor at gauging their client's experience of the alliance (Hannan, Lambert, Harmon, Nielsen, Smart, Shimokawa, & Sutton, 2005; Tryon, Collins, & Felleman, 2006). For example, in one recent randomized controlled trial, 40 therapists were asked in the early stages of treatment to predict which of their 550 clients would deteriorate over the course of treatment; the therapists were only able to identify one of the 40 clients that eventually deteriorated and in doing so showed a limited ability to accurately perceive clients' engagement and collaboration in the alliance (Hannan et al., 2005). Since outcome is strongly predicted by the alliance and clients' perceptions of the alliance matter more than clinicians' perception of the alliance, it stands to reason that finding ways to improve clients' experience of the alliance on a large scale will also improve outcome on a large scale.

This is where Feedback Informed Treatment (FIT) comes in. Since the early 2000s, a growing body of scholars and clinicians has pursued research in the area of FIT, which is a pantheoretical technique that involves therapists routinely asking clients to give feedback (using a brief pencil and paper measure) about their perceptions of the quality of their therapeutic progress and of the therapeutic alliance. The general hypothesis behind FIT research follows the reasoning presented above: if client perception of the quality of the alliance is the most significant factor in therapy outcomes and therapists are not able to accurately gauge clients' experience of the alliance, then creating methods by which therapists can consistently and

directly learn their clients' experience of the alliance will strengthen therapists' ability to ally themselves with their clients, resulting in better psychotherapy service and better outcomes. An increasing tide of randomized controlled trials has supported this hypothesis in a variety of clinical settings (Anker, Duncan, & Sparks, 2009; Miller, Duncan, Brown, Sorrell, & Chalk, 2006; Reese, Norsworthy, & Rowlands, 2009). For example, a recent meta-analysis of FIT research (Shimokawa, Lambert, Smart, 2010) from the past decade showed that feedback interventions enhanced the efficacy and effectiveness of treatment, especially improving outcomes for at-risk clients (those defined as not on track in terms of session-to-session positive change).

Miller, Duncan, Brown, Sorrell, and Chalk (2006) evaluated the effect of using two feedback instruments, the Outcome Rating Scale (ORS) and Session Rating Scale (SRS), on monitoring the process and outcome of therapy in a quasi-experimental study involving 75 therapists and 6,424 clients over a two-year period. The therapists came from several different disciplines, including clinical psychology (45%), social work (35%), and marriage and family therapy (20%). The clients represented a culturally and economically diverse cross-section of clientele of an international Employee Assistance Program based in Austin, Texas, and the severity of problems clients presented was comparable to those seen in typical mental health clinics. While the quasi-experimental design limits the conclusions that can be drawn, it was found that providing client feedback to therapists resulted in significant improvements in both client retention and outcome over the non-feedback baseline period, including doubling the overall effect size of services. Furthermore, clients of therapists who failed to access and utilize client feedback were three times less likely to return for a second session of therapy and had significantly poorer outcomes.

Similarly, Anker, Duncan, and Sparks (2009) conducted a randomized controlled trial investigating the effects of providing client feedback to couple therapy clients and their clinician. The study was designed to be as pragmatic as possible; it was conducted in a typical community-based outpatient setting rather than a research setting. Four hundred and ten clients (all white, Scandinavian, and heterosexual) were randomly assigned to one of two groups: treatment as usual (TAU) or feedback. It was found that couples in the feedback condition demonstrated significantly greater improvement than those in the TAU condition at posttreatment, achieving nearly four times the rate of clinically significant change; furthermore, they maintained a significant advantage on the primary measure of outcome at a 6-month follow up while attaining a significantly lower rate of separation or divorce. Similar results were found in a trial by Reese, Norsworthy, and Rowlands (2009) that compared outcomes between feedback and TAU conditions in a university counseling center. It was found that 80% of clients in the feedback group experienced reliable change as compared to 54% in the TAU group, a significant difference in effect size.

In conducting an exhaustive literature review, the present author was only able to locate two qualitative investigations of FIT. In Bowens and Cooper's (2012) series of interviews with 10 therapists (two male, eight female, average experience 8.8 years) who use a feedback tool, the following themes surfaced in dialogue about the positive and negative effects of using the tools: all therapists felt that FIT gave them a better understanding of what clients want from therapy; all felt a greater sense of permission or freedom to alter their practice as a result of guidance from clients (tailoring practice to clients' needs); most felt that FIT stimulates a process of reflection and learning; most therapists felt that FIT generates an increased awareness of how clients perceive them; many believed it empowered clients and increased their autonomy and

responsibility; most felt it made it easier for clients to express or assert things that may ordinarily have been left unsaid; and finally, almost all felt encouraged or reassured by client feedback that helped them know they were on the right track with regard to therapeutic process. Some therapists saw negative aspects of FIT being the potential for therapists to become overly self-critical or for the forms to make the relationship feel too bureaucratic or impersonal. An overarching theme was that therapists felt that FIT helped move the therapy forward and deepen the therapeutic relationship earlier in the treatment.

In Sundet's (2010) qualitative investigation of clients' and therapists' experiences of FIT at an outpatient family unit in Norway (four therapists and 10 client families), it was reported that all participants found FIT methods to be valuable tools for creating and shaping conversations. In general, participants' experiences revolved around several themes: clients and therapists found that FIT initiated *processes of communicating* (invitation to express anything that came to mind), *processes of focusing* (using visual analogue scales helped participants generate verbal explanations of nonverbal impressions), *processes of structuring* (helping to co-create treatment plans organically), and *processes of exploration* (generating new discoveries in clients' and therapists' knowledge about their perceptions of reality). In summary, the use of FIT tools were helpful in keeping therapy flexible while upholding positive structure in the work; likewise, they facilitated the expression of unspoken stories and deepened the exploration of all participant's experiences.

Limitations, Biases, and Next Steps

As these findings demonstrate, there is significant evidence in both quantitative and qualitative research that FIT practices can enhance client outcomes and clinician effectiveness in diverse settings and among diverse populations. As such, committing further time and effort to

conduct research in this field has the potential to be of benefit to helping professions as a whole. In particular, given the limited qualitative investigation in the literature, it would be beneficial to investigate more deeply the interpersonal processes involved when therapists solicit feedback about the alliance from clients, especially in terms of therapeutic and racial power dynamics. This speaks to two major limitations in the majority of the literature reviewed.

First, almost all FIT studies lack a detailed analysis of *process* as a result of their quantitative methodology: namely, investigators have primarily explored statistical outcomes of FIT methods using experimental and quasi-experimental methods at the expense of exploring the interpersonal processes involved in seeking feedback within the therapy dyad. For example, most of the randomized controlled trials in the literature do not go into specifics about how clinicians were trained to use the feedback tools and no randomized controlled trial in the literature monitored clinicians' behaviors or attitudes during therapy sessions in which feedback was requested. In the meta-analysis cited above, Shimokawa et al. (2010) stated that the "reliability of treatment implementation may have been an issue in individual studies because the use of feedback interventions by therapists was not closely controlled or monitored," (p. 309). Likewise, Miller et al. (2006) write in their methods section that participating therapists were trained in gathering feedback during several site visits by the first two authors of the study over a 6-month period but give no further explication of what the training entailed or what therapists were encouraged to do to maximize the likelihood that clients would give genuine feedback. Finally, as Miller and Bargmann (2010) point out, soliciting feedback from consumers of therapeutic services is more than simply "administering" a paper and pencil scale. It is incumbent upon the therapist to create an atmosphere in which clients can feel free to rate their experience and outcome of services "without fear of retribution, and . . . with a hope of having an

impact on the nature and quality of services delivered," (p. 199). This is an important point, as it hints at the interpersonal complexity of creating an atmosphere of hope and positive expectation while avoiding an atmosphere of fearful silence. Furthermore, the word retribution acknowledges the role of power dynamics within the therapeutic relationship.

A second major bias in FIT research is that participant samples have primarily been drawn from dominant racial groups (e.g. white populations). As an example, in Anker et al. (2009) and Sundet (2010), all client participants were white Norwegians and the authors did not provide the race of the therapists. In Reese et al. (2009) and Shimokawa et al. (2010), at least 80% of client participants were white and neither study provided the race of the therapists. While two qualitative studies (Sundet, 2010; Bowens & Cooper, 2012) explicate the interactional processes of FIT to a greater extent than quantitative studies, they nevertheless neglect to explore the dynamics of race and racism.

Since the feminist and civil rights movements of the 1960s and 1970s, the helping professions have slowly but steadily incorporated more complex investigations of sociocultural factors such as race, gender, class, sexual orientation, and spirituality (among other identity constructs) into their analyses of therapeutic dynamics (Hays, 2008). Hays (2008) points out that psychotherapy practice and research has historically been grounded within a framework of Euro-American cultural values and thus tends to place emphasis on creating a sense of egalitarianism between therapist and client, often necessitating the silencing of differences in power between therapist and client such as social class, ethnicity, disability status, and race during therapy discourse. Such a peer-oriented approach to rapport building ignores other cultural models of relating, potentially privileging certain kinds of alliance-building or feedback-generating behaviors at the expense of others which are equally valid or perhaps even more effective given

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the cultural preferences of the client. She notes that in many cultures (including Latino, African American, Asian, Arab, and Indigenous cultures) the concept of respect is just as important as rapport. For example, she cites Abudabbeh's (1996) research on the intersectionality of age, family reputation, and socioeconomic status in Arab constructions of the relational notion of respect as well as Falicov's (1996) writings on the emphasis of *respeto* in Mexican families. These ideas suggest that asking a client to provide feedback to a therapist may have the unintended effect of producing a kind of cultural cognitive dissonance and possibly generate tension, rather than increased cohesion, in the alliance.

Similarly, research by Chang and Yoon (2011) illustrates how the experience of everyday prejudice and invalidation (e.g. microaggressions) may cause ethnic minorities to censor their negative reactions and defer to white clinicians' authority as a self-protective strategy in therapy. Such strategies of self-protection are likely evident among other clients depending on their targeted identities in relationship to dominant identities of the therapist, including gender, social class, ability status, and immigration status. Given such findings, it is clear that the process of seeking client feedback is very much affected by the assumptions and behaviors of both client and therapist; this variable may negatively impact the ability of therapists to solicit genuine client feedback, especially in situations in which the therapist's social identities are aligned with dominant, mainstream white values and the client's social identities are aligned with racially oppressed values (at least in a U.S. setting).

In summary, given the complex manifestations of power dynamics in therapeutic relationships, and the fact that current FIT literature largely omits these dynamics from the focus of analysis, it is apparent that conducting more in-depth qualitative studies of therapists' feedback-soliciting behaviors and attitudes would be beneficial to this emerging field of inquiry.

CHAPTER III

METHODOLOGY

Study Design and Rationale

This is an anonymous, primarily qualitative exploratory study utilizing an internet-based data collection method. While the study is largely qualitative, it has distinctive quantitative elements— including attention to the relative frequency of themes within the data and to the demographic characteristics of the sample. The purpose of this study is to investigate how mental health clinicians who use feedback informed treatment (FIT) create a "culture of feedback" with their clients; additionally, the study explores how clinicians perceive the manifestation of interpersonal and social power dynamics (including racial dynamics) within the process of soliciting feedback with clients. Using open-ended questions in an internet survey, participants were asked to reflect on two main questions: 1) When soliciting feedback from clients about their experience of the alliance using the Session Rating Scale (SRS) form (Miller et al., 2003), how have they increased their clients' comfort and increased the chance that clients will offer genuine feedback? 2) How do power dynamics between clinician and client help or hinder the solicitation of genuine feedback, from the clinician's perspective? Clinicians were asked to consider both the power dynamics inherent in the therapeutic relationship as well as power dynamics inherent in the interplay of the racial identities of themselves and their clients.

Research Method and Design

An exploratory qualitative, open-ended online survey was the method of investigation. While this research design may have limited the depth of data obtained (it is likely that participants did not reflect as deeply or as extensively when filling out an online survey as they would have in verbal interviews), it cast a wide net (exposing a greater number of clinician

experiences). Since there are relatively few mental health clinicians in the United States who use FIT methods and they are spread out geographically and practice in diverse professional communities, using an open-ended online survey was deemed a worthy trade-off that allowed a wider array of participant experiences to be represented while still generating an acceptable depth of information on a participant-by-participant basis.

One limitation of the study is that it featured a never before used survey instrument and there were insufficient resources to pre-test it for reliability between participants and over time. Since the study is exploratory in nature, external validity is not a primary concern. The intention of the study is to explore and describe the real-world behaviors and perceptions of a self-selecting group of clinicians rather than extrapolate the findings to *all* clinicians who use FIT methods.

Sample and Recruitment Process

The population of interest of this study is all licensed mental health clinicians who use FIT methods in everyday practice with psychotherapy. Clinicians were be eligible to participate if they were licensed mental health clinicians, if they read and write English, and used the Outcome Rating Scale [ORS] and Session Rating Scale [SRS] tools with clients (Duncan et al., 2003; Miller et al., 2003). Originally, only U.S. based licensed clinicians were allowed to participate; however, after several international clinicians contacted the researcher via email to express their desire to participate, the exclusion criteria were changed to include international clinicians (with HSR approval). This also benefited the sample size of the study given the increased numbers of survey responses generated after exclusion criteria were expanded. The discussion section will explore in more depth the possible ramifications of deciding to include international clinicians, especially with regards to ways that non-U.S. conceptions of

race/ethnicity may have factored into participants analysis of racial dynamics in therapy. Likewise, the discussion section will include consideration of the ways in which including international clinicians both strengthened and weakened the ability of this study to draw conclusions about FIT practitioners' beliefs, experiences, and practices in general.

While there are other feedback scales, the ORS and SRS are the most researched in the literature and also most utilized by practitioners. Since the population of clinicians who use these tools is still relatively limited, and given the fact that these clinicians are situated in diverse professional contexts and social identities, the sampling method did not exclude clinicians based on any set of identity characteristics, professional degree, years of experience, or private or agency practice. Due to the fact that previous FIT literature has shown bias by failing to adequately represent the experience of non-white clinicians or clients in their samples and additionally neglected to investigate the dynamics of race and power within the process of FIT (for example, see: Anker, Duncan, & Sparks, 2009; Miller, Duncan, Brown, Sorrell, & Chalk, 2006; Reese, Norsworthy, & Rowlands, 2009), the current study excluded clinicians who did not work with clients of multiple races or ethnicities; extra efforts to recruit nonwhite clinicians were also taken (the call for participants encouraged participation among clinicians who identified with non-white racial groups by naming the historical lack of representation in clinical research in the recruitment pitch). This exclusion criteria was deemed necessary to implement as a corrective for past gaps in research and as a means to explore power dynamics that are a focus of the current study.

The current study employed nonprobability sampling (including availability and snowball methods) to garner participants. There was an aimed-for minimum of 50 participants. This minimum was chosen due to Smith College Master's Thesis guidelines as well as for the level of

diversity of experience the researcher hoped to garner while not setting an unrealistically high

number of participants (higher numbers of participants may have been difficult to secure given

the relatively limited number of practitioners who utilize FIT methods at this point in time).

Furthermore, with the goal of fifty participants, this exploratory research aimed to have a wide

enough scope so as to be able to tentatively sketch out suggestive trends in the thought process

and behavior of FIT-employing clinicians. The researcher acknowledges that by the nature of

this study, which is a preliminary exploration utilizing self-selected volunteer participants, very

tentative conclusions about trends in clinicians' behavior must be drawn regardless of sample

size.

The researcher also hoped to minimize the possibility that the sample would be entirely

composed of white clinicians, by setting a hoped-for minimum at least ten clinicians of color.

The goal of ten clinicians of color is an attempt to accurately represent the proportion of

clinicians of color working as clinicians in the helping professions. The participation of

clinicians of color was actively sought out and encouraged via targeted recruitment methods.

Despite these efforts, a sample with high racial diversity unfortunately could not be guaranteed.

A description of the study and link to an online survey (Appendix A) was posted in two

online communities of U.S. mental health practitioners who use FIT methods (including the

International Center for Clinical Excellence's website, found at

http://centerforclinicalexcellence.com/groups, and the *Heart and Soul of Change Project's* email

list, found at http://heartandsoulofchange.com/); the posts encouraged practitioners to forward

the survey to professional colleagues who qualify for participation. Before posting in these

online communities, the researcher emailed the webmasters/directors of the communities to ask

permission to post and inquire whether there may be other useful avenues to recruit participants

(Appendix B). Email approval of the project from all online community administrators was submitted to the Human Subjects Review committee in advance of any recruitment-taking place. Dr. Scott Miller, one of the pioneers of feedback informed treatment, was also emailed in order to generate gateways to additional participant pools and advice about the best way to solicit participation using the ICCE web forum.

Upon clicking the link in the recruitment post in online web communities, participants were directed to the first page of the survey instrument located on surveymonkey.com. Participants read the following text ("Thank you for your interest in participating in this survey. Please review the following four screening questions. If your answer to all four questions is "yes," please check the "yes" box to continue. If your answer to any of the questions is "no," you are not eligible to participate in this study and will be exited from this survey upon checking the "no" box") followed by four screening questions ("Are you a licensed mental health clinician in the United States?"; "Do you read and write English?"; "Do you use both Outcome Rating Scale (ORS) and Session Rating Scale (SRS) feedback tools with your clients?" and "Do you work with clients of diverse racial or ethnic backgrounds?"). If the participants indicated that their answer to any of the questions is "no," they were thanked for their time and exited out of the survey by being directed to the disqualification page. If their answer to all questions is "yes" and they clicked "yes," participants were sent to the second page of the survey. The second page contained the letter of consent including potential risks and benefits of participation, ethical standards and measures to protect confidentiality, and the researcher's contact information for questions and comments. On the consent form page, participants were advised that their choice to participate in the study would be established when they clicked the "I agree" button on the bottom of the page. If they chose instead to click "I do not agree," they were exited from the

survey after being redirected to the disqualification page.

Overall, 74 respondents clicked on the link to participate in the online survey over the two month period during which it was open to participation. Of the 74 who clicked the link, only 30 participants completed the full survey (including all demographic and open-ended survey questions). Of the 44 participants who clicked the survey link but did <u>not</u> complete the full survey: eight exited the survey before reading the informed consent page; twelve declined to the terms of informed consent and were exited from the survey; fourteen agreed to the terms of consent but failed to answer any subsequent questions; and 10 agreed to terms of consent, completed demographics questions, but failed to complete any open-ended survey questions. It is impossible to ascertain with certainty the reason(s) such a large proportion of participants dropped out of the survey before completion, since there was no follow-up questionnaire that would allow participants to indicate their reason for early exit from the survey. Given the significance of this yield issue, the researcher acknowledges the reality that self-selection bias has undoubtedly played a major role in the sample make-up; this bias will be explored in more depth in the Discussion chapter.

This recruitment method was cost effective and ideal because of the geographic distance between clinicians who use FIT methods and their relative scarcity in the field of mental health. The main limitation of this recruitment process was that it likely resulted in a highly self-selecting sample group of FIT practitioners that may not be representative of the larger population of FIT practitioners. The participants, by virtue of their connection to online FIT communities, may have been more likely than typical FIT practitioners to be self-reflective, sensitive, or passionate about the way they generate a "culture of feedback" with clients. Likewise, the participants may have exhibited positive bias (alliance effects) towards the

beneficial aspects of FIT methods and their experiences of FIT interventions with clients.

It is also worth noting that this survey methodology likely eliminated the participation of clinicians without Internet access, strong familiarity or comfort with the Internet, or knowledge of the particular online communities contacted. Historically, this type of limitation has prevented lower-income and non-technologically fluent people from being represented in samples. Based on anecdotal evidence of the widespread use of computers among professional health care workers in the United States, it is presumed that the vast majority of clinicians who utilize FIT tools in their psychotherapy practices have access to the Internet and are capable of completing a brief online survey, thus minimizing ethical concerns.

Finally, given the anonymous nature of online surveys and the fact that all mental health practitioners involved in the sample were be over the age of 18, it was not necessary for the researcher to procure special permission to engage with the sample participants.

The Nature of Participation

Upon completion of the informed consent, participants were asked to provide demographic information including age, gender, racial/ethnic identity, and amount of experience using Feedback Informed Treatment methods with clients (in years). Next, they read a brief explanation of the intention behind the current study and guidelines on answering the open-ended questions with thoughtfulness, thoroughness, and concrete detail. Upon completion of this explanation section, participants moved on to the body of the survey, in which they were posed the following three open-ended questions in successive order:

1) When soliciting feedback from your clients about their experience of the therapeutic alliance using the Session Rating Scale (SRS) tool, what do you do to increase your clients' comfort? What helps to increase the chance that they will give you genuine feedback? Please give at least one concrete example of what you might say to a client, what attitudes you might convey, or how you would act in session.

2) How does the difference in power between you and your client affect the process of asking for feedback about the therapeutic alliance? Please give at least one concrete example from your personal experience.
3) How does the racial dynamic between you and your client affect the process of asking for feedback about the therapeutic alliance? Consider situations in which you are working with clients of your own racial/ethnic group as well as different racial/ethnic groups. Again, please use at least one concrete example if possible.

Participants were allowed to abandon the survey at any point by closing the web browser window. After finishing the open-ended questions, participants were directed to the last page of the survey instrument, which thanked them for their time and included references to pertinent research that informed the study. The entire survey was expected to take between 15-20 minutes for participants to complete. All data was collected anonymously and electronically via the website SurveyMonkey.com.

While there were limitations in using an open-ended online survey instrument (e.g. clinicians may not reflect as deeply as they might in an interview situation), these were hopefully mitigated by a few factors: 1) The researcher explicitly requested in the guidelines section for participants to write at least a paragraph or two and use concrete examples in their responses; 2) There were a limited number of questions to which participants were asked to respond (with the idea being they were more likely to respond in depth if they knew there were not an interminable series of questions); 3) The participants were self-selecting. Since the recruitment occurred on online web communities of practicing clinicians who actively seek out professional community, support, and feedback about their work, it seems likely that those who participate in the survey would be relatively interested in the topic and willing to write in detail about their thoughts and experiences.

A full facsimile of what participants saw when logging on to and completing the survey is included in Appendix C.

Ethical Precautions: Risks and Benefits of Participation, Confidentiality, and Consent

Participating in the study posed a low risk to participants. However, because participants were asked to reflect on their own past behavior with clients, including behavior around racial power dynamics, it is possible that participation may have caused participants to experience uncomfortable feelings such as guilt or embarrassment. The initial consent form included the researcher's contact information as well as the contact information of the chair of the Smith College HSR committee and encouraged participants to contact either party with any questions or concerns they may have had about the background, methodology, or purposes of the study. Participants were made aware prior to participation that although all responses were to be anonymous and confidential, they had the right to refuse to answer any question on the survey without repercussions and the right to exit the survey at any time.

In terms of benefits, participation in the study may have provided participants a unique experience to reflect upon their experience of FIT interventions and the process of creating a trusting therapeutic alliance with their clients. Some clinicians may have experienced participation in the survey as a learning opportunity or a way to better understand their own approach to soliciting feedback. Likewise, participants may have gained more insight or developed more interest in exploring the ways that power dynamics play out between themselves and clients. This could motivate them to consult with colleagues, bring such issues up in supervision, or seek out more support around these issues via Internet communities or professional organizations. Ultimately, the study offered clinicians an opportunity to bring their attention to ways in which they can serve their clients better; and when clients benefit, clinicians benefit. Unfortunately, no tangible benefit or monetary compensation was able to be offered to participants in the study.

After entering the survey by answering the four screening questions affirmatively, they were directed to the Informed Consent form. Participants were asked to read through the text explaining the consent process and accept or decline the terms of participation by checking a box ("I agree" or "I disagree"). Participants were unable to move on to the survey unless this procedure was completed. A copy of the Informed Consent form can be found in Appendix D.

Participation in the study was anonymous and data was kept confidential. Data was only be accessed by the researcher and his research advisor. When participants accessed the survey instrument online, no information (such as their email address or IP address) was collected or stored that would allow their identity to be traced. The researcher ensured that Surveymonkey.com's firewalls were set in place to prevent the researcher from collecting identifying information. Participants were asked not to identify themselves in any way. Demographic questions were general and could not lead to any personal identification. In the case of open-ended questions, clinicians were cautioned not to provide any identifying client information in their responses (no participant revealed identifying information about clients in responding to survey questions).

All data collected was stored on SurveyMonkey.com, which is a website that is firewalled, password-protected, and encrypted. All data will be stored on the website's server for three years as required by Federal regulations, after which data will be destroyed. Demographic data and participant responses to open-ended questions were also downloaded into Microsoft Excel for analysis and all data files were password-encrypted by the researcher. SurveyMonkey's Security Statement is listed in Appendix E.

Data Analysis

Demographic information of participants (including participant-identified age, gender, nationality, years using FIT, and race/ethnicity) was analyzed using Microsoft Excel. Descriptive statistics on the central tendency and variability of age and years using FIT methods was also calculated using this software.

The qualitative data (written responses to the three open-ended questions) was analyzed using thematic analysis (Braun & Clarke, 2006). Using thematic analysis, the researcher first identified common patterns across participant responses to the three questions by reading through each response and taking notes on the prominent ideas contained within. After two passes through all the data in this method, the researcher created a tentative draft of predominant themes in each question's responses using the observation notes; some themes were grouped together as subthemes described by a larger "main" theme. At this point, the researcher went back and coded the data using the established themes, using a "color coding" system in which sentence units of participant responses were highlighted according to which theme(s) they expressed. After coding, the researcher could use a numerical counting system to confirm the relative frequency of each theme and subtheme, thus confirming or disconfirming the initial subjective organization of themes based on predominance and helping the researcher further refine the final organization of themes.

CHAPTER IV

FINDINGS

Sample Size and Demographic Information

Of the thirty respondents who made up the final sample, the average age was 52.9 years (median 54 years). The average number of years using FIT methods was 5.08 years (median 4 years). Exactly half (15) identified as male gendered and half (15) female gendered. Two-thirds of the participants (21) were clinicians practicing in the United States and one-third of participants (9) identified as international (including two Canadian clinicians, six Australian clinicians, and one clinician in New Zealand). In terms of racial/ethnic identification, the respondents identified themselves as predominantly white and/or in the dominant racial/ethnic group in their country of residence. Eighteen participants identified solely as "white." Four participants identified as "white" plus another racial or ethnic descriptor, including "Anglo with NZ Maori ancestry," "White, Arab-American," "White Jewish," and a white clinician who identified her ethnic heritage as "Scots Irish." A few participants identified their race/ethnic background in terms of race and/or national identity, including "French/Australian," "Anglo-Australian," and "Greek Australian." Two participants identified as African-American.

Given the non-conformity in respondents' self-referential racial/ethnic terminology, it is clear that leaving this particular demographic question open-ended allowed participants to define themselves with a range of words and identifiers that do not necessarily fit within easily "counted" categories. For example, while it is clear that the majority of the sample identified as white or from a dominant racial/ethic group, it is unclear how many claimed a mixed racial/ethnic identity from these responses. Likewise, it is unclear what kind of racial identity or skin privilege respondents using nationality as a signifier of race/ethnicity experience in their

lives. Combined with the inherent categorical ambiguity of race and ethnicity, it is impossible for the researcher to give a straightforward percentage of participants who identify as various races/ethnicities. However, above all else, it is apparent that the sample consisted predominantly of clinicians who identified as being part of dominant racial/ethnic groups, with a very small minority of clinicians who solely identified as being part of historically oppressed racial/ethnic groups.

Organization of Themes and Subthemes

Responses to the three open-ended questions were analyzed using thematic analysis (Braun & Clarke, 2006). The researcher organized and interpreted the data by a progressive analysis utilizing the notation of significant and repeated ideas, grouping of ideas into themes and sub-themes, and the numerical counting of themes in order to qualify a given theme's frequency. Themes were identified as sets of ideas repeated throughout survey responses that shared defining characteristics. Some themes were broad enough that sub-themes within the main themes were identified to convey notable characteristics of the main theme. In such cases, presentation and explication of sub-themes serves to represent the range of content of the main theme. Additionally, in a few cases, sub-themes themselves were multifaceted enough to warrant further explication in sub-sub-themes, which serve the same purpose sub-themes serve for main themes.

In the presentation of themes and sub-themes in this chapter, relative frequency is indicated by a number in parentheses at the beginning of the theme section (e.g., "9"). This number indicates the number of respondents out of the total sample of 30 who touched on elements of the theme in their response to a given survey question. It is important to note that while the content of sub-themes make up the entirety of the content of main themes, the content

of sub-sub-themes do <u>not</u> make up the entirety of the content of sub-themes; rather, they convey one or two elements of the sub-theme that might not be explicated otherwise. Finally, in some cases, themes are not presented in order of predominance, but rather in respect to their relationship to one another. For example, if "theme C" is less predominant than "theme B" but primary elements of "theme C" bear a closer relationship to "theme A," "theme C" is presented subsequent to "theme A" for purposes of coherence and flow in the analysis.

Summary of Major Findings

The major findings of this survey were derived from respondents' answers to three open-ended questions: 1) How do respondents engage with clients to create a "culture of feedback" in which clients are more likely to offer genuine feedback to respondents? 2) In respondents' experience, what effect does the difference in power between themselves and clients have on the feedback process? 3) Specifically, how does the racial/ethnic dynamic between respondents and their clients affect the feedback process, in respondents' experience?

Overall, respondents reported that they strive to create a "culture of feedback" by framing feedback as a way to increase the value of therapy for clients, particularly by emphasizing the ways in which feedback promotes a more collaborative dynamic between therapist and client. Participants discussed their awareness of the difficulty of offering genuine feedback, especially given the interpersonal offense or rupture many clients fear it might cause as well as many clients' backgrounds of multiple oppressions and abuse by authority figures. Respondents emphasized ways that they strive to be flexible and sensitive in their feedback interventions as a result. Respondents often articulated how feedback interventions reinforce their larger therapeutic agenda of honoring and valuing the client's voice; in this sense, many clinicians viewed feedback as a tool to diminish power imbalances and create new relational paradigms

with clients. Indeed, respondents often reported that FIT methods serve as a powerful therapeutic intervention in and of themselves and that many clients express appreciation for the feedback process.

Despite respondents' best intentions, they reported that clients often feel hesitant to offer genuine feedback due to fear of negative repercussions and as a result of interpersonal and societal power dynamics present in the therapy room. Significantly, while most clinicians recognized how interpersonal and systemic power imbalances between therapist and client hinders genuine feedback on the part of the client, a third of respondents did not believe racial/ethnic dynamics operate as a major factor in the feedback process. Furthermore, in discussing the dynamics of race/ethnicity in the therapeutic alliance, the majority of survey respondents (who were predominantly white) neglected to address their own race/ethnicity or the dynamics between themselves and white clients, choosing instead to focus entirely on their experience of clients from racial/ethnic minority backgrounds. In this thread, many respondents (again predominantly white) drew on their experiences with international or non-English speaking clients in responding to the question about race/ethnicity without addressing such clients race/ethnicity; in conflating nationality/immigration status with race/ethnicity, it was unclear the extent to which respondents were confused by the survey question or simply blind to the intricacies of racial/ethnic identity characteristics, perhaps due to their own membership in dominant racial/ethnic groups.

Organization of Analysis Sections

The findings sections presented in the rest of this chapter are organized by respondents' answers to the survey questions in the order they were presented. That is to say, the first section explicates main themes in respondents' answers to the first open-ended survey question (about

how they engage with clients to create a "culture of feedback" in which clients feel comfortable offering genuine feedback). The second section explicates themes found in respondents' answers to the second open-ended survey question (about power dynamics and the feedback process), and the third section focuses on themes in respondents' answers to the third question (about racial/ethnic dynamics in the feedback process). Finally, the fourth and final section serves to summarize all significant themes and sub-themes as well as highlight themes that appeared in multiple sections.

Section 1: Engaging with the client to create a "Culture of Feedback"

This section explores common themes in respondents' answers to the first open-ended survey question, copied here in full: "*When soliciting feedback from your clients about their experience of the therapeutic alliance using the Session Rating Scale (SRS) tool, what do you do to increase your clients' comfort? What helps to increase the chance that they will give you genuine feedback? Please give at least one concrete example of what you might say to a client, what attitudes you might convey, or how you would act in session.*"

There were four main themes identified in respondents' answers to this question. Themes included: 1) Framing feedback as a way to increase the value of therapy; 2) Addressing the difficulty of giving direct feedback; 3) Treating therapy as a collaborative process; and 4) Communicating sincere desire to hear the client's voice. Each theme will be explored in depth using narrative quotes from participants' actual responses as examples; analysis will include mention of the numerical frequency of each theme, as well.

Theme 1.1: Framing Feedback as a way to increase the value of therapy

Over half of respondents (17) touched on this theme in their response to Question 1. In

general, respondents described speaking with their clients about ways in which feedback

interventions serve to enhance the effectiveness of therapy and improve the chance of a

successful therapeutic outcome. The content of this main theme is described best by breaking it

into three sub-themes: A) Explaining the purpose of FIT, B) Framing therapy as a client

investment, and C) Reframing critical feedback as positive for therapy.

Sub-theme 1.1A) Explaining the purpose of FIT

A third of respondents (11) touched on this sub-theme. Many participants articulated that

most of their clients were unfamiliar FIT as a therapy practice and it was helpful to explain the

purpose of it to help clients feel less confused and skeptical about it. In this vein, clinicians

explained that by clarifying the purpose of FIT for clients — namely, to improve the quality and

fit of therapy services being offered with guidance from the client — they hoped to engender

more trust and acceptance of the process, strange as it may seem to clients. The following

statements by respondents exemplify this sub-theme:

> *"I let clients know why I think feedback is important and why I value their feedback, especially their feedback about what didn't go well or quite work for them. E.g. I say things like: feedback will help us to develop a strong working alliance and that in turn will influence the ORS which is a clear indicator of positive change (the reason why they have come for counselling)."*

> *"When I re-introduce the SRS, I always emphasize how much I want their honest feedback because it can really help me make any changes I need to improve their experience. Sometimes I will tell clients a little about the research and how often counselors THINK everything is going well when it is not and why it's so important to know early if there's a mismatch between our idea about what is going to be helpful."*

> *"I will usually explain the reasons I use the SRS, by letting them know that I take a different approach with each client and try to modify the approach to best suit the needs of that client."*

> *[Respondent says the following to client]: "Your views of our interaction is helpful in keeping me on track and will improve our likelihood of success."*

Respondents such as these clearly articulated in their own words to the client that the reason they use a feedback intervention is to improve the experience of therapy, the respondents' ability to fit their approach to the needs of the client, all in the name of increasing the "likelihood of success." As evidenced, some respondents even went to the extent of explaining some of the empirical research supporting the efficacy of FIT practices to their clients. Overall, this sub-theme articulates respondents' strategy of gaining client "buy-in" by making the reasons behind their feedback intervention transparent, explaining that both therapist and client have something to gain ("positive change") by engaging in honest feedback.

Within the framework of this sub-theme, a small number of clinicians (3) discussed using analogies or examples to illustrate the way feedback has helped improve a therapy outcome in their past work. For example:

> *I tell a little story about perhaps being in a restaurant and the server comes by and asks "how was your meal?" Most people say fine even though they just told someone at their table that the meal was too salty. Without their input the meal remains salty to some people when perhaps it would taste better if people could season according to their personal tastes and have just a little better experience.*

In this quotation, the respondent uses a "restaurant" analogy to demonstrate how the client might improve their experience of therapy (helping it "taste better") by offering genuine feedback to the respondent. Again, this example demonstrates how clinicians aim to familiarize the process of feedback to clients, de-mystifying what might feel like an intimidating and strange interaction.

Sub-theme 1.1B) Framing therapy as a client investment

A fifth of respondents (6) touched on this sub-theme in their answers. Overall, this sub-theme speaks to the way that respondents utilized the language of value and investment to describe therapy, highlighting the importance of clients' getting the most valuable service (regardless of whether it is from the respondent or another therapist) in return for their financial,

emotional, and time investment. The following are a sampling of respondent quotations to this effect:

> *"I openly talk about the fact this is a fiduciary relationship and that therapy is 'expensive business'. We want to make sure they get the value out of their investment of time, money and energy, or they can take their money and spend it on something more worthwhile. I refer to the expensive business through the therapy so the financial relationship is not out of sight. I refer to myself as 'Hired by you to do a job. You need to make sure I am delivering what you want, just as you would if you hired any other consultant or plumber.'"*

> *"I reassure them that fit is very important when working in therapy and they will not hurt my feelings if they do not feel like we are fitting into a working alliance toward their goals. I tell them that should that happen, I am happy to refer them to another therapist or someone who may be able to help them."*

> *[Respondent says to client] "I want your honest feedback, so I can learn how to help you and so this class is valuable to you."*

In these responses, participants explicitly name the "value" of therapy, emphasizing their desire to make the therapy as valuable as it can be for the client. Several respondents note the importance of gauging whether the fit between themselves and clients is of high enough value to merit continued partnership; if not, respondents indicate that they speak with clients about the possibility of referring to another therapist. This example illustrates the way that many respondents stressed the importance of the client getting the high quality services they deserved (e.g. services that fit them the best) *over* the client using the services of the respondent (if such services do not fit the client's needs best). In this way, respondents reframe therapy as client-driven, invoking the idea that it is *clients* who will be the evaluators of whether or not therapy is as successful and valuable as they'd like it to be. This idea reinforces the importance of the clients offering genuine feedback to the therapist.

Sub-theme 1.1C) Reframing critical feedback as positive for therapy

One-sixth of respondents (5) touched on this sub-theme in their answers to Question 1. The

basic idea underlying this sub-theme is that clinicians reported flipping the script about the assumed value of critical feedback when speaking with clients. That is to say, given clients' concern about negative feedback hurting the therapeutic relationship (thus lessening the value of therapy), respondents offered the perspective that critical feedback actually *helps* the therapeutic relationship (thus increasing the value of therapy). Participants articulated this in different ways:

> *"I frequently say 'There is no good news or bad news, just news that we can use.'"*

> *"I also tell [clients] while it is great to hear if a session is great, it is often much more helpful to get feedback about what didn't work even if it is something really small."*

> *"I tell the client that I am not interested in perfect scores because that won't help us to create the best experience for change."*

In these examples, respondents strive to alter clients' perceptions about what is "bad news" and what is "helpful." By reframing critical feedback as more useful than "perfect scores" (on the clients' rating of the therapist using the in-session SRS measure), respondents encourage clients to give more genuine feedback, attempting to free them from the belief that genuine feedback is unwelcome if it is critical.

Theme 1.2: Addressing the discomfort of giving direct feedback

While the common thread linking sub-themes of Theme 1 is an emphasis on value (including increasing the value of therapy, framing therapy as an investment, and framing critical feedback as valuable), the common thread linking the sub-themes of Theme 2 is the importance respondents placed on addressing clients' discomfort with direct feedback. Half of the respondents (15) addressed this discomfort both indirectly and directly, nonverbally and verbally. The primary strategies participants used comprise the two sub-themes of this section: A) De-escalating the stakes; and B) Acknowledging the interpersonal discomfort of offering

feedback.

Sub-theme 1.2A: De-escalating the stakes

Approximately a third of participants (13) touched on this sub-theme in their answers to

Question 1. Respondents reported attempting to make feedback feel like a normal, unthreatening

aspect of the therapy process for clients. They did this by reassuring clients that their feedback

would not hurt respondents' feelings or result in negative consequences (such as termination of

services), keeping a casual tone and using self-deprecation in conversation, as well as responding

to clients' nonverbal discomfort cues by de-escalating the stakes of a given feedback interaction.

A sampling of respondents' thoughts reflects these strategies:

> *"Reassurance that client is not rating "me," but instead "taking the temperature" of our session on that particular day."*

> *"I say things like 'I am thick skinned so you will not hurt my feelings.' "*

> *"I say, 'This has nothing to do with my treatment recommendations.' or 'This has nothing to do with my decision about whether you are ready for license reinstatement.'"*

> *"The only thing I can think of that I might do to increase the chance people will give 'genuine' feedback is that I am generally fairly self-depreciating (Columbo approach) and that seems to lead to a more casual, mutual conversation."*

> *"I say, 'Please be as honest as you can stand' while making a praying motion with my hands.*

> *"Look away from them as they complete it."*

As demonstrated in these quotes, de-escalation can take the form of reframing feedback as a way

to feel out the experience of the "session" instead of the personal qualities of the therapist or

reassuring the client that feedback will not "hurt [his or her] feelings." Likewise, creating a

casual tone through self-deprecation, light humor about the process, and eliminating client

worries about feedback being used against them (having a negative impact on "treatment

recommendations"), helps de-escalate the perceived risk of offering genuine feedback. Finally, as one clinician states, using non-verbal strategies such as looking away from the client as they complete the feedback form at the end of the session (instead of staring at them intently) also helps to reduce the pressure of the feedback interaction; combined with attunement to subtle client cues that they may be too uncomfortable in the moment to offer direct feedback, respondents aim to create an atmosphere in which clients feel more comfortable with the feedback process.

Sub-theme 1.2B: Acknowledging the interpersonal discomfort of offering feedback

A small contingent of respondents (4) reported using the strategy of verbally acknowledging to clients the interpersonal discomfort that might get in the way of the client offering genuine feedback. For example, one respondent writes:

> *"I tell them very early (and they can tell) I am a big personality. While that can be fun and useful, I am also aware that can make giving me challenging feedback tricky at times for some people, especially if giving others challenging feedback is hard for them elsewhere in their lives."*

And another relates:

> *"I do the usual spiel but I also tell them that clients are often very polite and when they are asked about how the session went ... they often smile and nod and tell you that it is good but then they might leave the room and say 'that was terrible' and don't come back."*

In one case, the respondent acknowledges that it may be difficult for some clients to offer feedback to her because of her personality style or because it is a challenge for them to do so as a rule. In the other example, the respondent acknowledges and normalizes how clients may be tempted to follow social norms by being "polite" and clarifies that such politeness might actually threaten the therapeutic working relationship (even to the point of premature termination).

Interestingly, respondents had more to say about the ways they might verbally acknowledge the discomfort of offering feedback when answering open-ended questions about power and racial/ethnic dynamics in the therapy room. Perhaps those later questions prompted clients to become more thoughtful about how they approach client discomfort, or perhaps those questions raised systemic or structural issues around offering feedback whereas the first question prompted respondents to think more on an interpersonal level. In any case, it's clear that one primary strategy respondents use to increase the chance of receiving genuine feedback from clients is to address client discomfort by de-escalating the stakes of feedback and acknowledging and normalizing the discomfort in the first place.

Theme 1.3: Treating therapy as a collaborative process

More than half of respondents (18) touched on this theme in their answer to Question 1. In general, respondents aimed to treat clients as valued members of the therapy process, communicating with them directly and indirectly that they hoped to work *with* clients collaboratively rather than *on* clients, as a surgeon might. The primary ways that respondents framed this task are represented by four sub-themes: A) Honoring what the client brings to the process; B) Emphasizing the primacy of the client's therapy goals; C) Framing therapy as a cooperative task; and D) Replacing the notion of therapist as "expert" with the idea of therapist and client as "co-experts."

Sub-theme 1.3A: Honoring what the client brings to the process

Approximately a quarter of respondents (8) touched on this sub-theme in their response to Question 1. Two significant aspects of honoring what clients bring to the process of therapy involved verbally thanking clients for their feedback when it was offered as well as

actually implementing changes based on client feedback. Examples of these behaviors are

reflected in several respondent narrative responses:

> *"If the client has specific feedback, I write this down in front of the client and remind myself to do it at the next session. E.g. write larger on the white board, provide a glass of water, provide photocopies to read etc."*

> *"I tell them that I welcome the feed back and then thank them when done. ... I always thank them for negative feedback."*

> *"I honor the client's voice at all times so that, by the time the SRS is offered, the client knows that they are empowered, honored, and that I am already impressed by what they bring to the process. When they give me a tiny kernel of something that is not totally positive, I explore it and show true appreciation which reinforces the safety of doing something that is very hard to do: give feedback."*

> *"I ask about the SRS results at the end of the session in terms of what they would have liked different from me, and what they would like to have different next time. If there is something , I bear in mind and try to modify my actions/ manner next time. Next time, if I have modified, I'll ask if that was sufficient or if I still need to change more."*

As seen here, respondents viewed it as important to recognize clients' feedback contributions,

especially when such feedback is critical ("I always thank them for negative feedback").

Likewise, respondents relate the importance of not just listening to client feedback but actually

honoring the feedback that is offered by making noticeable changes in their service and checking

back in with clients to make sure that the changes made are what the client had in mind. These

efforts serve to reinforce clients' experience of having their contribution to therapy taken

seriously and acknowledged for how valuable it is to the process.

Sub-theme 1.3B: Emphasizing primacy of client's therapy goals

Along these lines, approximately a quarter of respondents (8) described emphasizing the

importance of seeking out and working towards the *client's* goals, a process facilitated by client

feedback. By demonstrating with clients that *their* goals (not the therapist's) are the primary

focus of therapy, respondents again highlight the collaborative nature of therapy. Respondents articulated this in several ways:

> *"For example, I may begin by asking, 'What do you want to accomplish here?' I operate from a collaborative approach to counseling; therefore, I inform the client from the beginning that we will be focusing on what they want to achieve, their strengths and resources, and what they can do more of to get what they want. ... I have had folks who were curious about the idea that there are different "approaches" to counseling, so this form is an avenue, at times, into conversations about the different ways that counselors can work with people."*

> *"To make sure, the best that I can, that we are on track for their desired outcome and that we did what they wanted today. I tell them that I welcome the feed back and then thank them when done."*

> *[Respondent says to client] "I want to make sure we're on the right track here, that we're talking about what you want to and helping you take away what you'd like from treatment."*

> *I operate from a collaborative approach to counseling; therefore, I inform the client ... that we will be focusing on what they want to achieve, their strengths and resources, and what they can do more of to get what they want.*

Respondents ask clients what they "want to accomplish here," what their "desired outcome" is, what they'd "like from treatment," and tell them that they "want them to get the results they want." In some cases, it appears that respondents use this type of dialogue with clients outside the context of the feedback intervention; however, it is also clear that the feedback intervention reinforces the active solicitation of client goals and the end of the session—when clients score the SRS form and offer feedback about that session— serves as an opportune moment to pull for client disclosure about whether or not the treatment feels on track with their therapy agenda.

Sub-theme 1.3C: Framing the client as helper to the helper

In a third of respondents' answers (9) to Question 1, the notion of cooperation and collaboration in therapy was invoked in ways dissimilar from the previous two sub-themes. Primarily, participants used the language of "help me help you" to communicate their hope that

clients help them (participants) be a better therapist for them by offering genuine feedback. For example:

> *"I say, 'Filling this out helps me out a lot. It is a way for you to help me with your therapy.' It puts them in the helping role, and I think most people want to be helpful if they can."*

> *"I frame this in terms of my role in being a support and advocate for the client and explain the role of feedback from them in assisting me to help in the best way that I can."*

> *[Respondent says to client] "This is not the place to say that I'm a nice guy; this is where you can help me be more useful to you."*

In these quotations, it's clear that respondents hope to instill a sense of collaborative helping in the therapeutic working alliance by explicitly asking clients for help in helping them. As one participant implies, requesting help from clients turns the tables and allows clients to be "helpful" in a way that most people experience as ego syntonic. Furthermore, framing the client as "helper" appears to serve as a counterbalance against clients' perceptions that offering critical feedback is destructive or hurtful; similar to sub-theme 1C (Framing negative feedback as positive), this strategy serves to shift clients' understanding of what it looks like for a therapist and client to "help" each other in the working relationship.

Within the context of Sub-theme 3C, a fifth of respondents (7) communicated to clients that by helping the therapist do better work with them, they would also be helping the therapist do better work with all their other clients. In this respect, there was a sub-sub-theme, the primary element of which was the implicit communication "help me help others." For example:

> *"When I first introduce the SRS, I say 'This is to help me improve my practice and my work with you and so I'd like you to be very honest in your assessments, because it will help me and all of my clients.'"*

> *[Respondent says to client] "I'm really curious how this went for you today. how was this for you? I want to make sure this is helpful to you and I want to try to learn how to be more helpful with other patients too."*

[Respondent says to client] "I use this scale to help me learn how to be a better therapist. Your honest feedback helps me do better and helps me learn from my mistakes instead of making the same mistakes over and over again."

[Respondent says to client] "If you are honest and help me help you better than you also help the next client."

Similar to the message "help me help you," "help me help others" puts the client in a position of power and reframes feedback as a process by which the client can not only improve their own treatment (and their own relationship with the respondent) but also improve other, unknown clients' treatments. As such, this message implies that by offering genuine feedback, clients have the capability to help their therapist become a better overall therapist, not just a better therapist for them (the client offering the feedback).

Theme 1.4: Communicating sincere desire to hear the client's voice

Slightly more than a third of the respondents (12) touched on elements of the final theme in their responses to Question 1. Similar in some ways to Theme 3 (Treating therapy as a collaborative process), this theme focuses more on the relational act of respondents communicating with clients how important and valuable their client's voice is to them.

[Respondent says to client] "Your experience of our work is very important to me. Try to answer these questions as honestly as you can."

[Respondent says to client] "It's important to me to know how you are experiencing our work together."

"When they tell me that it was all good, I ask them to provide a small example of what worked for them so that I will know what they liked and can repeat it. This sends a message that I don't just want to hear that all was good (10's) but that I want to really understand what they liked. If they are not being genuine with me, next time they will be more forthcoming since they know that I am truly interested in the positive as well as the negative and that saying it was all "good" does not end my interest in what they have to say."

"I let them know that my goal is to be as helpful as possible and that I truly want to

hear the things that could have made our time together more productive for them."

While the respondent answers quoted here encapsulate many of the prior themes, one subtle

element stands out: the sincerity with which respondents communicate the "importance" of their

client's experience. Respondents emphasized this with phrases such as "I want to really

understand," "very important to me," and "I truly want to hear." The element that distinguishes

this theme from others in respondents' answers to Question 1 is the intensity of respondents'

communication to their clients that the client's voice is desired and valued.

Section 2: Power Dynamics and the Feedback Process

This section explores common themes in respondents' answers to the second open-ended

survey question, copied here in full*: "How does the difference in power between you and your*

client affect the process of asking for feedback about the therapeutic alliance?   Please give at

least one concrete example from your personal experience."

There were three main themes identified in respondents' answers to this question.

Themes included: 1) Power differential hinders client willingness to engage in feedback; 2)

Addressing the power differential by acknowledging it and being sensitive to it in feedback

interventions; and 3) Potential of the feedback intervention to reduce the power differential. Each

theme will be explored in depth using narrative quotes from participants' responses.

Theme 2.1: Power differential hinders client willingness to engage in
feedback

Almost half of respondents (13) touched on elements of this theme in their responses to

Question 2. In general, respondents reported reduced client willingness to engage in the feedback

intervention due to issues relating to the power differential between respondent (more power)

and client (less power). Specifically, three sub-themes were identified: A) Clients fear that negative feedback will result in negative consequence; B) Clients with oppressed identities are skeptical about feedback; and C) Clients who view therapists as experts not to be questioned are less likely to engage in feedback process.

Sub-theme 2.1A) Clients fear that negative feedback will result in negative consequence

Approximately a quarter of respondents (7) touched on this sub-theme in their answers to Question 2. Overall, the common element was an understanding that many clients feel hesitant to offer negative feedback because they believe the respondent might retaliate by using their institutional or systemic power to punish them by reducing or eliminating needed services, including the therapy service itself. Respondents touched on this in various ways:

> *"In some cases, I think there's a fear from clients that negative feedback will result in loss of access to service. In situations, for example, where they're mandated by someone else (court, employer or even a partner)......."*

> *"Some clients fear that I will be mad at them if they give negative feedback. Trouble is the very people who are afraid to give negative feedback are also afraid to say they are afraid to give negative feedback ... Many clients are afraid the results* [of feedback intervention] *will be used to deny them desperately needed services."*

> *"I have had an adolescent or two ask if they rate me as a total jerk, will I stop working with them... to which, I usually shake my head and warn them that then I'll work with them twice as hard!"*

Respondents relate that many clients are at a power disadvantage in relation to the respondents (e.g. clients who are mandated to attend therapy) and as such hesitate to offer negative feedback due to the expectation that the respondent might "deny them desperately needed services" or use their power to bring about a "loss of access to service." In the quotation about one respondent's adolescent clients, the client came right out and inquired whether negative feedback would result

in termination of therapy—though the implication from many respondents' answers was that clients are rarely so direct about their fears of being punished as a result of the power differential.

Sub-theme 2.1B) Clients with oppressed identities are skeptical about feedback

Along similar lines to the first sub-theme, one-sixth of respondents (5) explicitly discussed their observation that clients who experience significant oppression due to their social location are reasonably skeptical about respondent's sincerity about wanting feedback, often because of oppressive past experiences with figures of authority or power; this results in clients being less willing to engage in the feedback process. For example:

> *"I am constantly making adjustments to the wording and how much I emphasize different elements depending on the person and their background and their previous experience with people who have power over them e.g., probation and parole guys who come in at the direction of their parole officer."*

> *"Most of our clients are therapy veterans and have been public sector recipients. In other words, they are very skeptical about the sincerity of their providers. While this is clearly an expression of the power differential, we can't overcome this inherent imbalance in any direct way. We must work to bridge this gap and view the scales as one vehicle for accomplishing this. We recognize that there will always be the power imbalance, but we must be humbled by the work and recognize that it is our responsibility to acknowledge the differential in power and support the customer to risk communications that may have resulted in negative consequences with previous providers. No matter how we try, we do represent the "system" and are agents of social control.."*

As the first respondent above articulates, it is important to understand the impact of clients' life experiences in public systems of power and control (e.g. "probation and parole") when seeking feedback. Likewise, the second respondent acknowledges that clients who "have been public sector recipients" in a significant way are likely to be skeptical and reasonably hesitant to offer genuine feedback because such "communications . . . may have resulted in negative consequences with previous providers." This statement implicitly recognizes the

reality that the systemic dynamics of oppression, as manifested through even well meaning social service structures such as agencies and governmental assistance programs, often silences and disempowers clients. Clients' experience of past providers is that they have reinforced the machinery of control even as they (on rare occasions) attempt to dismantle it through the limited service they can offer their clients. As such, clients find themselves in a double bind in which they must be wary of truly speaking up for themselves as such action may result in institutional penalty. Respondents speaking to this sub-theme in their narrative responses acknowledged the difficult situation clients find themselves in and empathized with clients' skepticism about offering genuine feedback — after all, how can they be sure that this provider (unlike multiple past providers) is actually sincere about wanting to hear their agenda, their goals in life, their experience of a relationship that by its very nature involves a power differential? And moreover, even if the provider is serious about wanting to hear such feedback, how can the client be sure that their feedback will be taken seriously or used to improve service?

Sub-theme 2.1C) Clients who view therapists as experts are less likely to engage in feedback process

Approximately a quarter of respondents (7) touched on this sub-theme in their answers to Question 2. Participants reported that clients who view the therapist as an expert and themselves as non-expert are less likely to engage in the feedback process, perhaps as a result of doubting their own thoughts and feelings or seeing their experience as less valid than their therapist's. Participants had various ways of expressing this:

> *"The therapist may be seen as the expert, so that also makes the therapist's reaction to the feedback likely to be a key issue as well - the client may doubt they have the 'right' perception on the issue and what's going on."*

"Patient asks me whether his response is right, not trusting own thoughts."

"A concrete example of this is that a client would say to me, 'you're the boss.'"

"Clients who approach therapy in such a way that they see the therapist as an 'expert' or 'doctor' often take longer to give honest feedback. I notice that older clients may not feel confident to give feedback regarding aspects of therapy which are unhelpful and tend to find the SRS less useful with these clients."

"For some people, they seem to really want me to be the "Dr" or the "expert", sometimes to ask for feedback seems to make them uncomfortable, like I might not know what I'm doing, like I might not be able to help them if I have to ask for their input."

Clients' expectation that their therapist is the "expert," the "doctor," or a "boss" not to be questioned may derive from a variety of dynamics, including clients' familiarity with the medical model, clients' past experience with service providers who expected to be treated as authority figures, or the clients' own expectations about interactions with service providers that are rooted in their upbringing or cultural background (e.g. older clients may have different expectations of therapy providers than younger clients). In this sense, clients' experience of the realities of the power differential between themselves and therapists combines with the internalization of schemas of authority and power that clients' themselves bring into the room (which, granted, are a result of clients being embedded in systems of power and oppression in the first place). Respondents' general impression was that it is often more difficult to elicit genuine feedback from such clients, given the twin dynamics of their belief that feedback is unwarranted with an "expert" such as the therapist and their distrust of their own, non "expert" thoughts and feelings. Interestingly, as the last quotation illustrates, such clients may also be concerned that therapists who seek feedback are less "expert" than the client would prefer in a provider, raising insecurities that further reduce the chance of a genuine feedback interaction.

Theme 2.2: Addressing the power differential by acknowledging it and being

sensitive to it in feedback interventions

More than a third of participants (12) invoked elements of this theme in their responses to

Question 2. The primary thread linking components of this theme is respondents' decision to

address the power differential by acknowledging it verbally and taking steps to shape sensitive

feedback interventions to limit the extent to which it interferes with clients' feeling comfortable

giving feedback. This theme breaks down into three separate sub-themes: A) Naming the power

differential; B) Being flexible and sensitive in feedback interventions; and C) Therapist

persistence, patience, and encouragement.

Sub-theme 2.2A: Naming the power differential

Approximately a third of respondents (9) touched on this sub-theme in their answers to

Question 2. In general, participants reported speaking with their clients about the reality of the

power differential between them, noting how it might silence the client unless both parties are

active in examining its effect. Two examples of how respondents addressed this issue are as

follows:

> *"If they are mandated by a court, I think it does require me to point out the power issue at length and find out how it is impacting them."*
>
> *"I recognise that it's almost always harder for the person in the one-down position to answer questions about feedback put to them by the one in the higher power position. I name that there are issues of fear of loss of privileges, fear of judgment, of loss of relationship support, of 'punishment' or emotional cut off. I acknowledge that all of this comes into play in the therapy relationship."*

In the first example, a respondent states that in cases in which a client is attending therapy by a

very explicit power mandate (such as court ruling), it is necessary to discuss with the client how

such a power differential impacts their experience of therapy. In the second example, the respondent indicates that empathizing with clients about the difficulty of offering feedback from a "one-down" (less powerful) position and also names the possibility that clients may fear negative repercussions ("loss of privileges . . . support") if they offer negative feedback. In each instance, respondents imply that one way they hope to counteract the silencing nature of the power differential is to explicitly bring it into the room via an open conversation, learning about the client's experience of it in order to create a more comfortable and productive therapeutic working relationship.

One way that two respondents named the power differential was by utilizing self-disclosure, reflecting with clients about times that they have been in a less powerful role and the difficulty they experienced with that situation. A quotation from one of the respondents might illustrate this best:

> *"I have also used as an example when I was preparing to have cataracts operated on ten years ago and I had a conflict with my ophthalmologist. I say to clients that I felt the vulnerability of wanting him to operate because I had known him for 18 years and didn't want to lose that, but I also had a major trust issue about how he was treating me and I couldn't bear to go under the knife with him if I didn't name it and find a way for us to resolve it. I tell them I felt awful, scared, unsure, and like a 'difficult woman', but I persisted. I tell them I loved that he wanted the best care for me more than he wanted me to stroke his ego and he listened, and we cleaned it up. We preserved the relationship and he operated on me."*

While using self-disclosure as a method to name the effects of a power differential was not a common strategy reported by respondents, as this example illustrates, it is yet another way to open up dialogue with clients about the ways a power differential in a helping relationship can impede genuine feedback.

Sub-theme 2.2B: Being flexible and sensitive in feedback interventions

To this end, a quarter of respondents (8) described ways they attempt to make clients

more comfortable with the feedback intervention given the power differential. In general, participants reported learning how to be flexible and sensitive in their implementation of the intervention, customizing it as best as they can to fit the needs of their clients. For example:

> *"Sometimes I have been known to ask, 'If you feel uncomfortable rating me yourself for any reason, you can skip the rating or rate me like you think another of my clients might rate me'. I also remember saying to a person once, 'If you have any qualms about giving me feedback for any reason, that is okay. I don't need feedback for everyone every time. Is there anything you'd like to share with me without writing it down... and, is there a way I can do better in working with you?'"*

> *"Clients are not used to giving feedback to the person they are working with...some are hesitant. I have done some qualitative research into the process with my clients and have specific feedback about how it was particularly difficult to score while I am in the room."*

> *"I pay a lot of attention to non verbals - this is often where people express their discomfort before they are even conscious of it, or even able to put it into words. By stopping the process and focusing on such things, and telling them openly I would rather we addressed every hesitation and respected their pace than have me inadvertently hurt them or proceed with something that isn't right for them, I hope I convey deep respect for the truth of how they are experiencing the process with me and my desire to hear their feedback."*

As is evidenced by these reflections, this portion of respondents viewed flexibility and sensitivity in the feedback intervention as an invaluable way to increase comfort and trust in the process among their clients. Flexibility and sensitivity ranged from not requiring clients to offer feedback using the pencil-and-paper forms, not requiring feedback at every session, leaving the room or averting one's eyes during the scoring part of the intervention, and pausing the intervention to check in with clients to explore any discomfort or hesitation they may be having about the process. Respondents also reflected how such behaviors sent the meta-message to clients that they (respondents) would strive to minimize the extent to which they exercised power in a harmful or painful way in interactions with clients, demonstrating a desire to share with clients the power of deciding how, when, and at what pace they'd prefer to engage in the feedback

process.

Sub-theme 2.2C: Therapist persistence, patience, and encouragement

The question of time played a role in another sub-theme a sixth of respondents (5) touched upon in their responses to Question 2. Namely, participants reported that since many clients are unused to being asked for their feedback in relationships with service providers (and likely other figures, such as parents), and since many clients are also all too familiar with the experience of being silenced because of power differentials in their daily lives, it is often necessary to provide consistent encouragement (over the course of treatment) and reassurance that the therapist continues to want to hear genuine feedback. In a manner of speaking, respondents articulated that it takes patience to develop a new relational paradigm in which clients feel empowered to have their voice heard. Respondent narratives provided a variety of articulations of this sub-theme:

> *"Clients are not used to giving feedback to the person they are working with...some are hesitant."*

> *"The process requires that I take some leadership in the conversation, eg asking questions, shaping the conversation so that it is productive, ending on time as well as seeking feedback for the experience of therapy."*

> *"So, in addition to the SRS, I ask clients approach questions throughout my sessions, often asking them to make a forced choice. For example, I recently said, 'Our official goals are <these>, and recently you've been talking about <this>. I'm happy to focus on either. What do you think would be more useful for you?'"*

> *"We recognize that there will always be the power imbalance, but we must be humbled by the work and recognize that it is our responsibility to acknowledge the differential in power and support the customer to risk communications that may have resulted in negative consequences with previous providers."*

As one participant reflects, being encouraging and persistent takes the form of taking "leadership in the conversation" and playing an active role in "shaping the conversation." Likewise, another

participant finds it necessary to build feedback questions into the body of the session (instead of just instigating the feedback intervention at the end of the session, as FIT protocol suggests); by asking clients to "make a forced choice" and have their voice heard throughout each session, this respondent aims to normalize the process of feedback over time. By recognizing that many clients have experienced disempowering relational paradigms with previous significant life figures, therapists gain a degree of patience and understanding as they attempt to establish a new, more empowering paradigm.

Theme 3: Potential of the feedback intervention to reduce the power differential

A third of respondents (11) touched on this theme in their responses to Question 2. Along similar lines to the previous sub-theme, respondents articulated that overall, the feedback intervention served as a therapeutic and empowering practice in and of itself; by explicitly asking clients to put a hand on the steering wheel of their therapy sessions and by giving them an opportunity to give constructive feedback to their providers, the power differential between therapist and client becomes more balanced. The metamessage of the feedback intervention is that respondents value clients' right to exercise and equalize power in the relationship, with an emphasis on collaboration instead of coercion in the therapeutic endeavor. Participants expressed this in several ways:

> *"Working with feedback in this way tends to assist with reducing the power difference and producing or fostering an awareness around how power is used and respected within the session, by all parties. This in itself can be immensely therapeutic and empowering."*

> *"I think this exchange between the client and me helps to reduce the effect of the power differential by giving them permission to exercise power of their own by commenting on me and the process and having those ideas and feeling respected and acted on. Over time, the power differential is further reduced when the client learns that feedback is actually welcomed and respected and an important part of their therapy."*

"Trust is most important. And communicating a willingness to collaborate with my clients on their goals and how they see our therapeutic relationship helps reduce the power differential between us. So, to me, therapy is mostly about the type of relationship my clients and I have together - one that is making a difference in progressing toward their goals within a context of collaboration and trust. In fact, I believe that what helps people change is not what I tell them, but what I get them to tell me."

From the narrative responses quoted above, one respondent articulated that the feedback intervention assists both therapist and client to gain awareness of "how power is used and respected" in therapy, by implication opening up the possibility for clients to own more of that power by having a voice in its analysis. Another respondent reflects that the act of "commenting on [the respondent] and the process" of therapy, as well as "having those ideas . . . acted on" is itself an empowering process; it is a very concrete way to share authority and influence with clients. Finally, the last quoted respondent expresses the view that the key ingredient for therapeutic change is this very process of a client becoming more empowered to "tell" the therapist things they have not previously felt empowered and comfortable enough to say. Furthermore, this change process is possible primarily because of "a context of collaboration and trust."

Another element expressed within the theme of reducing the power differential is clients' experience of feeling like a partner in the therapeutic work, or offering feedback with the intention of becoming more of a partner. Three respondents reported the different ways that clients had expressed this to them in the context of feedback interventions:

"My objective is always to have the client recognize that he/she has the "power" in our relationship. My approach and language strives to re-enforce that objective. Yesterday, with a second-session client, I asked if we had agreement on the 3 objectives we had outlined in our session .... She said she appreciated being in charge of her own progress."

"Clients are not used to giving feedback to the person they are working with...some

are hesitant ... Many said that that made them more of a partner in the process of therapy."

The most frequent and useful example is when the client says, re: Goals/Topics that "we haven't talked about " such and such. Very often the topic is a very important subject, often it's something that surprises them or just came up in session.

As one respondent reported, when a client was asked if she agreed with the therapy objectives the therapist had outlined in the session, she "appreciated" the expectation and atmosphere of "being in charge of her own progress." Likewise, another respondent reported that many clients say that the feedback intervention makes them "more of a partner in the process of therapy." Finally, a respondent writes that their clients often "surprise" themselves by bringing up a "very important subject" that had not been addressed when given the opportunity to offer feedback about how therapy was going for them. This example reinforces the notion that many clients have the capability and interest in being more of a partner in their therapy work but are often unaware that they have the capability to hold that role until explicitly asked to do so.

Section 3: Race/Ethnicity Dynamics in the Feedback Process

This section explores common themes in respondents' answers to the third open-ended survey question, copied here in full: "*How does the racial dynamic between you and your client affect the process of asking for feedback about the therapeutic alliance? Consider situations in which you are working with clients of your own racial/ethnic group as well as different racial/ethnic groups. Please use at least one concrete example if possible.*"

There were four main themes identified in respondents' answers to this question. Themes included: 1) Race/ethnicity of client and therapist has no impact on feedback process; 2) Clients' racial/ethnic identity hinders client willingness to engage in feedback if client is of a non-dominant group; 3) Racial/ethnic difference between therapist and client prompts greater

sensitivity in feedback intervention; and 4) Heightened potential of feedback intervention to be

therapeutic if client is of a non-dominant racial/ethnic group.

Theme 3.1: Race/ethnicity of client and therapist has no impact on feedback process

A third of respondents (12) reported that in their experience, the racial/ethnic identities of

both therapist and client played no role in the process of feedback. It's important to note that the

sample of 30 respondents who answered all three survey questions were predominantly white;

likewise, of the 12 whose responses fell into this theme, all identified as being members of a

dominant racial/ethnic group (one respondent identified as "White/Arab American," another as

"Greek Australian", and a third as "New Zealander of European Descent," while all others

identified simply as "white"). The implications of the racial/ethnic composition of respondents

on themes reported in this section will be explored in more depth in the Discussion chapter. A

sampling of respondents' narrative responses that fit within the framework of this theme include:

> *"In my own experience, I haven't had the sense that race has been a dynamic in giving or receiving feedback, nor, to my knowledge has it been a concern for a client."*

> *"I have not noticed any difference by race in reaction to or use of the feedback tool."*

> *"Race is not the issue in asking for feed back. "Are we focusing in this session on what is important to you, to your goals?" does not seem to be responded to by those whose ethnic background is different from mine in any significant variance from those who share my background."*

> *"Maybe you don't want to use my responses after all. I don't see any patterns related to ethnic or racial minorities. The patterns may be there, but I don't see them amongst the noise of individual differences. Or I'm seeing them as individual differences instead of ethnic or racial differences."*

> *"I don't think it affects the process much, at least on a conscious level. I ask for explicit feedback, both verbally and via the SRS, in every session. Some clients seem less comfortable giving me low scores than others, and one such client is a black man*

from Jamaica. But I have plenty of white clients who also give me consistently high scores."

In general, respondents whose responses fit into this theme expressed that they did not see a difference in the dynamics of the feedback process with regards to their or their clients' race/ethnicity. A general trend seemed to be that respondents emphasized individual differences in clients' response to the feedback intervention, denying variability in willingness to engage in feedback based on racial or ethnic identity characteristics. Likewise, respondents reported that they felt equally comfortable engaging in the feedback intervention with clients of their own racial/ethnic background as with clients of a different racial/ethnic background; they did not report noticing any significant differences in the way they interacted with clients during the feedback intervention based on awareness of their own racial/ethnic identity. Overall, the tone of respondents whose narrative responses fell into this theme could be articulated as dismissive of the possibility that race/ethnicity play a significant role in feedback process and/or dismissive of the possibility that racial group differences play a larger role than individual differences.

Theme 3.2: Clients' racial/ethnic identity hinders client willingness to engage in feedback if client is of a non-dominant group

In contrast to the twelve respondents who dismissed race/ethnicity as having a significant impact on the feedback process, more than a third of respondents (13) reported the experience that clients of non-dominant racial/ethnic groups felt less comfortable and willing to engage in the feedback intervention. This theme was divided into two sub-themes: A) Clients from non-dominant racial/ethnic group less willing to engage in feedback; and B) Clients' ethnic background may hinder feedback due to ethnicity-related disinclination to criticize authority.

Sub-theme 3.2A: Clients from non-dominant racial/ethnic group

less willing to engage in feedback

Approximately a third of respondents (9) touched on this theme in their response to

Question 3. In general, respondents reported practice-based observations of having clients from

non-dominant racial and ethnic groups be less willing to engage in the feedback process.

Respondents also commented on this dynamic in a variety of ways:

> *"The factors multiply when working with people from different racial backgrounds. There can be histories of institutional systemic discrimination or abuse or gender issues, etc."*

> *"Yes. Hispanic staff report Hispanic clients reluctant to use numerical scales."*

> *"I have had some clients from a migrant or refugee background decline completion or the ORS/SRS on the computer and prefer a paper version, or decline to complete it due to fears and insecurities regarding monitoring and lack of trust in relation to experiences of corruption and lack of safety in their home countries"*

> *"Patient doubts I can understand what it is like to be a Native American in 20s."*

As is evident, respondents addressed this issue from various vantage points. One respondent

made the simple observation that "Hispanic clients" were more "reluctant" to engage in the

feedback intervention, without exploring possible reasons. Another respondent spoke in

generalities, explaining that the feedback process becomes more complicated and sensitive for

both client and therapist ("the factors multiply") due to a client's experience of institutional

discrimination because of their non-dominant racial identity. Along those lines, another

respondent articulates the ways in which "migrant" or "refugee" clients (which the respondent

implies are racial/ethnic minorities) experience more fear of the feedback intervention due to

past "experiences of corruption and lack of safety" due to oppression in home countries. Yet

another element of the sub-theme is expressed by a respondent who reflects that racial/ethnic

minority clients (such as a young Native American client) may be less willing to engage in

feedback out of skepticism that their therapist would understand their life experiences.

Significantly, respondents touching on this theme (who were predominantly white) neglected to

explicitly articulate the way their own dominant racial/ethnic identity affected the feedback

process; many implied that racial/ethnic minority clients felt less willing to offer feedback

because of distrust of past experiences with oppressive systems while leaving unspoken the

reality of their own (respondents') racial/ethnic location of privilege within such systems.

Significantly, one respondent articulated the possibility of client disinterest to engage in

feedback due to client feelings of superiority to the clinician: *"Conversely they may feel that*

ethnically they are superior and there is little you can 'teach' them. Important to have a good

sense of client to place them at ease to provide honest feedback." The respondent who expressed

this point of view was one of the two African-American participants. None of the white

respondents' narrative answers included any mention of clients being less willing to engage in

feedback due to feeling ethnically superior.

Theme 3.2B: Client's ethnic background may hinder feedback due to ethnicity related disinclination to criticize authority

A fifth of respondents (6) touched on this theme in their response to Question 3.

Respondents generally referred to clients from "Asian" ethnic backgrounds when discussing the

dynamic of a client hesitating to give feedback out of a desire not to criticize an authority figure:

> *"As a sweeping generalisation, some of my Asian (Chinese) clients … find it very difficult to "criticise" authority because it is considered disrespectful in their culture. The SRS challenges them in this area."*

> *"Conveying the impression that soliciting feedback is a cultural norm of therapy is generally accepted. With some Asians this requires more sensitivity as some are strongly attracted to not giving any personal offense … But this goes on with non-Asian folk too, just need to be more clear about that with some Asian people."*

"...Other individuals I see are from non-English speaking and refugee backgrounds and they don't always have good experiences with authority figures or have backgrounds that emphasise politeness e.g., some of my Afghani clients or indirectness e.g., Indigenous clients. I have to work very hard to elicit their feedback."

"I have more clients of Asian background or international students from China than when I first started working. I try to … explain how helpful it is to me and that it is only for our use and that I am not going to get into trouble if they rate me lower."

"With certain Asian people from cultures heavily influenced by Confucianism where they must not disagree and must show respect for an older person, I tell [them] *'I know in your culture of origin, it is often seen as very rude and disrespectful to tell a person of my age that you don't like something they are doing or that they said, or to disagree with them. I would really like you to see if you would consider setting aside your culture's training for the sake of our working relationship.'"*

Respondents acknowledged that making generalizations about an entire group of clients based on their ethnic background was slightly problematic while also focusing on many clients' hesitancy to "criticize authority" out of cultural prescriptions to "show respect" or be polite to figures such as their therapist. One respondent articulates that clients of "Asian background," such as international students from China, may be hesitant to offer feedback out of a worry that critical feedback would get the respondent "into trouble." The predominant trend in this sub-theme was a focus on "Asian" clients, though respondents did not tend to distinguish between clients who grew up in an Asian country and later immigrated to the respondent's country of clinical practice versus clients of Asian ancestry and/or ethnic upbringing who were residents of the respondent's home country from birth. Furthermore, as evidenced by the narrative responses quoted, another element of this sub-theme was respondents' typical relational stance with regard to client hesitancy to offer feedback: respondents attempted to "challenge" such clients to go against their ethno-cultural socialization and offer critical feedback, as one respondent put it, "for the sake of our working relationship." This respondent behavior is significant, as it reveals an underlying respondent assumption that clients should adopt feedback as a normative and necessary aspect of

their therapy service to the extent that it is comfortable for them.

Theme 3.3: Racial/ethnic difference between therapist and client prompts greater sensitivity in feedback intervention

Slightly over a third of respondents (12) touched on this theme in their response to Question 3. In general, respondents expressed that they strived to be aware of ways in which racial/ethnic differences between themselves and clients might negatively impact the feedback process and tailor their communication about the intervention accordingly.

> *"I say there are different ways to let me know if what I am saying or doing is making sense to you. I say they can use words, pictures, symbols or gestures."*

> *"I am not Mexican, but my wife is. We speak Spanish in our home. I self disclose about this to Spanish-Speaking clients. ... I find that it is an instant "in". Without a little knowledge of my home-life and racial views, I don't believe I will be receive accurate feedback. I have not found a way to do this with African American clients."*

> *"If there is a difference it is best to acknowledge the difference. Example one client wrote on his paper he is a racist. I immediately noted that fact and stated "This is very uncomfortable for you? Would you like to stop now and reschedule with someone else or should we continue?" The client felt because I understood his answers would be accepted at face value with no judgment. Non judgment is the issue whether of same race or different."*

In these examples, respondents illustrate the ways in which their sensitivity to potential mistrust and/or misunderstanding inherent in the experience of a racial/ethnic division between themselves and their clients prompts them to make an extra effort in soliciting feedback. For example, one respondent makes it clear that feedback need not be circumscribed to the filling out of the paper-and-pencil SRS scale but can also be given in "words, pictures, symbols, or gestures" given the client's preference. Likewise, another respondent indicates that when working with "Spanish-speaking" clients from Mexico (who are implied to be a different race/ethnicity than the respondent), it is useful to disclose that he speaks Spanish at home

because it creates more trust and a greater chance of them offering genuine feedback. Significantly, the respondent notes less success tailoring his approach (through disclosure) with African American clients, with the implication being that he receives less accurate feedback as a result. The third quoted respondent (who identified as African American) discusses being flexible in her feedback intervention when a client used the paper feedback form to indicate that he was "a racist"—with the implication being that he held prejudice towards her due to her racial identity. The respondent checked in with the client and asked if he'd prefer to work with another clinician due to discomfort brought on by the presence of his own racism. She reports that due to her sensitivity and willingness to listen to the client's voiced racial experience, he decided to continue to work with her.

Another common element in this theme was respondents' reflecting the way the feedback intervention reinforced their effort to explore with clients how racial/ethnic difference (or similarity) might result in clients' not feeling fully seen or understood. Respondents articulated this in various ways:

> [Respondent says to client]*"So, I notice that you are African American and I am an old white guy. Will you please point out to me when you think I might not be getting you, or if you feel I am way off base about something?"   My initial broaching of diversity depends upon my initial perceptions of any incongruence I sense.*
>
> *While I am more likely to be on the lookout for problems in the alliance with clients with whom I differ in race, gender, class, sexuality, the SRS is also helpful when I make assumptions about clients who may look like me and share my background but who may have very different ideas about the world than I do. The SRS is such a great way to start a conversation about the potential barriers to an effective alliance and to acknowledge differences up front that could lead to miscommunication.*
>
> *With people of non-white descent and Aboriginal people, I will name that I am white and that this may get in my way when we work together. It may mean I stereotype them and leave them feeling disrespected and unseen, it may mean my white privilege might mean I don't 'get' what their experience is like because of that blind spot, it may mean my white/French directness might feel offensive and intrusive to them. I also name that I am aware that in some of these cultures, it is disrespectful to name*

directly what isn't working for people as conflict is seen as offensive. I say to them, "I have tried to learn some things about your culture in order to be more respectful and aware, but I am also aware that I am terribly ignorant as well. If I at any stage end up making you feel like I am stereotyping you and you don't feel seen by me, or you feel I am being insensitive to how you prefer to relate, I would really like you to tell me. It is more important for me that I show you respect and that I approach things in a way that will work for you than to impose my way onto you."

As articulated in the first narrative quote, some respondents used the feedback intervention as an opportunity to ask clients to tell them if they are "off base" or not "getting" them because of race or ethnicity. Likewise, as illustrated in the third quotation, some respondents reinforce their desire to know about times they may make missteps with clients because of their own racial/ethnic privilege, voicing the fact that despite making efforts to be culturally competent they are still likely to exhibit ignorance, be "offensive and intrusive," or insensitivity. Some respondents also reflected their awareness that such missteps are possible even when they share a racial and/or ethnic group with their clients, as illustrated in the second narrative quotation above. Overall, the common thread within respondents' answers that fit within this sub-theme was a sensitivity to the ways in which racial and ethnic dynamics may negatively affect the feedback process and working relationship, *whether or not* the respondent is aware of such dynamics as they play out in session. Furthermore, such respondents tended to discuss ways in which they attempt to explore and deal with such dynamics in such a way as to limit their negative impact on soliciting genuine feedback. Significantly, this finding contrasts with the sub-theme (expressed by a similarly prevalent subset of respondents) that racial/ethnic dynamics *do not* play a role in the feedback process, going hand in hand with respondents' non-effort to explore or negotiate the potentially limiting effects of such dynamics.

Theme 3.4: Heightened potential of feedback intervention to be therapeutic

if client is of non-dominant racial/ethnic group.

Approximately a fifth of respondents (7) touched on this theme in their responses to

Question 3. Overall, similar to the third main theme of Question 2, the common element of this

theme revolved around the potentially therapeutic nature of the feedback intervention itself,

especially in the context of its use with clients from non-dominant racial/ethnic groups.

Respondents reflected on the notion that the empowering nature of the feedback process was in

itself beneficial for clients, in some cases reducing their experience and/or expectation of

experiencing racism in the context of their therapeutic working alliance:

> *"I have recently had the experience of working with clients from a very different culture. They very much appreciated the feedback process. Looking back the request for feedback showed equal respect for male and female input and experience of the session, and cultural respect. I think it gave them a clear message that this was a space free of racism or bigotry with a clear and genuine desire to understand their individual and cultural perspectives."*

> *"I have used this with African American and Latino clients routinely, as well as with other ethnicities. The SRS surprises them since they are used to the kind of systemic oppression (referred from child welfare, juvenile justice, mental health systems, etc.) that they have typically experienced their whole lives and most definitely in their experiences with our "helping" systems. Thus, when I ask for their opinion on things, this throws them off ... The SRS is inconsistent with what they expect and is wonderful in building trust and helping them see that all of us that represent the system do not come from a blaming, one-down, perspective."*

> *"As you are probably aware the ORS/SRS suite have been translated into other languages - so we can (and sometimes do) offer the forms in another language. I think doing that can in itself be therapeutic as it suggests an attempt to meet the client - even though, say, I don't speak Chinese, say, past a level of greeting."*

> *"I would say in general clients from a different race (and different cultures and from different socio economic classes) are even more surprised that I am asking and perhaps even more appreciative."*

As exemplified by narrative quotations such as these, respondents reported that clients

"appreciated" the feedback intervention with respect to its emphasis on elevating and

empowering the client's voice. As one respondent wrote, clients from oppressed racial/ethnic backgrounds (e.g. "African American and Latino clients") who have experienced silencing "helping systems" throughout their lives are surprised and encouraged by a provider using feedback processes to dismantle the "blaming, one-down perspective" in therapy. Another participants cites using non-English language SRS forms as a way to "meet the client," a therapeutic gesture that communicates respect for client comfort and a desire to hear the client's voice. Similar to respondents' sentiments in response to the survey question about power dynamics, the primary element of this theme is based on the reality that clients' race/ethnicity plays a major role in the kinds of systemic power they have access to; thus, by privileging clients' voices through interventions such as the SRS feedback tool, clients symbolically and literally gain more power in the therapy room. Again, in line with other sub-themes in this section, respondents tended not to focus on the experience of clients from the dominant racial/ethnic group in their country of practice, and likewise neglected to mention their own racial/ethnic identity (which for the vast majority of respondents was 'white').

Section 4: Summary of Chapter

In summary, the predominant findings of this survey related to the ways in which respondents consciously strive to create a "culture of feedback" with their clients; furthermore, the findings related to respondents' understanding of how power dynamics in the therapeutic dyad (including race/ethnicity dynamics) affect and are affected by the feedback process.

With regards to creating a "culture of feedback," respondents reported that they strive to increase client trust, comfort, and confidence in the feedback process by framing feedback as a way to increase the value of therapy for clients, particularly by emphasizing the ways in which feedback promotes a more collaborative dynamic between therapist and client and explaining

why feedback increases the chances for a better therapy outcome. Participants reported they address the difficulty of giving direct feedback by attempting to de-escalate the stakes of feedback by reassuring clients that negative feedback will not be taken personally, by keeping a casual tone, and by acknowledging social inhibitions around offering genuine feedback. Respondents emphasized the importance of treating therapy as a collaborative process by honoring the feedback clients offer them, emphasizing the primacy of the client's therapy goals, and framing the client as a "helper to the helper." Finally, participants communicated a sincere desire to hear their clients' voices, attempting to instill in clients a felt sense that their voiced experience of the therapeutic encounter is highly valued by the therapist.

In terms of predominant findings about the ways in which power and race/ethnicity play into the feedback process, respondents reported awareness of the extent to which the power differential between client and therapist hinders client willingness to engage in feedback. Participants discussed clients' fear that offering genuine feedback may result in negative consequences, especially given many clients' backgrounds of multiple oppressions and abuse/punishment by past authority figures, including past service providers. A large contingent of respondents (predominantly white) focused on the way in which they experience clients from minority racial and ethnic groups to be less willing to engage in feedback, in part due to the experience of oppression by authority figures and in part due to ethnic backgrounds that emphasize respect for authority figures. Likewise, when focusing on the effects of the power differential between themselves and clients irrespective of racial/ethnic identity, respondents articulated that clients who view therapists as "experts" not to be questioned are less likely to engage in genuine feedback. Power and race/ethnicity dynamics was also found to affect the feedback process in the way that respondents reported addressing the power differential by

acknowledging it and being sensitive to it in feedback interventions. Participants named how the power differential might silence their clients in various ways and encouraged them with patience and persistence to voice their experience of therapy during feedback interventions, attempting to create new power paradigms within the therapeutic relationship. Respondents reported acknowledging difference between themselves and clients, particularly when there was a difference in racial/ethnic identity, and sought to be flexible and sensitive in their implementation of the feedback intervention by altering it in various ways from the original protocol so as to make clients more comfortable with it. Respondents also discussed the potential of the feedback intervention to reduce the power differential between client and therapist by explicitly valuing collaboration and the client's voice in the working relationship. Respondents reported clients' having therapeutic experiences in the feedback interaction by virtue of the fact of being able to risk communications (such as critical feedback) that may have resulted in negative consequences with past powerful figures. Many participants (predominantly white) articulated their experience of the heightened potential for this type of therapeutic dynamic to occur when their client is of a non-dominant racial/ethnic group. Finally, a large proportion of respondents (all white) reported their experience that the race/ethnicity of therapist or client has no impact on the feedback process. This finding was significant not only for its predominance among respondents but also for the reason that it seemingly contradicted other major findings. For example, there were no participants who articulated that the power differential has no impact on the feedback process. In general, the major themes in respondents' answers to Questions 2 and 3 paralleled each other except for this last finding.

As will be explored in depth in the Discussion Chapter to follow, in general, these findings reinforce the perspective that feedback interventions are most effective when they draw upon and

honor the empowered collaborative efforts of clients. Likewise, the findings are largely

consistent with the core tenets of the common factors, the theoretical construct underlying the

development of FIT methodology. Significantly, respondents' perspectives on power and

race/ethnicity dynamics are both consistent and divergent from previous research; indeed, one of

the most notable findings was the *omission* of respondent reflection on the impact of their own

race/ethnicity on the feedback process. While these findings remain merely exploratory, they

suggest a host of questions about the ways in which clinicians and clients can best work together

using feedback informed treatment practices.

CHAPTER V

DISCUSSION

Introduction

Overall, the current study's findings shed light on clinicians' experience of the

interpersonal process of feedback interventions. The study explores how clinicians aim to create

a "culture of feedback" with clients and investigates how clinicians understand power and

race/ethnicity dynamics within the context of the feedback process. Since this study covers areas

not previously explored in quantitative or qualitative research on FIT interventions, the findings

serve as a tentative first look into one aspect of a complex interpersonal process.

The findings reveal several major themes that confirm and expand upon previous FIT

research. For example, the findings reinforce the perspective that feedback interventions are most

effective when they draw upon and honor the empowered collaborative efforts of clients.

Likewise, the findings are largely consistent with the core tenets of the common factors, the

theoretical construct underlying the development of FIT methodology. Significantly,

respondents' perspectives on power and race/ethnicity dynamics are both consistent and

divergent from previous research; indeed, one of the most notable findings was the *omission* of

respondent reflection on the impact of their own race/ethnicity on the feedback process,

generating a host of implications which might be further explored in future research. While the

findings remain merely exploratory, the current study aims to raise new questions about how

clinicians and clients can best work together using feedback informed treatment practices to

improve therapy outcomes.

Organization of Discussion Sections

This chapter addresses how this study's findings relate to findings from other research

and theory. Additionally, it explores how clinicians might enhance their work with clients based on the findings. Finally, it suggests ripe avenues for future qualitative research in the area of FIT.

The first major section discusses the demographic make-up of the study sample, including consideration of self-selection bias, racial homogeneity in the sample, and potential reasons for the large number of dropout participants. Section two explores the relationship between this study's findings on "culture of feedback" practices and other research findings. Section three explores the relationship between this study's findings on power and race/ethnicity dynamics and other research findings. Section four discusses the implications the current study raises for social work practices, including how clinicians using FIT interventions might improve their work with clients. Section five investigates theoretical implications of this study's findings, including how the findings relate to the Common Factors framework. Section six discusses the limitations of this study, including limitations in recruitment, survey design, participation, and scope, among other factors. Section seven, the final section, recommends areas for future research, including ways future research might improve upon the current study and other fruitful directions research might take given the questions raised by this study.

Section 1: Demographics of the sample

Before delving into the qualitative findings, it is important to explore the implications of the demographic characteristics of the sample. This is partly done with the purpose of tempering any generalizations that may be read into this study's findings and partly to help locate this study in relationship to the demographic characteristics of other FIT research. As reported in the Findings Chapter, 74 participants clicked the link to the study but only 30 completed the full survey, including demographics and open-ended survey questions. The implications of this are several: first, it seems a truism that using an online survey instrument increases the likelihood of

retention issues in participation, especially since there are few obstacles or social pressures present to disinhibit participants from dropping out as soon as they lose interest; second, it's possible that many participants clicked the link without realizing the 15-20 minutes necessary to fully participate in the study, despite advance warning of this in solicitation materials; and third, of the 10 participants who filled in demographic information but exited the survey before finishing the open-ended survey questions, six were international clinicians (hailing from Ireland, Denmark, Romania, Zimbabwe, and Norway). This suggests that the survey questions may have been confusing for a subset of international participants (no Canadian or Australian participant dropped out of the study, by contrast). Aside from international status, there were no major differences in demographic characteristics between participants who completed the survey and those who entered demographic information but exited before answering the survey questions.

There are undoubtedly a variety of reasons participants prematurely exited the study and it would be foolhardy to attempt to explicate every possibility. However, some common reasons may have played an important role in mediating the findings, providing ample reason to explore them in depth. For example, it's likely that self-selection bias was at play, limiting the final sample to a subset of respondents who were both persistent and enthusiastic enough about the research topic to motivate them not to drop out. This possibility is heightened by the fact that participants were recruited by postings on two online communities of therapists who use FIT methods. It seems plausible that the final set of sample respondents do not represent an average group of clinicians using FIT, given their involvement in online FIT communities (reflecting commitment and engagement in the model) as well as their willingness to participate in a somewhat time-consuming online survey. With this in mind, the reader should only generalize

this study's findings to a larger population of clinicians "with a grain of salt," so to speak.

Additionally, it's possible that the sample was self-selected as a result of the negative associations respondents may have had with the task of exploring the dynamics of power and/or race. Given the predominance of white respondents in the final sample, it may have been the case that more clinicians of color started the study than finished it, not wishing to experience potential racial microaggression triggers in the content of the survey questions. Alternately, perhaps many white clinicians dropped out of the study due to discomfort with talking about race/ethnicity, resulting in a sample of predominantly white respondents who are more comfortable talking about race/ethnicity than the average white clinician. Finally, it's also possible that there are few clinicians of color using FIT practices and fewer still who engage in the online forums solicited for participants. While the racial homogeneity of the sample will be addressed in more depth in the limitations section of this chapter, it bears mentioning that this study failed to improve upon the racial/ethnic diversity found lacking in past FIT research, as discussed in the Literature Review chapter. Again, this demographic aspect of the sample necessitates caution in generalizing results. Furthermore, inasmuch as the racial/ethnic identities of the participants themselves may have influenced their responses to the survey questions (including questions about their understanding of racial dynamics between themselves and clients), it behooves the researcher to take such demographic realities into consideration in interpreting the findings and comparing with other pertinent research.

Section 2: Interpreting and Comparing "Culture of Feedback" Findings

The aims of the present qualitative study diverge somewhat from the two other qualitative studies on FIT in the literature. While Bowens and Cooper (2012) sought to explore therapists' view of the positive and negative therapeutic effects of using FIT and Sundet (2010)

aimed to investigate both clients' and therapists' general experiences of using FIT tools, this study seeks to explore the way therapists' attempted to enhance the effectiveness of the FIT intervention (by creating a more comfortable "culture of feedback"). It also explores clinicians' understanding of how power and racial/ethnic dynamics affect the feedback process. As such, some findings from this study are comparable to findings in the previous qualitative studies while some findings are not comparable, given the divergence in research aims.

For example, one major finding in this study is that respondents strived to increase client trust, comfort, and confidence in the feedback process by framing feedback as a way to increase the value of therapy. This finding is consistent with Bowens and Cooper's (2012) and Sundet's (2010) findings that therapists and clients alike tend to experience FIT as a valuable way to enhance therapy services. In the former study, an overarching theme was that therapists felt that FIT helped move therapy forward and deepen the therapeutic relationship. In the latter study, a summary finding was that FIT was helpful in keeping therapy flexible while upholding positive structure in the work while deepening the exploration of all participants' experiences. On the other hand, the finding in the current study is not merely expressing the observation that therapists' believe FIT to be a valuable tool; it also illustrates that therapists communicate their belief in the value of FIT (often using anecdotes, examples, and occasionally explanations of research) to their clients in hope that it may engender positive hope and expectancy effects, enhancing the value of the tool by increasing clients' willingness to engage in the intervention in a genuine way. Likewise, the finding that respondents framed therapy as a financial and emotional "investment" for which clients could maximize their "return" was not comparable to findings in either of the prior qualitative research. Again, the focus of the finding is on a behavioral strategy or type of communication respondents' used to enhance the effectiveness of

the FIT intervention rather than on their experience of the outcome of the intervention.

Another finding was that respondents aimed to elicit genuine feedback by addressing the difficulty of offering direct feedback, doing this by explicitly reassuring clients that there would not be negative consequences and by de-escalating the stakes with a casual and relaxed approach to the FIT intervention. This finding is consistent with Sundet's (2012) finding that FIT initiated a variety of processes of communicating — that it engendered flexibility in the conversation — as well as Sundet's findings on how FIT enhances processes of exploration, including new discoveries in clients' and therapists' knowledge about their perceptions of reality. Respondents in this study spoke of regularly engaging with their clients about how they would feel most comfortable offering feedback and what unspoken assumptions might hinder feedback, both of which involve opening up a discussion of the process of the therapeutic working relationship. As with the previous finding, aspects of this finding are not comparable to other qualitative research. For example, neither of the other studies explored therapists' technique of using self-deprecation to lower the stakes of the feedback interaction or their appreciation and sensitive response to nonverbal cues of discomfort by clients. These elements reveal the extent to which respondents aimed to stay attuned to the moment-to-moment comfort level of their clients during feedback interventions, echoing Rogers' (1957) emphasis on accurate empathy and being genuine about their intentions.

Another major finding in the current study is that respondents emphasized the importance of treating therapy as a collaborative process with their clients, communicating the primacy of the client's therapy goals and honoring client feedback. This finding parallels Sundet's (2010) description of the ways in which FIT helps create "processes of structuring," particularly in the organic co-creation of treatment plans that places emphasis on the client's therapy goals.

Likewise, this finding is consistent with Bowens and Cooper's (2012) finding that therapists using FIT experienced a better sense of what their clients wanted from therapy and felt greater permission and freedom to alter their practice based on client feedback. All three findings make it apparent that the FIT intervention serves to privilege clients' goals for therapy by eliciting them in the feedback conversation on a regular basis. There is also an interesting divergence in the ways that therapists described the changes they made based on client feedback: in Bowens and Cooper's research, participants spoke of the "freedom" to alter their practice, evoking a sense of increased flexibility. In the present study, therapists focused more on the importance of following through with client feedback (especially concrete feedback that could be monitored easily) for the purpose of helping the client feel more empowered and heard. Of course, it's possible that respondents in the present study also felt increased "freedom" in their practice when responding to client feedback but that the framing of the research question directed them to focus more on how they hoped to improve the relationship with the client by honoring their feedback.

The finding of treating therapy as a collaborative, mutual effort is certainly consistent with Bowens and Coopers' (2012) finding that therapists experienced FIT as a way to increase client autonomy and responsibility in the therapy relationship. However, there were no comparable correlates to the current study's finding of respondents' use of the "helper to the helper" conversation with clients. Again, while some participants in Bowens and Cooper's research reported that using FIT helped them be better clinicians with all their clients (not just clients with whom they sought feedback), it was not reported that they discussed this with clients or, as in the current study, used it as a strategy to empower clients and perhaps convince them to be more genuine in their feedback.

The last major finding relating to creating a "culture of feedback" in the present study is

that respondents communicated a sincere desire to hear their clients' voices, attempting to instill

in clients a felt sense that their voiced experience of the therapeutic encounter was highly valued

by the respondent. While it does not directly correlate to findings in the other qualitative

research, focused as it is on a behavioral and relational approach designed to elicit genuine

feedback rather than an experience of the process or outcome of feedback, this finding does

invoke elements of Sundet's (2010) explication of the various "processes of communicating" and

"processes of exploration" engendered in the context of FIT interactions. Inherent in Sundet's

description of the theme of "processes of communicating" ("an invitation to express anything

that came to mind") is the implication of participants sincerely inviting clients to express

themselves. Indeed, this implied invitation is the entire thrust of the FIT intervention. The

difference between the current finding and similar ideas in Sundet's research is primarily that of

intensity: respondents expressed that part of their effort to draw out client feedback was rooted in

the heightened and highly emphasized nature of their plea, so to speak. Respondents appreciated

how important it could be for a client to hear, repeatedly, that the respondent *did* want to hear

their voice and that their voice *was* important. In a sense, the finding reflects a way respondents

attempted to communicate how they prized their clients in hopes that this would help clients feel

comfortable enough to risk genuine feedback. This "implied prizing," reminiscent as it is of

Roger's (1957) notion of unconditional positive regard, becomes all the more important given

therapists' understanding of the power dynamics that have shaped the client's past life as well as

the current relational matrix with the therapist.

Section 3: Interpreting and Comparing Power and Race/Ethnicity Findings

The present study's findings about power dynamics (including racial/ethnic dynamics) in

the feedback intervention share fewer connections with the other two qualitative FIT studies than

the findings about creating a "culture of feedback," primarily because this study is the first to explicitly investigate how such social and interpersonal dynamics affect the process of feedback. Some consistency can be found, however, in certain constructs within the findings of previous qualitative research. For example, this study finds that respondents were aware of the extent to which the unequal power differential between themselves and their client hindered the client's willingness to engage in feedback. Bowens and Cooper (2012) found that therapists believed one of the more negative aspects of the FIT intervention was that it may feel too "bureaucratic," creating uncomfortable distance between clinicians and clients. This finding echoes the view of many respondents in the current study that the therapist's role as service provider and the client's role as service consumer is often experienced as disempowering by the client, especially given many clients' backgrounds of multiple oppressions and abuse, punishment, or disservice by past authority figures. Indeed, respondents in the current study spoke about attempting to reduce the power differential, given its tendency to silence clients. In both Bowens and Cooper's (2012) and Sundet's (2010) findings it is apparent that therapists experienced the FIT intervention as a way to empower clients to express themselves more fully, claim more agency in the therapeutic holding space, and explode the "expert" and "non-expert" dichotomy which characterizes many clients' assumptions about their working relationship with their therapist. These findings paralleled findings in the current study reflecting respondents' experiences of clients feeling like more of a "partner" in therapy, feeling more empowered, and experiencing the FIT intervention as a therapeutic end in itself given the corrective relational experience with an authority figure it has the potential to generate.

The similarities between findings in the current study and past research are limited, however. Neither of the other qualitative studies reported findings addressing how clients'

identities and their relationship to power *negatively* influenced their engagement in feedback interventions. Likewise, neither of the other studies attended to the way therapists' identities and relationship to power affected their role in the feedback dynamic, including their understanding and co-construction of clients' experiences. In this respect, this study's findings articulate a variety of clinician positions regarding power, race, and ethnicity in the therapeutic working relationship that are worth interpreting in depth.

Respondents largely understood how clients from different backgrounds (including international backgrounds, different ethnic upbringings, or clients from older generations) may hold different assumptions about how to interact with authority figures than the therapist, or may assume that the therapist has more authority than s/he actually has. This often resulted, by respondents' report, in the respondent pushing gently against these assumptions; clinicians aimed to remain sensitive to clients' preferences around feedback while challenging them to shift into new relational and power paradigms in which offering direct and sometimes critical feedback to an authority figure was acceptable. Unremarked on by most respondents, however, were the competing interests that emerged in such situations: to what extent should a therapist attempt to "change" a client's desire to interact with therapist as a certain kind of authority figure? Is not the effort to make the therapeutic working alliance more collaborative itself an assertion of a particular cultural power model that may not fit with clients' preferences?

In the current study, one respondent addressed this conundrum explicitly. Referring to a cohort of his clients born in Asian countries, he reported the experience of clients offering him the feedback during the FIT intervention that they prefer a more "directive" approach —an approach in which he asks them for *less* feedback. He quipped, "Is that irony?" Another clinician told a story of "young Korean/Chinese woman" she worked with who expressed her hesitance to

offer feedback based on cultural prescriptions against showing disrespect to elders. The respondent reported that she told her client: "I would really like you to see if you would consider setting aside your culture's training for the sake of our working relationship." While it's easy to read many things into this interaction, it does raise a thorny issue for those practicing feedback interventions with clients who may prefer not to engage in them. How to determine how hard to push for feedback? When does gentle challenging become unspoken pressure? This is especially salient given the fact that clinicians so often articulated their belief that FIT offers a chance to empower their clients. In what ways may therapists be unwittingly applying coercive power with their clients in an attempt to reduce the power differential?

Another finding worth interpreting in the present study is the fact that respondents, to a large extent, focused on the *client's* identity when exploring how the power differential and racial/ethnic dynamics affected the feedback process. For example, in discussing ways that race/ethnicity dynamics may hinder clients' genuine feedback, respondents focused largely on clients' non-dominant identities (or non-Western ethnic upbringing) as a way to understand them, while neglecting to explore or even mention their *own* racial/ethnic identity – including how their negotiation, understanding, and unconscious enactment of their own identity may negatively impact clients' willingness to offer genuine feedback. This seems likely related to the fact that respondents in this study predominantly identified as being from dominant racial/ethnic groups. Significantly, of the large proportion of respondents (almost half) who did not view the race/ethnicity of themselves or their clients as an important factor in the feedback process, all identified as part of a racially dominant group (e.g. white) in their country of practice. While it's possible that respondents' experiences were accurate — that is to say, that race/ethnicity dynamics play a negligible role in feedback interactions — it seems far more likely that

respondents are simply not aware of the ways in which race/ethnicity dynamics are operating in the relational matrix of the working alliance. As Hays articulates (2008), one characteristic of colorblind racism is the tendency for those in dominant racial groups to selectively ignore the effects of their own social location and in many instances not see themselves as "raced" in the same way that those of oppressed racial groups have a "race"; furthermore, those in privileged groups are less likely to understand the experience of those in oppressed groups, given the "blocked" nature of their perspective.

Furthermore, even white respondents who reflected the view that clients can feel disempowered when working with them because of race/ethnicity dynamics largely neglected to explore their own contribution to this racial/ethnic disempowerment. This effect was also prominent in white respondents' answers in the way that they selectively responded to the question about race/ethnicity by focusing on interactions with clients who were "different" than them. For example, they largely ignored how race/ethnicity may have an impact between clients and therapists of the *same* racial/ethnic background. It's also worth noting that one of the only times a respondent mentioned their own race was an African American clinician discussing a time an (implied white) client expressed the view, during the feedback intervention, that he held racist attitudes and felt doubtful that he would benefit from therapy with her.

While a main finding of this study was that respondents were generally sensitive to the reality that power differences (including racial/ethnic power differences) have a substantial effect on whether clients feel comfortable giving genuine feedback, the relative lack of respondent reflection on their own racial/ethnic power indicates that this is an area in which respondents can and should increase their understanding. By increasing their understanding of these realities, clinicians can in turn enhance the sensitivity, flexibility and effectiveness, of their feedback

interventions.

Section 4: Implications for Social Work Practice

Given this study's findings and the various interpretations this researcher has derived from them, several implications for the field of social work practice (and the field of feedback informed clinical treatment) are apparent.

First, creating a culture of feedback can empower clients and serve as a means towards therapeutic ends. Clinicians are encouraged to use a variety of tools to bring such an atmosphere of trust about, including talking in a genuine way with clients about the benefits of feedback, communicating a sincere desire to know how the client is experiencing their service provider, and honoring clients' feedback by thanking them for the risk they take by offering it as well as making concrete changes based on the feedback, then checking back in to see whether the changes addressed what the client had hoped to address.

Naturally, clients (like the rest of us) face multiple barriers when asked to provide direct and genuine feedback to another person: they may fear that feedback will generate negative consequences in the relationship or even the termination of the relationship, they may fear negative consequences in the provision of other desperately needed services, they may experience cognitive dissonance because of cultural prescriptions against criticizing authority figures or raising an issue that may result in conflict, and/or they may experience frustration and/or an inability to communicate directly through feedback because of their service providers' ignorance about the complex power dynamics at play in the relational matrix and in society at large. Clinical social workers may feel confusion about how much emphasis to place on soliciting genuine feedback if their client seems uncomfortable with the process: on one hand, feedback has the potential to dramatically improve the service provided and is worth seeking out

despite the subjective discomfort it may trigger in clients. In a manner of speaking, "you've got to break some eggs to make an omelette." On the other hand, it's possible that for many clients the risk of offering genuine feedback is too high a price to pay for the treatment gains their service providers believe would accrue as a result. In this sense, the best wisdom seems to be to trust the client to know for themselves what amount of exposure feels appropriate given the level of trust and comfort established in the therapeutic relationship.

Furthermore, challenging clients to push themselves to take risks can only be successful if the service provider is prepared to meet clients in the field of vulnerability. In the current study's findings, it is apparent that many white respondents feel confident that race/ethnicity play a negligible role in the dynamics of feedback. Given the extent to which respondents universally expressed an understanding of how differential power dynamics (in a general sense) hinder the expression of feedback, and given the inextricable relationship between race/ethnicity and interpersonal and societal power/privilege, it would behoove service providers in dominant racial and ethnic groups to reflect more deeply and educate themselves further about ways in which the effects of their skin privilege may operate to silence and/or hinder their clients in feedback interactions. By becoming vulnerable enough to admit the possibility of their own racial not-knowing, white clinicians will be more likely to create an atmosphere of openness and fallibility that engenders client trust.

Section 5: Implications for Theory

This study's findings both confirm and expand the tenets of the common factors, the theory underlying the development and research of FIT methods in therapy.

Clinicians confirmed that in their experience, genuine feedback from clients strengthened the working alliance and resulted in better outcomes. A main point they made was that for

clients, the process of offering feedback to a service provider who wanted to hear and honor it was in and of itself an empowering and therapeutic enactment. Furthermore, the quality of the alliance improved because the clinician was able to tailor their style of work better to client. Many respondents reported the belief that their clients underwent a corrective experience by working with a caring, responsive authority figure who was open, curious, and empathic in relationship to the client's voice. This finding is consistent with meta-analyses of common factors research showing that value of a strong therapeutic alliance is the most robust predictor of positive therapy outcome (Horvath & Symonds, 1991; Baldwin, Wampold, & Imel, 2007). It also coheres with Rogers' (1957) construct of the core conditions of change, which emphasize acceptance, accurate empathy (knowing exactly how and what client is thinking/feeling), and genuineness on the part of the therapist. While Rogers was not classified as a common factors theorist, his core conditions certainly represented a pantheoretical approach towards the process of psychotherapy. In this respect, this study's findings bolster the theoretical position that improving the strength and quality of the working relationship regardless of the clinician's preferred therapy model/technique has a global positive effect on the outcome of therapy, at least in the perspective of respondents who participated in this survey.

This study's findings are also consistent with the role of expectancy factors (Lambert, 1992) within the larger common factors paradigm. One of the major findings was that respondents attempted to instill confidence and hope in the feedback intervention in their clients by describing its purpose, giving examples of past times it worked with other clients, making analogies about its benefits, etc. And from respondents' reports, such efforts were not in vain. They experienced clients as more willing to engage in genuine feedback given such reassurance and explanation, reporting that while many clients are at first doubtful about the purpose and

efficacy of the FIT intervention, they gain trust and confidence in it over time, acquiring an expectation that it might help to improve the quality and investment of their therapy efforts. Many respondents articulated that the more their clients were "on board" with the FIT intervention, the more likely they were to offer genuine feedback, and the more effective the working alliance would become.

Another aspect of the findings consistent with common factors theory is the emphasis respondents placed on communicating the collaborative nature of therapy through feedback interventions, particularly focusing on the primacy of clients' therapy goals and drawing out clients' therapy goals through feedback. As common factors research shows (Horvath & Symonds, 1991), the client's rating of the working alliance (which includes agreement between client and therapist about the goals of therapy) is the most significant predictor of therapy outcome. Thus, it's perhaps no surprise that respondents repeatedly came back to this idea as a major aspect of their FIT interventions. By seeking out clients' hopes and goals for therapy on a session-by-session basis, respondents acted with an understanding of the importance of clients playing an active role in the working alliance.

One aspect of this study that expands the theoretical construct of the common factors is its focus on how clinicians' understanding of power dynamics – including race/ethnicity dynamics — can augment or hinder the likelihood of clients offering genuine feedback. While common factors research has demonstrated that therapists are relatively poor at gauging their client's experience of the alliance (Hannan et al., 2005), it has not investigated this effect in the context of power dynamics between client and therapist. As this study demonstrated, respondents reflected a wide range of perspectives about how their clients' experience of power in the working relationship (and society at large) affected their willingness to engage in genuine

feedback. And, as this researcher suggests, it seems likely that therapists in positions of power and privilege (including the predominantly white clinicians who participated in this survey) are vulnerable to ignorance about the part their own identities play within the working alliance, their client's experience of the feedback intervention, and related therapy outcomes. While common factors research has confirmed that the race of clients and their therapists does not predict therapy outcomes with reliability or anywhere near the degree of robustness that the quality of the working alliance does (Orlinsky, Rønnestad, & Willutzki, 2004), it remains an open inquiry whether and how therapists' understanding of racial/ethnic dynamics (including their own contribution to such dynamics) impacts the quality of the working alliance. In this respect, this study asks the question: how does interpersonal and societal power operate within the space of the working alliance in the context of feedback interventions? The way that clients and their therapists understand and relate with their own power, it is suggested, should be considered an additional factor in considering the characteristics of the working alliance.

Section 6: Limitations of the current study

The present study was not without limitations that constrain its findings' generalizability to a larger population of clinicians. As mentioned earlier in this chapter, the recruitment methods were especially prone to generating a self-selecting base of participants, focused as they were on online communities of service providers who were comfortable participating in a somewhat time-intensive, anonymous online survey. This issue raises the possibility that the findings generated from respondent answers may be a reflection of some shared characteristic of respondents who were likely to participate in this study, such as enthusiasm for seeking out client feedback or heightened sensitivity to issues of power dynamics, rather than a reflection of the "average" clinician who uses FIT methods in their work. Likewise, while participation was open

to internationally practicing clinicians and a third of respondents hailed from Canada, Australia, and New Zealand, the lack of clinicians from non-Westernized countries limits the extent to which this exploratory study's findings may be viewed as representative of how internationally-based clinicians practice FIT methods. Additionally, given this study's focus on race/ethnicity dynamics and its recruitment goal of representing clinicians of color in more than a tokenistic way, the predominance of white respondents represented a recruitment failure and major limitation of the study. While the solicitation text specifically named the historic lack of clinicians of color in the field of psychotherapy research and requested that participants forward on the participation notice to clinicians of color who may have been eligible, this recruitment strategy nonetheless failed to garner the hoped-for number of respondents of color. It's possible that there was also a selection bias at play in that clinicians of color may have been less interested in participating in a study partially focused on race/ethnicity dynamics, due to the potentially triggering nature of the content; it's also possible that clinicians of color are not yet well represented in the ranks of service providers who have adopted FIT methods, for one reason or another. Regardless, given this study's aim to explore racial/ethnicity dynamics in feedback interactions, the predominance of white respondents certainly limited its ability to do so in a more comprehensive way.

Finally, the age and gender demographics of this study's respondents may have impacted the generalizability of the findings. There was an equal split in male versus female identified clinicians, which does not necessarily reflect gender ratios in certain fields of mental health care and service provision (many of which reflect a much higher percentage of female providers than male providers). As such, the findings may overrepresent experiences and viewpoints more likely to be held by male clinicians. For example, given the realities of gender privilege, perhaps

male identifying clinicians are less likely to understand the intricacies of power dynamics in the therapeutic relationship than female identifying clinicians or those who identify as transgender, transsexual, or genderqueer. This would result in findings that fail to reflect the extent to which the majority of service providers are sensitive to issues of power. Likewise, given that the average age of respondents was 52.9 years old (median 54 years) and that the average age of mental health providers may be lower in a variety of professional arenas that use FIT, it's possible that certain perspectives – for example, views on power, race, and ethnicity – more typical of older generational cohorts were overrepresented in the findings. One might also imagine that younger clinicians are more politically progressive than older clinicians, for example, or that younger clinicians tend to practice using more postmodern therapy models than older clinicians. If this is the case, the findings may not accurately reflect the extent to which therapists who use FIT am to create a "culture of feedback" through more ample use of self-disclosure, for example.

One limitation of the study was its reliance on open-ended survey questions in an online questionnaire, as opposed to in-person or over-the-phone interviews with participants. While the benefits of such a design included the ability to cast a wider net (including international clinicians), reach service providers practicing in a variety of geographic locations and clinical settings, and potentially gain the participation of those who might not be willing to engage in a more time-intensive interview, the downsides were also numerous: it's likely that clinicians typing their answers to open-ended survey questions did not go into as much detail as they might have in an interview and that the medium of written responses was less apt to capture subtle intonations and represent complex ideas of the respondents. Indeed, while some respondents wrote lengthy responses with detailed explanations of their experience, some wrote much shorter

answers with limited explication of their meaning. Additionally, using an online survey tool limited the extent to which the researcher could reduce potential confusion among respondents about the intention behind survey questions. For example, in an in-person interview, if a participant is confused about what the researcher is asking her to reflect upon, she can ask the researcher to clarify or rephrase the question. In an online survey, some questions and prompts inevitably confuse some respondents who have no immediate recourse for extra clarification.

One additional limitation of the research is the nature and process of thematic analysis, performed by the researcher alone (without significant input from other eyes). Given this researcher's social location as a twenty-something, white, straight, upper middle class, male graduate student, it's inevitable that his subjective interpretation of the data — including his categorization of themes and subthemes — was biased as a result of his social lens. While researcher bias plays a role in all scientific endeavors to a certain extent, given this study's aim to investigate the dynamics of power and race/ethnicity in particular, such biases should be taken into special account and viewed as a limiting factor.

Section 7: Recommendations for Future Research

Given the limitations in the current study and the implications its findings hold, several recommendations can be made about fruitful areas for future investigation in the field of FIT research. First, given the relatively small and racially homogeneous sample size and limited scope of the current study, qualitative researchers might do well to perform a similar qualitative investigation with a wider sample of clinicians in addition to their clients, preferably with a higher diversity of racial/ethnic backgrounds among the participants. This would shed more light on how a diverse array of clinicians and their clients understand the dynamics of power, race, and ethnicity within the context of the feedback interaction and working alliance. Along more

quantitative lines, it might prove useful to investigate whether there are any differences in outcomes between therapists who believe race/ethnicity to impact the feedback process versus those who deny that it has a role. Perhaps clinicians who exhibit more sensitivity to subtle racial dynamics in feedback interactions are more likely to solicit genuine feedback from their clients and/or score higher on client ratings of the working alliance? While this potential study could be designed to look specifically at inter-racial therapist client dyads, it would behoove the field of FIT to expand its lens to also look at therapist client dyads that share racial/ethnic backgrounds as well.

Secondly, future research might further investigate the ambiguous territory of correlation versus causality in the "culture of feedback." While the current study suggests that using a feedback intervention prompts clinicians to use a variety of engagement tactics that appear empowering and therapeutic for clients (primarily that of actively seeking out and honoring the client's role in shaping the therapy process), it may be the case that clinicians who use FIT interventions in practice with their clients may have used such engagement tactics before implementing FIT. That is to say, perhaps it is simply a personality characteristic of the sub-population of clinicians who use FIT to seek out feedback and engage with clients in such a way as to promote collaboration in therapy, and the fact that they have adopted FIT merely reveals that it is an intervention that suits their working style. A longitudinal research study comparing clinicians' interventions and outcomes *before* implementing FIT as a part of their regular practice and then again *after* implementing FIT could shed light on whether FIT is itself causing clinicians to shift their working style or whether it simply reinforces already present tendencies. If it's the case that FIT interventions are not in and of themselves causing the positive outcomes seen in previous research, but rather characteristics of the practitioners who are likely to use FIT

in the first place, the field would be wise to place more energy on exploring the clinicians'

attributes rather than the technology of the FIT intervention.

Finally, while the current study focuses on clinicians' experience of what kinds of

behaviors, attitudes, and interactions increase the chance that their clients will offer genuine

feedback, it would be invaluable to perform more qualitative research on clients' perspective on

this issue. After all, it is *clients* who are being asked to provide genuine feedback and they know

better than their service providers what helped (or hindered) them in the process of sharing their

experience. While clinicians' voices are important, the entire endeavor of feedback informed

treatment rests on the acknowledgement that discovering better ways to hear clients' voices is

one of the most efficacious ways to improve therapy outcomes. Given the fact that research has

consistently demonstrated that therapists are relatively poor at gauging their clients' experience

of the alliance (Tryon, Collins, & Felleman, 2006), the current study's findings should be taken

with a healthy dose of skepticism. While respondents reflected many common themes about

what seemed to put their clients at ease and help build trust in the feedback process, it's possible

that other themes — perhaps even unexpected ones — would emerge in a similar exploratory

study focusing on clients' experiences of the feedback process.

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Appendix A

Description of study and participant recruitment text posted in online web forums.

Dear Colleagues,

My name is Andy Tew and I am a graduate student at the Smith College School for Social Work. I am writing to invite you to participate in a brief study I am conducting for my Master's thesis. It is a short (15-20 minute) online survey exploring your experience of how you "Create a Culture of Feedback" with your clients using ORS and SRS tools.

Because most of the research on these feedback tools has been quantitative and outcome-oriented, I am conducting a more qualitative, in-depth study on the interpersonal dynamics of soliciting client feedback. I am specifically interested in what you do or say to increase your clients' comfort and trust in the feedback process, thus increasing the chance that they will offer genuine feedback. Furthermore, I am interested in how the interpersonal and social power dynamics (including racial power dynamics) between you and your clients affect the feedback process.

You are eligible to participate in my study if you are a licensed mental health clinician who reads and writes English. Furthermore, you must use ORS and SRS feedback tools with racially diverse clientele on a routine basis. I am looking for mental health clinicians of all backgrounds, professional degrees, ages, genders, races, nationalities, etc., to participate. **Given the historical lack of representation of clinicians of color in clinical research, I am particularly hopeful to include voices of clinicians from a diversity of racial and ethnic groups.**

If you meet these criteria, I hope you will take 15 minutes of your time to participate in the survey. Participation is completely anonymous. If you do not meet criteria, I encourage you to **forward this recruitment notice** to any acquaintances or colleagues you know of who may be eligible to participate. Please follow this link to start the survey:

www.xxxxxxx.com

If you have any questions about my research or the nature of participation, please feel free to contact me at xxxxx@xxxx.edu.

Thank you for your time!

Sincerely,

Andy Tew
MSW Candidate, Smith College School for Social Work

Appendix B

Text of email sent to webmasters and administrators of professional Internet forums.

Dear ___Web Forum Administrator___,

      My name is Andy Tew and I am a graduate student at the Smith College School for Social Work. I am writing to inquire whether it is acceptable for me to post a recruitment message for participation in my Master's Thesis study on this web forum.

      Participation in the study involves completing a short (15-20 minute) online survey exploring clinicians' experience of soliciting feedback from clients using ORS and SRS tools. By using qualitative methods to explore the process of soliciting feedback, I hope to generate more knowledge about how real world clinicians create comfort and trust so that clients will offer genuine feedback about the alliance. Furthermore, I am interested in how the interpersonal and social power dynamics between clinicians and clients affects the feedback process.

      I am looking for participation from licensed mental health clinicians of all backgrounds, professional degrees, ages, genders, races, nationalities, etc. Participants must read and write English and must work with clients of multiple racial groups. Finally, I aim to address the historical absence of the voices of clinicians of color in clinical research by encouraging participation of clinicians from a diversity of racial identity groups. Because the study is conducted using Surveymonkey.com, all participation is anonymous and data will be kept confidential.

      Please let me know if it is alright for me to post a message recruiting for this study on the web forum. Also, if you know of any other avenues (preferably online) that I might utilize to recruit for this study, please let me know! The bigger and more diverse sample, the better. Of course, if you are interested in participating or know colleagues who might be, you are welcome to participate yourself or **forward the study link (below)** to others.

www.xxxxxxx.com

If you have any questions about my research or the nature of participation, please feel free to contact me at xxxxx@xxxx.edu.

Thank you for your time!

Sincerely,

Andy Tew
MSW Candidate, Smith College School for Social Work
Northampton, MA

Appendix C

Facsimile of what participants will see when participating in the survey (start to finish).

Creating a Culture of Feedback with Your Clients: An Exploratory Survey

Thank you for your interest in participating in this survey.

Please review the following four screening questions. If your answer to all four questions is "yes," please check the "yes" box to continue. If your answer to any of the questions is "no," you are not eligible to participate in this study and will be exited from this survey upon checking the "no" box.

✻ 1. Are you a licensed Mental Health Clinician in the United States?
2. Do you read and write English?
3. Do you use both Outcome Rating Scale (ORS) and Session Rating Scale (SRS) feedback tools with your clients?
4. Do you work with clients of diverse racial or ethnic backgrounds?

☐ Yes.

☐ No.

[Next]

Creating a Culture of Feedback with Your Clients: An Exploratory Survey

LETTER OF INFORMED CONSENT

Dear Participant,

My name is Andy Tew and I am a graduate student at Smith College School for Social Work. I am conducting research for my Masters thesis, which explores mental health clinicians' experience of using feedback informed treatment tools such as the Outcome Rating Scale (ORS) and Session Rating Scale (SRS) measures (developed by Duncan et al., 2003; Miller et al., 2003). Because most of the research on these feedback tools has been quantitative and outcome-oriented, I am conducting a more qualitative, in-depth study on the interpersonal dynamics of soliciting client feedback. I hope to generate more knowledge about how real-world clinicians create comfort and trust so that clients will offer genuine feedback about the alliance. Furthermore, I am interested in how the interpersonal and social power dynamics (including racial power dynamics) between clinicians and clients affects the feedback process.

To participate, you must be a licensed mental health clinician currently practicing professionally in the United States. You must read and write English and must work with clients of multiple racial groups. Participants of all identity backgrounds, professional degrees, ages, genders, races, etc. are welcome and encouraged to take part in the study.

This study is conducted through a brief online survey that is administered via the website SurveyMonkey.com. You will be asked 4 demographic questions (such as gender identity, age, racial identity). Then, you will read an explanation of the research intention behind this survey and guidelines on how to approach the open-ended questions to follow. Finally, you will be asked to answer three open-ended questions by reflecting on past experiences with clients and writing your answers in the text boxes provided.

Because the survey will include reflections on your own experiences with clients, feedback interventions, and experience of power dynamics, there is a small risk that participation in the study could cause negative emotions to arise. Possible benefits from participating in the study include experiencing participation as informative and having the opportunity to reflect upon your practice. Unfortunately, no monetary or material compensation for your participation is able to be provided.

This survey is totally anonymous. If you choose to contact the researcher after participating, confidentiality will be maintained while anonymity will be lost, however. In the interest of confidentiality, you are asked not to provide any names or identifying information about clients in any of your responses. All data from the questionnaire will be kept in a secure location for a period of three years, as required by Federal guidelines, and data stored electronically will be fully protected. If the material is needed beyond a three year period, it will continue to be kept in a secure location and will be destroyed when it is no longer needed.

The response data will only be viewed by myself and my research advisor. When material from this study is used for future presentation and possible publication, any possible identifying information will be removed.

Your participation in this questionnaire is voluntary. You have the right to refuse to answer any question on the survey. You may also withdraw from the study at any time by navigating away from the webpage on your browser. If you do this, any answers you provided to any previous questions will be immediately deleted. However, once you complete and submit your answers to the full questionnaire, it will not be possible to withdraw, because you will not be able to be identified.

If you have any additional questions or concerns about your participation in this study, please feel free to contact me directly at atew@smith.edu. Should you have any concerns about your rights or any aspect of the study, you are encouraged to contact me or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974. Thank you for your participation.

BY CHECKING THE BOX BELOW THAT SAYS "I AGREE," YOU ARE INDICATING THAT YOU HAVE READ AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS; AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Please print a copy of this page for your records.

2. Do you agree to the conditions of the letter of consent?

☐ I Agree.

☐ I Disagree.

Prev   Next

Creating a Culture of Feedback with Your Clients: An Exploratory Survey

Please answer the following demographic questions
then proceed by clicking the "next" button.

✱3. What is your age?

✱4. What is your gender?

✱5. How do you identify racially and ethnically?

✱6. How many years have you been using the Outcome Rating Scale (ORS) and Session Rating Scale (SRS) feedback tools with your clients?

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Creating a Culture of Feedback with Your Clients: An Exploratory Survey

Below, you will read an explanation of the aim of this survey. After reading it carefully please proceed to the open-ended survey questions by clicking "next" at the bottom of the page.

As Miller and Bargmann (2010) point out, soliciting feedback from your clients is more than simply "administering" a paper and pencil scale. It is necessary to try to create an atmosphere in which clients can feel free to rate their experience of the outcome and alliance "without fear of retribution, and . . . with a hope of having an impact on the nature and quality of services delivered," (p. 199). In this sense, therapists must strive to create a positive "culture of feedback" with their clients.

One factor at play in the process of asking for feedback is the power dynamics between therapist and client. As much research illustrates, power dynamics may manifest in multiple ways. For example, the therapist knows more about the client's life than the client knows about the therapist's life. The client usually pays the therapist for his or her services, putting the therapist in a position of service. Additionally, the social locations (e.g. class, race, gender, sexual orientation) of both client and therapist affect how they experience themselves in the relationship.

On the following pages, you will be asked to answer three open-ended questions. The aim of these questions is for you to relate how YOU create a "culture of feedback" with your clients—in other words, what do you do to help clients be comfortable enough to give genuine feedback? You will also be asked to reflect on the ways power dynamics influence your experience of the feedback process.

Since most of the current research on feedback has generated horizontal data on the effects of feedback rather than vertical narratives about the process of feedback, it is important that you write in as much depth and detail as you can— preferably a paragraph or two for each open-ended question, using concrete examples from your own practice when possible.

Finally, as you answer these questions, please be mindful not to include any identifying information about yourself or your clients.

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Creating a Culture of Feedback with Your Clients: An Exploratory Survey

✱ 7. When soliciting feedback from your clients about their experience of the therapeutic alliance using the Session Rating Scale (SRS) tool, what do you do to increase your clients' comfort? What helps to increase the chance that they will give you genuine feedback?

Please give at least one concrete example of what you might say to a client, what attitudes you might convey, or how you would act in session.

Prev   Next

✱8. How does the difference in power between you and your client affect the process of asking for feedback about the therapeutic alliance?

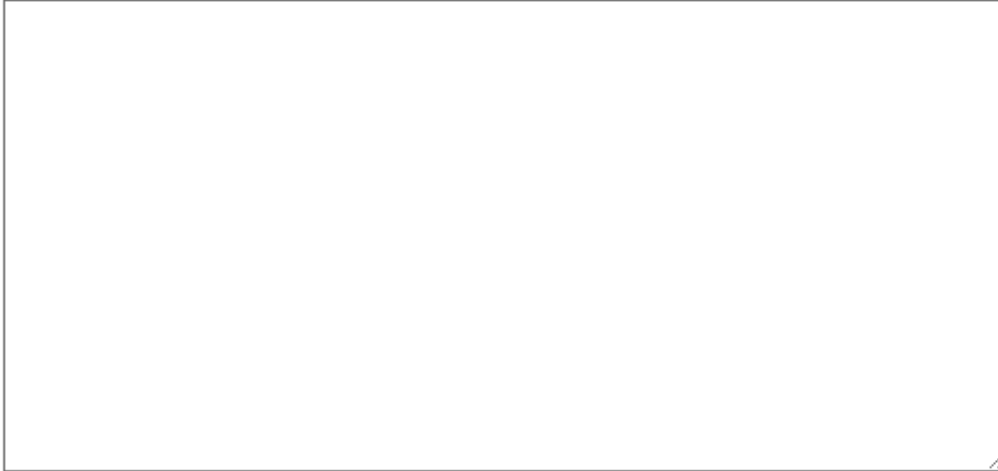**Please give at least one concrete example from your personal experience.**

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Creating a Culture of Feedback with Your Clients: An Exploratory Survey

Question 9

✱9. How does the racial dynamic between you and your client affect the process of asking for feedback about the therapeutic alliance? Consider situations in which you are working with clients of your own racial/ethnic group as well as different racial/ethnic groups.

Again, please use at least one concrete example if possible.

Prev   Next

Creating a Culture of Feedback with Your Clients: An Exploratory Survey

Thank you for your time.

Your participation in this exploratory study is now complete. You may exit by clicking the "exit" button at the bottom of the page.

The following is a limited list of peer-reviewed articles that inform the current study. If you have questions or concerns about your participation, please do not hesitate to contact the researcher at atew@smith.edu.

Anker, M., Duncan, B., Sparks, J. (2009). Using client feedback to improve couple therapy outcomes: an RCT in a naturalistic setting. Journal of Consulting and Clinical Psychology, 77, 693-704.

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. Journal of Consulting and Clinical Psychology, 75(6), 842–852.

Chang, D. F., & Yoon, P. (2011). Ethnic minority client's perceptions of the significance of race in cross-racial therapy relationships. Psychotherapy Research, 21, 567–582.

Duncan, B.L., Miller, S.D., Sparks, J.A., Claus, D.A., Reynolds, L.R., Brown, J., et al. (2003). The session rating scale: Preliminary psychometric properties of a "working" alliance measure. Journal of Brief Therapy, 3, 3-12.

Harmon, C., Hawkins, E.J., Lambert, M.J., Slade, K., & Whipple, J.L. (2005). Improving outcomes for poorly responding clients: The use of clinical support tools and feedback to clients. Journal of Clinical Professional Psychology: Research and Practice, 35(5), 485-491.

Miller, S. D. & Bargmann, S. (2010). Feedback informed treatment: Improving outcome with male clients one man at a time. In J. Ashfield (Ed.), Doing Psychotherapy with men. Norwood, South Australia: Peacock Publications.

Miller, S.D., Duncan, B.L., Brown, J., Sparks, J.A., & Claud, D.A. (2003). The outcome rating scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. Journal of Brief Therapy, 2, 91-100.

Miller, S.D., Duncan, B.L., Brown, J., Sorrell, R., & Chalk, M.B. (2006). Using formal client feedback to improve retention and outcome. Journal of Brief Therapy, 5, 5-22.

Reese, R. J., Norsworthy, L., & Rowlands, S. (2009). Does a continuous feedback system improve psychotherapy outcome? Psychotherapy: Theory, Research, Practice, & Training, 46, 418–431.

Shimokawa, K., Lambert, M. J., & Smart, D. W. (2010). Enhancing treatment outcome of patients at risk of treatment failure: Meta-analytic and mega-analytic review of a psychotherapy quality assurance system. Journal Of Consulting And Clinical Psychology, 78(3), 298-311.

10. You may exit the survey by clicking the link below.

◯ Exit the Survey.

Prev   Done

Appendix D

Informed consent.

Dear Participant,

My name is Andy Tew and I am a graduate student at Smith College School for Social Work. I am conducting research for my Masters thesis, which explores mental health clinicians' experience of using feedback informed treatment tools such as the Outcome Rating Scale (ORS) and Session Rating Scale (SRS) measures (developed by Duncan et al., 2003; Miller et al., 2003). Because most of the research on these feedback tools has been quantitative and outcome-oriented, I am conducting a more qualitative, in-depth study on the interpersonal dynamics of soliciting client feedback. I hope to generate more knowledge about how real-world clinicians create comfort and trust so that clients will offer genuine feedback about the alliance. Furthermore, I am interested in how the interpersonal and social power dynamics (including racial power dynamics) between clinicians and clients affects the feedback process.

To participate, you must be a licensed mental health clinician currently practicing professionally in the United States. You must read and write English and must work with clients of multiple racial groups. Participants of all identity backgrounds, professional degrees, ages, genders, races, etc. are welcome and encouraged to take part in the study.

This study is conducted through a brief online survey that is administered via the website SurveyMonkey.com. You will be asked 5 demographic questions (such as gender identity, age, racial identity). Then, you will read an explanation of the research intention behind this survey and guidelines on how to approach the open-ended questions to follow Finally, you will be asked to answer three open-ended questions by reflecting on past experiences with clients and writing your answers in the text boxes provided.

Because the survey will include reflections on your own experiences with clients, feedback interventions, and power dynamics, there is a small risk that participation in the study could cause negative emotions to arise. Possible benefits from participating in the study include experiencing participation as informative and having the opportunity to reflect upon your practice. Unfortunately, no monetary or material compensation for your participation is able to be provided.

This survey is totally anonymous. If you choose to contact the researcher after participating, confidentiality will be maintained while anonymity will be lost, however. In the interest of confidentiality, you are asked not to provide any names or identifying information about clients in any of your responses. All data from the questionnaire will be kept in a secure location for a period of three years, as required by Federal guidelines, and data stored electronically will be fully protected. If the material is needed beyond a three year period, it will continue to be kept in a secure location and will be destroyed when it is no longer needed.

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answers to the full questionnaire, it will not be possible to withdraw, because you will not be able to be identified.

       If you have any additional questions or concerns about your participation in this study, please feel free to contact me directly at xxxx@xxxx.edu. Should you have any concerns about your rights or any aspect of the study, you are encouraged to contact me or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974. Thank you for your participation.

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_____ I disagree   _____ I agree

Please print a copy of this page for your records.

Appendix E

SurveyMonkey.com's Security Statement (http://www.surveymonkey.com/Monkey_Security.aspx)

User Security
SurveyMonkey requires users to create a unique user name and password that must be entered each time a user logs on. SurveyMonkey issues a session "cookie" only to record encrypted authentication information for the duration of a specific session. The session cookie does not include either the username or password of the user. When a user accesses secured areas of our site, Secure Sockets Layer (SSL) technology protects user information using both server authentication and data encryption, ensuring that user data is safe, secure, and available only to authorized persons. Passwords and credit card information are always sent over secure, encrypted SSL connections. Accounts which are SSL enabled ensure that the responses of survey respondents are transmitted over a secure, encrypted connection. We are PCI-DSS compliant

Physical Security
-Our data center is located in a SAS70 Type II certified facility
-Data center staffed and surveilled 24/7
-Data center secured by security guards, visitor logs, and entry requirements (passcards/biometric recognition)
-Servers are kept in a locked cage
-Digital surveillance equipment monitors the data center
-Environmental controls for temperature, humidity and smoke/fire detection
-All customer data is stored on servers located in the United States

Availability
-Fully redundant IP connections
-Multiple independent connections to Tier 1 Internet access providers
-Uptime monitored constantly, with escalation to SurveyMonkey staff for any downtime
-Database is log-shipped to standby servers and can failover in less than an hour
-Servers have redundant internal and external power supplies

Network Security
-Firewall restricts access to all ports except 80 (http) and 443 (https)
-Intrusion detection systems and other systems detect and prevent interference or access from outside intruders
-QualysGuard network security audits are performed weekly
- McAfee SECURE scans performed daily

Storage Security
-All data is stored on servers located in the United States
-Backups occur hourly internally, and daily to a centralized backup system for offsite storage - Backups are encrypted
-Data stored on a RAID 10 array
-O/S stored on a RAID 1 array

Organizational Security
-Access controls to sensitive data in our databases and systems are set on a need-to-know basis
-We maintain and monitor audit logs on our services and systems (we generate gigabytes of log files each day)
-We maintain internal information security policies, including incident response plans, and regularly review and update them

Software
-Code in ASP.NET 2.0, running on SQL Server 2008, Ubuntu Linux, and Windows 2008 Server
-Our engineers use best practices and industry-standard secure coding guidelines to ensure secure coding
-Latest patches applied to all operating system and application files
-Billing data is encrypted

Appendix F

HSR Approval Letter

SMITH COLLEGE

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950   F (413) 585-7994

January 25, 2013

Alexander Tew

Dear Andy,

Thank you for making all the requested changes to your Human Subjects Review application. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Marsha Kline Pruett, M.S., Ph.D., M.S.L.
Vice Chair, Human Subjects Review Committee

CC: John Erlich, Research Advisor