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The effect of therapist characteristics on the use and outcome of systematic client feedback in outpatient mental healthcare

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Abstract

Objective: Therapist characteristics are known to affect treatment outcome in general and could also influence the use of systematic client feedback (SCF). The current study explores the effect of feedback orientation, regulatory focus, self-efficacy, attitude towards feedback resources and perceived feedback validity on the use and outcome of SCF in outpatient mental healthcare.

Method: The data of therapists ($n = 12$) and patients ($n = 504$) of two outpatient centres offering brief psychological treatment were analysed when SCF, based on the Partners for Change Outcome Management System (PCOMS), was added to treatment as usual. The data of therapists were obtained through a therapist questionnaire composed of relevant characteristics from feedback studies in social and organizational psychology. The effect on the use of SCF was analysed using logistic regression; whereas, the effect on outcome was assessed using a two-level multilevel analysis. Regular use of SCF and the Outcome Questionnaire (OQ-45) were used as outcome variables. DSM-classification, sex and age of each patient were included as covariates.

Results: High perceived feedback validity significantly increased the use of SCF. No significant therapist characteristics effects were found on outcome, but high promotion focus was associated with treating more complex patients.

Conclusions: The perceived feedback validity of SCF is likely to have an influence on its use and is probably affected by the changes in the organizational climate.

KEYWORDS

outpatient psychological treatment, PCOMS, systematic client feedback, therapist characteristics

1 | INTRODUCTION

Systematic client feedback (SCF), also known as measurement-based care, feedback informed treatment or progress feedback, refers to the

regular monitoring of patients' progress over the course of their psychological treatment, using a standardized self-report outcome measure (de Jong et al., 2021). Evidence has accumulated in favour of routinely implementing SCF in mental health care. It appears to

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improve outcome in terms of symptom reduction, wellbeing, or lower drop-out rates. Other studies showed that SCF can also lead to reduction of treatment duration (e.g., Janse et al., 2017), reduction of costs (e.g., Delgado et al., 2021) or improvement of retention rates in forensic mental health care (Janssen et al., 2021). In a recent study, Delgado et al. (2022) found that SCF can reduce the gap between more and less effective therapists as well.

At the same time, apart from this increased evidence for its added value, there is growing evidence that implementing SCF can be challenging (Bickman et al., 2016; Brattland et al., 2018; Lewis et al., 2019; Lucock et al., 2015; Unsworth et al., 2012) and that therapists can be reluctant in using SCF. Therapist effects on therapy outcomes have been clearly shown through various meta-analyses (Heinonen & Nissen-Lie, 2020; Johns et al., 2019; Wampold & Owen, 2021). However, therapist effects on the use and outcome of SCF has been analysed sparsely. To our knowledge, only one study has been conducted to investigate whether therapist characteristics influence the actual use of SCF or treatment added with SCF (de Jong et al., 2012) and only a few studies have examined therapist effects on treatment added with SCF (de Jong & de Goede, 2015; Janse et al., 2023; Lutz et al., 2015).

de Jong et al. (2012) were among the pioneers in research of feedback and therapist characteristics. They selected the characteristics based on the Contextualized Feedback Intervention Theory (CFIT; Riemer & Bickman, 2007, 2011) composed of relevant characteristics from feedback studies in social and organizational psychology (Bandura, 1977; Herold & Fedor, 2003; Morran & Stockton, 1980). CFIT involves examining whether therapists pay attention to feedback and whether they consider the feedback to be relevant.

de Jong et al. (2012) found that not-on-track (NOT) patients had lower rates of change when their therapists rely more on their own opinion than on external feedback (a so-called high internal feedback propensity). In contrast, NOT patients of therapists who were committed to using feedback had a higher rate of change. Surprisingly, when feedback was actually provided for those therapists, it slowed down their patients' rate of change. In addition, De Jong and colleagues found that patients of therapists with a high self-efficacy improved faster in this study, when feedback was received. It emerged that the combination of patient characteristics, therapist characteristics and whether or not feedback was received determined the outcome. Finally, they found that a higher commitment to using feedback and being a female therapist increased the odds of using feedback.

In a second study de Jong and de Goede (2015) examined the effect of organizational factors on the effect of SCF, more specifically, the fit between personal values and organizational values of therapists (PO-fit). They found a negative effect between PO-fit and getting feedback, leading to slower change when feedback was provided. The PO-fit was high at the beginning of the study before they started adding feedback but decreased throughout the study. This might indicate that the implementation of feedback was altering the local organization culture leading to a poorer PO-fit and a negative organizational

Key Practitioner Message

- When perceived validity of the chosen feedback instrument is high, systematic client feedback is more likely to be used.
- The added value of systematic client feedback is likely to be determined by the combination of therapist characteristics, patient characteristics, organizational factors and the chosen feedback instrument.
- This study provides evidence that long-term involvement of therapists in the implementation of systematic client feedback can be necessary, when it is added to outpatient psychological treatment.

climate (Schneider et al., 2013). An interaction effect of patient factors, provision of feedback and therapist characteristics was also found in this study, when the influence of therapists' regulatory focus was observed. Therapists with a strong prevention focus, pursuing the prevention of harm, had a more positive attitude towards feedback but achieved slower symptom reductions with NOT patients. Therapist with a strong promotion focus, pursuing therapeutical success, achieved faster symptom reduction when feedback was provided.

Lutz et al. (2015) found that therapists who were satisfied with the feedback system and who made only one specific adjustment in their therapy based on the feedback, for instance tried to adjust their therapeutic interventions or tried to enhance the patient's motivation for therapy, had the best treatment outcomes. This added value of feedback diminished when the therapists made more than one adjustment. Patients of therapists who were dissatisfied with the feedback system and who nevertheless made more than one adjustment to their therapy based on this feedback, had worse outcomes.

The most recent scientific contributions on therapist characteristics and progress feedback are from Wampold and Owen (2021) and Janse et al. (2023). Wampold and Owen concluded that feedback can provide an improvement on outcomes, especially for NOT patients. This added value increases when therapists have a positive attitude towards feedback and a good relationship with their organization. Finally, Janse et al. (2023) found an interaction effect of patient factors, provision of feedback and therapist characteristics, showing that high self-efficacy was associated with worse outcome when feedback was not provided and with better outcome when high-intensity SCF was added. On the other hand, therapists with lower self-efficacy showed poorer outcomes when high-intensity SCF was provided but better outcomes when only low-intensity SCF was provided.

In summary, previous studies indicate that there are different therapist characteristics that influence different phases of SCF use and effect (see Figure 1). Personal characteristics such as regulatory focus (prevention or promotion focus) or internal or external feedback propensity and the fit between personal and organizational values, seem to influence the attitude towards SCF. This attitude towards

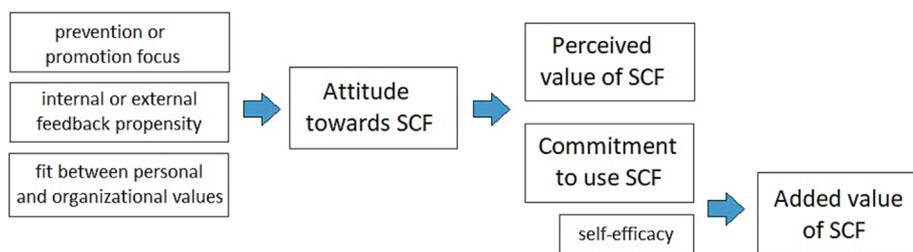


FIGURE 1 Overview of therapist characteristics influencing different phases of SCF.

SCF then seems to co-determine the perceived value of SCF and the commitment to use SCF. When SCF is actually used, personal characteristics such as self-efficacy seem to co-determine the added value of SCF on therapy outcome.

The number of studies on the effect of therapist characteristics and SCF is limited, and the specific interaction effects of organizational factors, therapist characteristics, therapist attitudes and provision of feedback co-determining the adoption and impact of SCF are still unclear. It seems obvious, however, that the therapist characteristics as found by de Jong et al. (2012) and Riemer and Bickman (2007, 2011) are relevant in further research into therapist effects in the implementation and effect of SCF.

The current study aimed to explore therapist characteristics in outpatient psychological treatment by adding the Partners for Change Outcome Management System (PCOMS) to treatment as usual (TAU). It focused on the effect of feedback orientation, regulatory focus, self-efficacy, attitude towards feedback resources and perceived feedback validity on the use and outcome of SCF. These characteristics are in line with the therapist characteristics selected by de Jong et al. (2012) and the CFIT of Riemer and Bickman (2007, 2011). Our primary hypothesis was that therapist characteristics, especially regulatory focus, feedback propensity and the fit between personal and organizational values, would influence the actual utilization (use or non-use) of SCF, and our secondary hypothesis was that therapist characteristics, in particular self-efficacy, would influence the outcome of treatment supplemented by SCF.

2 | METHOD

2.1 | Data

The current study is part of a larger multi-centre cluster randomized trial aiming to clarify the effects of SCF in outpatient psychological treatment (Bovendeerd et al., 2019, 2021). These centres are part of the centres of Mindfit, an outpatient mental health organization in the Netherlands with over 30 centres across the country offering brief psychological treatment. In two of the participating centres of this larger study, SCF was added to TAU, and the effect of therapist characteristics on its use and outcome was explored. Data of patients were collected from 1 January 2016 till 31 December 2017. Data of therapist characteristics were collected from 11 January 2018 till 18 February 2018. The DSM IV-TR classification (APA, 2000), sex and age of each patient were included as covariates. The design and

methods of the four-centre study and of the current study have been described in the study protocol (Bovendeerd et al., 2019).

2.1.1 | Procedure

Details on the procedure of the four-centre study on the added value of SCF to TAU are described in Bovendeerd et al. (2021). Outpatients ($n = 1733$) in that study were cluster randomized to four centres; two offering TAU (TAU-condition) and two offering TAU added with PCOMS (TAU-PCOMS condition). The Therapist Questionnaire, part of current study, was administered immediately after closing the patient inclusion period in the two centres of the TAU-PCOMS condition.

Primary outcome measure in the larger study was the Outcome Questionnaire (OQ-45; de Jong et al., 2009; Lambert et al., 2004). The administering of the OQ-45 was part of the Routine Outcome Monitoring (ROM) and was intended to be administered four times: at the beginning, after 5 weeks, after 13 weeks and at the end of therapy. The primary outcome in current study was regular use of SCF, and the secondary outcome was the change in the OQ-45 scores.

2.1.2 | Intervention

In current study, SCF was based on PCOMS, a feedback system using two brief, four-item visual analogue scales, the Outcome Rating Scale (ORS; Miller et al., 2003) and the Session Rating Scale (SRS; Duncan et al., 2003). In this study we used the approved Dutch version of these instruments, translated by Asmus, Crouzen and Van Oenen in 2000 (ORS) and 2002 (SRS).

The ORS, measuring intrapersonal, interpersonal, social and overall wellbeing, is administered at the beginning of each therapy session. The ORS-score and progress or decline from previous scores are discussed immediately and helped determine the topics of the session at hand. Miller et al. (2003) examined its psychometric properties, finding a high sensitivity to change, internal consistency and test-retest reliability.

The SRS, measuring the affective bond, topics and goals and approach or method according to the definition of the working alliance of Bordin (1979), is administered at the end of each session. The SRS-score and progress or decline from previous scores are discussed to see if there are suggestions for improvement in subsequent therapy sessions. Its psychometric properties were tested by Duncan et al.

TABLE 1 Sample characteristics.

	n or M	SD or %
Therapists (N = 12)		
Gender (% female)	9	75%
Discipline		
Senior nurse	1	8.3%
Nurse specialist	2	16.7%
Psychologist	8	66.7%
Social worker	1	8.3%
Age	42.5	11.26
Years of experience	14.8	11.49
Years at institution	12.75	9.59
Years at department	3.42	0.79
Internal feedback propensity	2.97	0.59
Prevention focus	3.56	0.93
Promotion focus	5.29	1.14
General self-efficacy	3.27	0.33
Self-efficacy in treatment	3.87	0.31
Attitude towards feedback resources	4.00	0.71
Validity of PCOMS	3.44	0.37
Validity of Outcome Rating Scale	3.93	0.38
Validity of Session Rating Scale	3.67	0.50
Patients (N = 504)		
Gender (% female)	311	61.7
Age	37.64	12.75
Disorder type		
Anxiety disorder	250	49.6%
Mood disorder	131	26.0%
Psychosomatic disorder	79	15.7%
Developmental disorder	21	4.2%
Other	23	4.6%
OQ-45 total score pre-treatment	76.53	20.57

Abbreviations: OQ-45, Outcome Questionnaire; PCOMS, Partners for Change Outcome Management System.

(2003), finding similar validity and reliability as longer alliance measures. In the study protocol of this study (Bovendeerd et al., 2019), the PCOMS-intervention is described in more detail.

2.1.3 | Patients

Patients were eligible for inclusion if they were treated by a therapist who was given a full training in the use of PCOMS and was supervised during the inclusion period by the lead researcher, a PCOMS senior therapist. Patients were at least 18 years old and suffered from mild to moderate psychological disorders. They mastered Dutch as their first or second language and had no objection to using their anonymized ROM data for scientific research. During

the inclusion period, 554 patients were referred to trained and supervised therapists in the use of PCOMS for psychological treatment by their general practitioner. Patients with less than three face to face contacts ($n = 50$) were excluded. Patients were not excluded based on a specific diagnosis. In total, data of 504 patients were included in the intention to treat (ITT) analysis. Characteristics of patients including the distribution of patients' diagnoses, can be found in Table 1.

In the per protocol (PP) analysis, patients who did not receive at least three face to face sessions with PCOMS ($n = 280$), or who did not complete therapy ($n = 31$), were excluded. The remaining 193 patients were analysed in the PP analysis. Patient flow through the study is presented in Figure 2.

This trial was registered in the Dutch Trial Register on 30 September 2015 with registration number NTR5466. The Medical Ethics Committee of the University of Twente (Enschede) approved this study (K15-11, METC Twente).

2.1.4 | Therapists

Twelve therapists participated in this study; all are licensed psychologists or psychiatric nurses. All therapists were trained in the use of PCOMS by a certified, experienced trainer of PCOMS, following the Dutch PCOMS manual translated by Crouzen (2010). All trained therapists completed the characteristics questionnaire. The mean number of patients per therapist was 42 ($SD = 18.08$; range 13–66). Demographics and characteristics of the participating therapists can be found in Table 1.

2.2 | Measurements

2.2.1 | Patient measures

The Dutch version of the OQ-45 (de Jong et al., 2009; Lambert et al., 2004) was used as patient outcome measure, capturing patients' wellbeing and psychiatric symptoms. It uses a five-point scale ranging from 0 (never) to 4 (almost always) on three subscales: Symptom Distress, Interpersonal Relationships and Social Role and contains 45 items. Examples of the OQ-45 are 'I feel angry enough at work/school to do something I might regret' or 'I feel annoyed by people who criticize my drinking'. In this study, the total score (ranging from 0 to 180) was used, calculated by the sum of all the item-scores. The higher this total score is, the more problems a patient describes. The reliable change index of this total score is 14 points, and its clinical cut-off score is 63.

The Dutch translation of the OQ-45 was examined by de Jong et al. (2007), finding similar reliability and validity as the original OQ-45, but with a clinical cut-off score of 55 instead of the American cut-off of 63. Based on their analysis of the Dutch data, De Jong and colleagues added a fourth scale to the OQ-45, called the Anxiety and Somatic Distress scale.

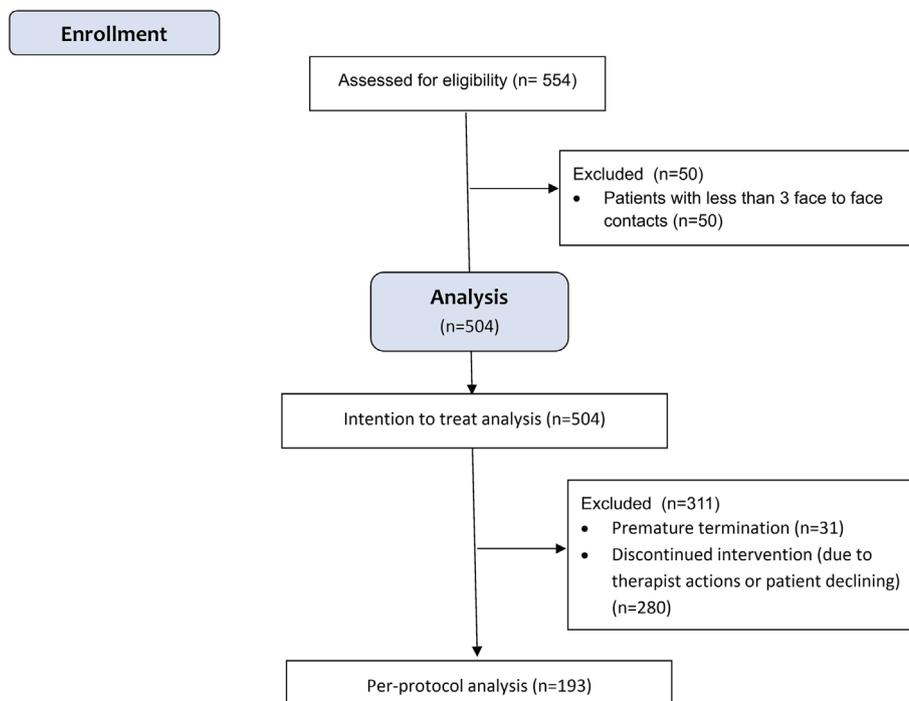


FIGURE 2 Enrolment.

2.2.2 | Regular use of SCF

In this study, regular use of SCF by a therapist was defined as administering feedback in at least three sessions of a completed therapy, in at least 25% of all treated patients. As an average therapy in the centres lasts just over eight sessions (8.26), this means that SCF is used in at least a third of the sessions. SCF was considered insufficiently adapted if a therapist used feedback in less than three sessions on more than three quarter of their patients. This 25% cut-off was based on the high end of the adherence rates found by Tschuschke et al. (2015) who studied adherence of specific interventions in eight treatment approaches and found rates ranging from 4.2% to 27.8%.

2.2.3 | Therapist Questionnaire

The Therapist Questionnaire contains 71 items on the following topics: feedback orientation, regulatory focus, self-efficacy, attitude towards feedback resources and perceived feedback validity. The elements of this questionnaire are composed of relevant characteristics from feedback studies in social and organizational psychology (Bandura, 1997; Herold & Fedor, 2003; Morran & Stockton, 1980).

Feedback orientation can be divided into internal and external feedback orientation (Herold & Fedor, 2003). People with a high internal feedback orientation take their own feelings and thoughts as the main source of feedback, for instance, 'How I think about myself and my work is more important to me than how others think about it.'; whereas people with a high external feedback orientation focus more on exterior feedback sources. Feedback propensity was measured

with the Internal and External Feedback Propensity Scales (IEFPS; Herold et al., 1997), with six items on both subscales. Participants rated on a 5-point rating scale ranging from 1 (strongly disagree) to 5 (strongly agree). The average scores of the six items per subscale lead to the total score. The minimum score is 1, and the maximum score is 5, the latter indicating a high internal or a high external feedback propensity.

The reliability of the IEFPS is 0.73 for the internal feedback propensity and 0.71 for the external feedback propensity scale (Herold et al., 1997). In our sample, the internal feedback propensity scale had a Cronbach's α of 0.81 and the external feedback propensity scale had an α of 0.01. The α of the external feedback propensity is extremely low in this study. This may be due to the relatively low number of items ($n = 6$) or the specific sample of therapists. When we removed three of the six items with low or even negative item-total correlations, the α was 0.72. As in that case we would have to remove half of the items, little of the original subscale would remain. We therefore decided to delete this subscale from further consideration.

Regulatory focus as described by Gorman et al. (2012) can be divided into prevention and promotion focus. Examples of regulatory focus items are 'I often fear that I will not be able to fulfil my responsibilities and obligations.' (prevention focus) and 'I regularly envision how I achieve what I wish to achieve.' (promotion focus). Regulatory focus was measured by an adaptation of the general regulatory focus questionnaire (Lockwood et al., 2002) to fit therapists in outpatient MHC, containing 18 items (nine prevention and nine promotion) similar to the study of de Jong and de Goede (2015). The items were rated on a 9-point rating scale ranging from 1 (not true at all) to 9 (completely true). The average scores of the nine items per subscale

lead to the total score. The minimum score is 1 and the maximum score is 9, the latter indicating a high prevention or promotion focus. de Jong and de Goede found a Cronbach's α of 0.63 for the prevention scale and 0.52 for the promotion scale. In this study, we found an α of 0.70 for the prevention scale and 0.81 for the promotion scale.

For self-efficacy, we made a distinction between general self-efficacy and self-efficacy in treatment. Self-efficacy is described by Bandura (1997) as a person's belief in the ability to achieve success. People with high self-efficacy seem to find negative feedback more helpful (Morran & Stockton, 1980). In this study, we measured self-efficacy with an adaption of the CFIT (Riemer & Bickman, 2007) User Survey, designed by the Center for Evaluation and Program Improvement of the Vanderbilt University (Riemer & Bickman, 2011). The general self-efficacy scale contains 10 items. Items are rated on a 4-point rating scale ranging from 1 (completely incorrect) to 4 (completely correct). The average scores of the four items lead to the total score. The minimum score is 1 and the maximum score is 4, the latter indicating a high general self-efficacy.

The self-efficacy in treatment contains seven items who are rated on a 5-point rating scale ranging from 1 (not at all) to 5 (to a very large extent). Examples of self-efficacy items are 'I always manage to solve problems if I put in enough effort.' (general self-efficacy) and 'I am confident in my ability to estimate a client's progress during treatments.' (self-efficacy in treatment). The average scores of the seven items lead to the total score. The minimum score is 1 and the maximum score is 5, the latter indicating a high self-efficacy in treatment. In this study we found a Cronbach's α of 0.81 for the general self-efficacy scale and an α of 0.54 for the self-efficacy in treatment scale.

The attitude towards feedback resources was measured with an adaption of the CFIT User Survey (Riemer & Bickman, 2007) with three items who are rated on a 5-point rating scale ranging from 1 (not at all) to 5 (to a very large extent). An example of an attitude towards feedback resources item is 'I value supervision when treating my patients.' The average scores of the three items lead to the total score. The minimum score is 1 and the maximum score is 5, the latter indicating a very positive attitude towards feedback. In this study we found a Cronbach's α of 0.76.

Finally, there were items questioning the perceived feedback validity of PCOMS, ORS and SRS, for instance with PCOMS 'I find it difficult to take the use of this type of feedback in treatment seriously.' or 'I really want to use the ORS and SRS feedback in the treatment.' Each time, there were four questions about the perceived value of the instrument and three questions about the commitment to use the instrument. These items are from a subscale of the CFIT User Survey and are rated on a 5-point rating scale ranging from 1 (strongly disagree) to 5 (strongly agree). The average scores of these items lead to the total score. The minimum score is 1 and the maximum score is 5, the latter indicating a perceived high feedback validity. In this study we found Cronbach's alphas of 0.67 (perceived validity PCOMS), 0.82 (perceived validity ORS) and 0.84 (perceived validity SRS).

In addition to these 71 items described above, an optional open-ended question was added: 'If you have any comments on the ORS and SRS, please indicate them below.'

2.3 | Statistical analysis

Data were analysed using IBM SPSS Statistics version 22 and MLWin version 3.05. Differences between the PP patient group and ITT patient group in sex and diagnosis were tested with chi-squared tests. T-tests were used to examine differences in age and in initial score on the OQ-45. In the primary analyses, we first computed correlations between use of SCF and therapist characteristics to select variables of interest. Looking at the percentage of use of SCF among the different therapists, it was noticeable that two groups could be distinguished; a group with relatively low use and one with relatively high use. These two different groups coincided with the two participating centres; one centre had an average use of PCOMS of 7% ($N = 5$, $SD = 0.04$, minimum 0.03, maximum 0.13), whereas the other centre had an average use of PCOMS of 68% ($N = 7$, $SD = 0.14$, minimum 0.48, maximum 0.89). We set the limit of regular use of SCF at 25% based on previous research by Tschuschke et al. (2015). In this study, scores are well above and below 25%; 'low use of SCF' is between 3% and 13%, and 'high use of SCF' is between 48% and 89%.

A Mann-Whitney test indicated that this difference was significant ($U(N_{centerA} = 5, N_{centerB} = 7) = 0.00$, $z = -2.847$, $p = 0.003$), effect size $\eta^2 = 0.74$. We therefore decided to divide the therapists into two groups, regular use of SCF and irregular use of SCF, instead of investigating the use of SCF per therapist. The large difference between these two centres was only found on attitude towards PCOMS, not on the other variables.

Spearman's rank correlation was used to estimate the correlation between regular use of SCF and therapist characteristics. Characteristics that showed a significant correlation with regular use of SCF were further analysed using a logistic regression to ascertain their effect on the likelihood of regularly using PCOMS.

In the secondary analysis, the effect of therapist characteristics on outcome of TAU added with SCF were compared using a multilevel model (Hox et al., 2018). The DSM classification, sex and age of each patient were included as covariates. Two analyses were carried out: one without and one with the interaction of log10time and therapist characteristics. Only two centres participated in the study, so a dummy for centre was used to account for the clustering on centre-level (Moerbeek et al., 2003). All available data were taken into account for calculation of the model.

The model analysing the effect of therapist characteristics on outcome over time was built with a two-level multilevel analysis, with repeated measures on the OQ total score of each patient on the first level and patients on the second level. Time was measured in days, and the baseline was coded with the value 0. A dummy variable was used to represent the centres. In addition, we checked the assumptions underlying the multilevel model, in particular homoscedasticity, normality of residuals and linearity between continuous predictor variables and the outcome variable. The deviance test was used to compare nested models to each other, where the deviance is calculated as $-2 * \log \text{likelihood}$.

The mean number of patients per therapist in the secondary analysis was 16 ($SD = 14.45$; range 2-38). Due to this limited number of

TABLE 2 Spearman correlations between therapist characteristics and regular use of systematic client feedback.

	Regular use of systematic client feedback
Internal feedback propensity	−0.223
Prevention focus	−0.074
Promotion focus	0.222
General self-efficacy	0.025
Self-efficacy in treatment	0.000
Attitude towards feedback resources	0.422
Perceived validity of PCOMS	0.685*
Perceived validity of Outcome Rating Scale	0.173
Perceived validity of Session Rating Scale	0.273

Abbreviation: PCOMS, Partners for Change Outcome Management System.

* $p < 0.05$.

patients per therapist, a preselection of variables of interest could not be made. To decide which model had the best fit, we calculated separate models for all therapist characteristics: first, without interaction with \log_{10} time, looking at the effect of therapist characteristics at intake, and then with interaction with \log_{10} time, looking at the effect of therapist characteristics on the outcome of TAU added with SCF. We retained the two best-fitting models achieved through this process.

3 | RESULTS

3.1 | Preliminary analyses

Pre-treatment test of the PP patient group and ITT patient group showed no significant differences in number of males and females, diagnosis, age or in initial score on the OQ-45.

3.2 | Primary outcome

3.2.1 | Effect of therapist characteristics on the actual use of SCF

To select variables of interest, we computed correlations between regular use of SCF and therapist characteristics. These correlations are presented in Table 2.

There was a positive correlation between ‘regular use of SCF’ and ‘perceived validity of PCOMS’, $r(1) = 0.685$, $p = 0.014$. Other therapist characteristics showed no significant correlations.

A logistic regression to assess the effect of perceived validity of PCOMS on the likelihood that PCOMS was used, which was

statistically significant, $\chi^2(1) = 80.519$, $p < 0.001$. The model explained a medium to large amount of the variance in PCOMS used (Cox & Snell R^2 : 14.8% and Nagelkerke R^2 : 19.9%) and correctly classified 67.7% of the cases. If the perceived validity of PCOMS increases with one point, the odds that a therapist will use PCOMS increase by a factor of 16.386, 95% CI [7.930–33.859].

As the outcome variable ‘regular use of SCF’ was significantly different between the two centres, we also analysed whether there was a significant difference between the two centres in ‘perceived validity of PCOMS’. Measured across all therapists, the perceived validity of PCOMS was 3.44 ($N = 12$, $SD = 0.369$, minimum 2.57, maximum 3.86). However, an average validity of 3.17 was found in one centre ($N = 5$, $SD = 0.345$) and an average of 3.63 in the other centre ($N = 7$, $SD = 0.217$). The highest value of perceived validity in the centre with the low use of PCOMS (3.43), was equal to the lowest value in the centre with the high use of PCOMS. A Mann–Whitney test indicated that this difference was significant ($U(N_{centerA} = 5, N_{centerB} = 7) = 4.50$, $z = -2.272$, $p = 0.03$), effect size $\eta^2 = 0.47$. The large difference between these two centres was only found on perceived validity of PCOMS. No significant differences between the two centres were found on the other therapist variables.

3.3 | Secondary outcomes

3.3.1 | Effect of therapist characteristics on outcome

After calculating separate models for all therapist characteristics without and with interaction with \log_{10} time, the models with promotion focus both without interaction with \log_{10} time (Akaike Information Criterion 8417.78) and with interaction with \log_{10} time (Akaike Information Criterion 8414.91) were retained as the two best-fitting models. These two models are presented in Table 3. All other multilevel models are available in the supplemental material (appendix A, Table A1 to A9).

At intake, significant differences between diagnoses on the outcome were found, and the model showed a significant effect of \log_{10} time as well. Inspection of QQ-plots of residuals and scatterplots of predicted OQ-score versus residual showed the assumptions of normality, and homoscedasticity was not violated. The difference between the two models was not significant ($-2\log\text{likelihood} = 2.81$).

In the analysis without \log_{10} time interaction, the model revealed a significant effect of promotion focus, showing a significant higher OQ-score at intake ($B = 5.599$, $SE = 2.322$, $p = 0.016$, 95% CI [1.047, 10.151]). This revealed that higher scores on promotion focus was associated with higher patients’ OQ-45 scores at intake.

In the analysis with \log_{10} time interaction, no significant effect was found. This revealed that the effect of \log_{10} time was not moderated by promotion focus ($B = 1.804$, $SE = 1.156$, $p = 0.119$, 95% CI [−0.462, 4.069]) or any other therapist characteristic administered in the therapist questionnaire.

TABLE 3 Best fitting two level models and dummy variables of therapist characteristics effects on outcome.

	Measure			
	OQ-45Without interaction log10time		OQ-45With interaction log10time	
	Estimate	SE	Estimate	SE
Fixed effects				
Intercept	32.584*	14.892	43.797**	16.536
Dummy centre	5.373	5.179	5.500	5.180
Age	0.026	0.092	0.026	0.092
Female	3.272	2.606	3.333	2.607
Anxiety disorder	6.650	6.248	6.893	6.251
Depressive disorder	15.637*	6.382	15.952*	6.386
Psychosomatic disorder	12.955	6.655	13.173*	6.657
Developmental disorder	-0.465	13.745	-0.025	13.747
Log10Time	-10.125***	0.635	-19.927**	6.315
Promotion-focus	5.599*	2.322	3.486	2.689
Promotion-focus* Log10Time	-	-	1.804	1.156
Random effects				
Level 1 (measurement)				
Residual	202.780	16.594	201.759	16.511
Level 2 (patient)				
Variance intercept	178.629	27.635	179.150	27.642

Note: OQ-45 = Outcome Questionnaire, time is in days.

* $p < 0.05$, ** $p < 0.01$, and *** $p \leq 0.001$.

3.3.2 | Therapist comments

The optional open-ended question about the ORS and SRS at the end of the Therapist Questionnaire was answered by two-thirds ($n = 8$) of the therapists: three out of five therapists from the low SCF use centre and five out of seven therapists from the high SCF use centre. These comments can possibly provide some insight in the difference in use of SCF. Although the open question was to give any comments on the ORS and SRS in general, a theme could be found, namely, the perceived added value of SCF related to the potential burden of using PCOMS. The comments could be divided into positive and negative comments and are displayed in Table 4.

When we divide the overall statements per centre, the therapists of the low SCF use centre make ambivalent to negative statements on average. The therapists at the high SCF use centre cover the entire range from positive to negative, but on average make more ambivalent/positive statements.

In summary, the added value of SCF was either argued in the more negative comments or emphasized in the more positive comments. In the more negative comments, it is also indicated that the administering can be a burden to the practitioner or patient. These comments are in line with the findings on the primary outcome showing that perceived validity of SCF is an important factor in its utilization.

4 | DISCUSSION

In this study we examined the effect of therapist characteristics on therapists' use of SCF and on the outcome of TAU added with SCF in outpatient psychological treatment. The perceived validity of the feedback instrument had a significant effect on the use of SCF; the higher the perceived validity, the more likely therapists were willing to use the instrument. No significant effects of therapist characteristics were found on the outcome of TAU added with SCF.

Recent meta-analyses suggest that therapist characteristics have an influence on treatment outcome (Heinonen & Nissen-Lie, 2020; Johns et al., 2019; Wampold & Owen, 2021). Heinonen and Nissen-Lie (2020) for instance found that cultivated interpersonal capacities had a positive effect on the therapy results. In the present study, therapist characteristics seem to have an effect on the use of SCF as well. The large difference in perceived validity and use of PCOMS coincided with the two participating centres: One centre showed relatively low perceived validity and low use of PCOMS, the other a relatively high perceived validity and high use.

This difference in centres is hypothesized to be linked to a changing organizational climate in the centre, with the lowest regular use of PCOMS (Schneider et al., 2013). As described in the study protocol (Bovendeerd et al., 2019), the centres were recruited in a Mindfit meeting, and participating in the study was voluntary. At the beginning of the study, both centres were open to SCF implementation and

TABLE 4 Therapist comments on the Outcome Rating Scale (ORS) and Session Rating Scale (SRS).

Positive comments	Negative comments	
'I would like to have the choice to use it where I expect it to add value'	'Clients quickly experience resistance when they have to fill in a form again, even if they see the added value of it.'	
'They can be useful questionnaires.'	'The ICT startup problems have had a negative influence. E.g. the fact that clients were constantly being sent the ORS and SRS at home; not having an internet connection.'	
'Usually these issues are already discussed with clients and the questionnaire doesn't add much, but sometimes it works better through a questionnaire than face to face.'	'By using the ORS/SRS I realize that I am already paying a lot of attention to progress, the treatment relationship and feedback from the client. Of course there is always room for improvement, but I notice that I don't get much out of it. That is why I don't think it is worth the investment of time.'	
'I know that there are colleagues [at Mindfit] who do have trouble with this and can benefit from it. So it seems to me valuable if this can be determined per practitioner.'	'I also experience that it does not offer added value in all processes. That's why I'm not 100% convinced and I also notice that I'm not easily inclined to take them away, whereas my experience is that it can work.'	
'Core is: (a) client feels taken seriously, (b) adjustment moment'	'It can also be a stress factor for the therapist.'	
'I think for sure it is an improvement'		
Kind of overall comment	High SCF use centre	Low SCF use centre
Positive	2	0
Ambivalent/positive	1	0
Ambivalent	1	1
Ambivalent/negative	0	2
Negative	1	1

open to participate in research. In the centre with the low use and perceived validity, however, three out of eight therapists (37.5%) dropped out of the study because of long-term absenteeism; whereas in the other centre, no therapists dropped out. In the monthly supervision, the remaining therapists of the low-use centre stated that, because of the absenteeism of their colleagues, their workload had vastly increased, which caused them to often fail to add PCOMS to TAU.

However, when we analyse the therapists comments administered at the end of the patient inclusion period, it is remarkable that increased workload is never mentioned as a reason to neglect SCF in the low SCF use centre. Instead, therapist raised more questions

about the added value of PCOMS itself. It thus seems that the changed organizational climate not only led to seeing adding SCF to TAU as a burden, but also altered the perception of the added value of PCOMS.

These findings are in line with the findings of Unsworth et al. (2012) who found that therapist can be anxious and resistant to use SCF at the beginning. The increased workload in the low use centre also started at the beginning of SCF use, which also disrupted the critical timing of administration as described by Lewis et al. (2019).

These findings are in line with de Jong and de Goede (2015). They found a negative effect between organizational climate and receiving feedback, indicating that the implementation of feedback was disturbing the organizational climate. In that study, the therapist's questionnaire about PO-fit was administered beforehand, but in retrospect, implementation of SCF seemed to have had a negative influence.

The literature review in our introduction indicated that previous research seems to suggest that therapists' attitude towards SCF plays a key role in its use and effect. This attitude towards SCF can be divided in the perceived value of SCF and the commitment to use SCF and is influenced by personal characteristics and by the fit between personal and organizational values. Our research suggests that organizational climate changes negatively influenced the perceived validity of SCF and decreased its use. In future research, it is recommended to frequently monitor the organizational climate when implementing SCF.

In the secondary analyses, higher scores on therapists' promotion focus were associated with higher patients' OQ-scores at intake. This suggests that therapists with a high promotion focus tend to accept patients of higher complexity for treatment. In line with the findings of Gorman et al. (2012), this may be related to positive associations of promotion focus with optimism and with self-esteem and the negative relationship of promotion focus with fear. It is plausible that more optimistic therapists with higher self-esteem and lower anxiety levels will be more likely to include more complex patients in their caseload. As we had no specific hypotheses about this finding, this may therefore be a coincidental finding. We must therefore be careful with our interpretations.

No therapist characteristics were found to influence the outcome of TAU added with SCF. The models with promotion focus with interaction with log10time were retained as the best-fitting model. This is in line with the findings of de Jong and de Goede (2015). They found that therapists with a strong promotion focus achieved faster symptom reduction when feedback was provided. In analogy to these findings, one could expect to find better outcomes on the OQ-45 for therapists with a strong promotion focus, but our model was not significant ($p = 0.119$).

This lack of findings on therapist characteristics may be due to the limited number of patients per therapist or to the fact that in our study, the organizational factors had more influence than specific therapist characteristics. As stated in the introduction, research in this particular field is relatively new and several relevant characteristics are found, but there is still little consistency. de Jong et al. (2012) found effects of internal propensity and self-efficacy de Jong and de

Goede (2015) of organizational factors, prevention focus and promotion focus, and Janse et al. (2023) found an effect of self-efficacy.

All previous studies found an interaction of therapist characteristics, patient factors, organizational factors and the feedback instrument on outcome. These interaction effects are in line with meta-analyses of therapist effects on therapy outcome in general. For instance, Johns et al. (2019) found that the therapist effect increases in more complex patients, and Heinonen and Nissen-Lie (2020) found that therapists' confidence in their own therapeutic skills exhibited a positive effect on therapy outcome in short treatments but had a negative effect in longer-term therapies. This interaction between patient factors and therapist characteristics is also found in the current study. Therapists with a strong promotion focus, pursuing therapeutical success, tend to accept more complex patients for treatment.

5 | STRENGTHS, LIMITATIONS AND FUTURE DIRECTIONS

The naturalistic design of this study helps understanding barriers and facilitators in therapist characteristics when implementing SCF into daily practice. Adding SCF to TAU is too often presented as a quick fix for improving therapy outcomes and more personalized care. Our findings suggest that successfully adding SCF to therapy is challenging and influenced by therapist characteristics and organizational factors. Limitations of this study are the small number of participating centres and therapists, leading to limited generalizability, a low Cronbach's α on one of the subscales of the Therapist Questionnaire and the lack of clarity about which therapist characteristics are most relevant to include in research into the added value of SCF. No significant therapist characteristics effects were found on outcome when SCF was added. All the same, it is possible that different, unmeasured therapist variables may have an influence on implementing SCF.

6 | CONCLUSION

This study provides evidence that the actual use of SCF is determined by the perceived validity of the feedback instrument and organizational factors. When perceived validity of the chosen feedback instrument is high, SCF is more likely to be used, but organizational factors can negatively influence the perceived validity. Future research should focus on further profiling relevant therapist characteristics when implementing SCF and investigate to what extent these characteristics change because of organizational influences. This study provides evidence that long-term involvement in the implementation of SCF is necessary when it is added to outpatient psychological treatment.

AUTHORS' CONTRIBUTIONS

Bram Bovendeerd wrote the study proposal and the manuscript and led the research project. Bram Bovendeerd, Erik de Groot and Jos

de Keijser developed the study design and coordinated the data acquisition. Jos de Keijser, Kim de Jong and Anton Hafkenscheid supervised the research project. Mirjam Moerbeek, Bram Bovendeerd and Kim de Jong developed the data-analysis. All authors provided comments on manuscript drafts and approved the final manuscript.

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CONFLICT OF INTEREST STATEMENT

All authors declare that they have no competing interest.

CONSENT FOR PUBLICATION

All authors have consented to publication of this article.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author, BB, upon reasonable request.

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SUPPORTING INFORMATION

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