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Utilizing Measure-Based Feedback in Control-Mastery Theory: A Clinical Error

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Clinical errors and ruptures are an inevitable part of clinical practice. Often times, therapists are unaware that a clinical error or rupture has occurred, leaving no space for repair, and potentially leading to patient dropout and/or less effective treatment. One way to overcome our blind spots is by frequently and systematically collecting measure-based feedback from the patient. Patient feedback measures that focus on the process of psychotherapy such as the Patient's Experience of Attunement and Responsiveness scale (PEAR) can be used in conjunction with treatment outcome measures such as the Outcome Questionnaire 45.2 (OQ-45.2) to monitor the patient's therapeutic experience and progress. The regular use of these types of measures can aid clinicians in the identification of clinical errors and the associated patient deterioration that might otherwise go unnoticed and unaddressed. The current case study describes an instance of clinical error that occurred during the 2-year treatment of a highly traumatized young woman. The clinical error was identified using measure-based feedback and subsequently understood and addressed from the theoretical standpoint of the control-mastery theory of psychotherapy. An alternative hypothetical response is also presented and explained using control-mastery theory.

Keywords: clinical error, anti-plan, patient plan compatibility, measure-based feedback, control mastery theory

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Therapists are generally not very good at predicting therapeutic change in their patients (Miller, Spengler, & Spengler, 2015) and tend to be unaware of poor treatment response as it develops over the course of therapy (Lambert, 2015). There is a growing body of research supporting the value of using measure-based feedback to assist clinicians in identifying and addressing clinical errors thereby reducing treatment failures and premature drop-out (Berking, Orth, & Lutz, 2006; Safran, Muran, & Eubanks-Carter, 2011). To identify and better understand a potential clinical error, it seems important to capture both the patient's experience of a therapy session (process measure) and the patient's concurrent level of functioning and distress (outcome measure). This case study describes how such a session-by-session feedback approach can be used in the detection and resolution of a clinical error in treatment.

Control Mastery Theory

A fundamental premise of control-mastery theory is that traumatic experiences lead to the formation of pathogenic beliefs and that these pathogenic beliefs form the root of psychopathology (Silberschatz, 2010). Control-mastery theory assumes that patients are highly motivated to relinquish pathogenic beliefs and come to therapy with a plan for how to disconfirm their pathogenic beliefs. These plans are frequently unconscious; nonetheless, they organize the patient's behavior and play an important role in evaluating and filtering information.

According to Weiss (1993), a primary way that patients work on their "plan" in psychotherapy is by actively "testing" the validity of their pathogenic beliefs in relation to the therapist, in the hope that the therapist will act in ways that disconfirm their pathogenic beliefs. When conceptualizing the patient's plan, a control-mastery therapist connects past traumas to current patient difficulties, and views in-session behavior as a way for the patient to test the validity of their pathogenic beliefs. Weiss (1993) posited that the patient's repeated experience of the therapist's "pro-plan" interventions leads to the disconfirmation of pathogenic beliefs.

The Patient's Plan as a Guide for Understanding Clinical Errors

The concept of the patient's plan provides a method for understanding why and how a particular intervention is clinically indicated. Considerable research evidence shows that when therapists provide interventions consistent with the patient's plan, patients achieve enhanced treatment outcomes (for reviews, see Curtis & Silberschatz, 2007; Silberschatz, 2005, 2010). For the purposes of this paper, we are interested in how the plan can aid in understanding errors and forecasting ruptures. According to control mastery theory, when the therapist acts in ways that are not in

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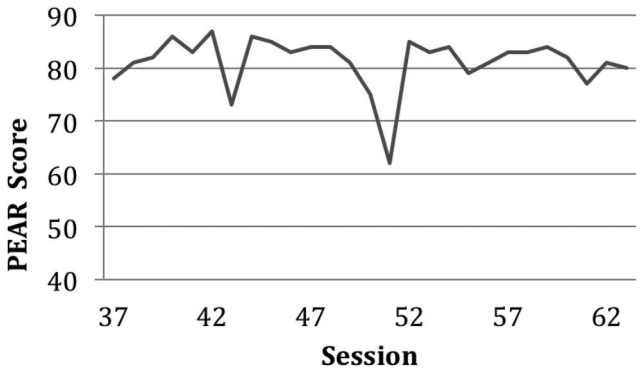

Figure 1. Ellen's reported experience of attunement and responsiveness. Ellen's experience of the therapist's attunement and responsiveness reported on the Patient's Experience of Attunement and Responsiveness scale (PEAR; Snyder & Silberschatz, 2016). Total PEAR score ranges from 0 to 90.

accordance with the patient's plan, the patient's pathogenic belief is confirmed, and the patient does not make progress, and in some cases may deteriorate. This constitutes a clinical error. The specific term for a clinical error in control-mastery theory is an "anti-plan intervention."

Although severe anti-plan interventions and the resultant obvious ruptures in the therapeutic alliance are probably easier to identify, subtler anti-plan interventions may go unnoticed by the therapist and may be more difficult to identify and address. Indeed, in their review of the literature on repairing alliance ruptures, Safran et al. (2011) pointed out that while the term rupture might imply a dramatic breakdown to some, therapeutic ruptures actually vary in intensity from relatively minor events of which participants may be only vaguely aware, to extremely severe breakdowns in the relationship. Subtler ruptures (or anti-plan interventions) may go unnoticed for a number of reasons. First, the patient's experience of an anti-plan intervention may not be visibly obvious in the patient's physical or behavioral reactions. Second, patients may be reluctant to voice dissatisfaction directly to the therapist in sessions, even though the exploration of such negative feelings might be therapeutic (Samstag, Batchelder, Muran, Safran, & Winston, 1998). Third, some anti-plan interventions may result in negative reactions that are not always conscious to the patient. Finally, an anti-plan intervention may go unnoticed when certain interventions may be anti-plan at a certain stage in therapy, but proplan at another stage (Curtis & Silberschatz, 2007). All of these reasons may interact in complex ways contributing to the difficulty of identifying clinical errors in therapy. Nevertheless, it is crucial to identify clinical errors because at best they do not contribute to patient progress, and at worst, they detract from patient progress potentially resulting in treatment failure (Macdonald & Mellor-Clark, 2015).

Case Information

Confidentiality

The patient signed specific informed consent paperwork to participate in research. The patient's name, age, place of origin, occupation, time, and location of therapy have all been disguised to protect confidentiality. Further, specific historical traumatic events experienced by this patient have been omitted, altered, or combined with that of multiple patients to further protect patient confidentiality. The relationship to traumatizers/perpetrators who were trusted adult figures has been altered.

Clinic

The patient was seen for weekly psychotherapy sessions at a low-fee outpatient psychotherapy clinic by the first author (an early career licensed clinical psychologist). Following standard clinic practice, the patient completed the process and outcome measures described below following each session.

Process Measures

Patient's Experience of Attunement and Responsiveness scale (PEAR; Snyder & Silberschatz, 2016) is a self-report measure designed to assess the patient's experience of the therapist's degree of attunement and responsiveness during a therapy session. The PEAR scale contains 30 statements about the patient's experience of the therapy session (e.g., "What my therapist did and said was helpful today"), each rated on a Likert-scale that ranges from 0 to 3 with a rating of 0 = *not at all*, 1 = *slightly*, 2 = *moderately*, and 3 = *very much*. These responses are then summed to achieve a total attunement and responsiveness score. This total PEAR score is correlated with outcome in psychotherapy and may be an important predictor of concurrent session outcome (Snyder & Silberschatz, 2016).

Outcome Measure

The Outcome Questionnaire (OQ-45.2; Lambert et al., 1996) was used as a session-by-session outcome measure to enable the therapist to assess the patient's functional level and change over time. The OQ-45.2 is a psychometrically sound measure with internal consistency reported to be 0.93 and test–retest reliability reported to be 0.84 (Lambert et al., 1996). The OQ-45.2 measures psychological functioning across three domains: symptomatic distress or discomfort, interpersonal functioning, and social role. Responses on the 45 items were aggregated to obtain a total score, with higher scores reflecting greater distress.

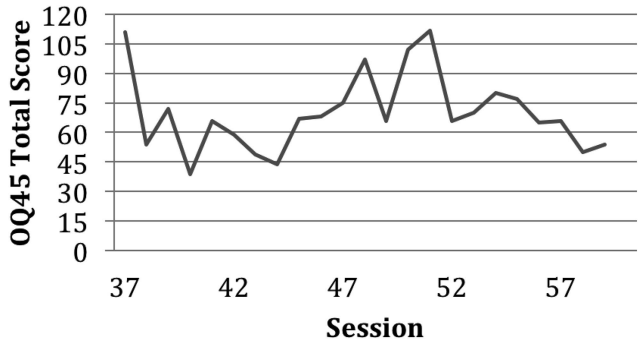

Figure 2. Ellen's reported experience of distress. Ellen's reported overall level of distress on the Outcome Questionnaire (OQ-45.2; Lambert et al., 1996). OQ-45.2 total score ranges from 0 to 180.

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Therapist

The therapist (the first author) was a 32-year-old, white, heterosexual male. He was an early career clinical psychologist who had completed 2 years of training in the control-mastery theory of psychotherapy. At the time the clinical error took place, he had been working in independent practice for 2 years.

Patient

Ellen, a 30-year-old, white, heterosexual, female bank teller, initially sought psychotherapy owing to feeling anxious, depressed, and overwhelmed with life. She reported she felt anxious around men and was worried about working with a male therapist, but nevertheless specifically sought out a male therapist because she wanted to work on this. She felt like she continuously dated men who did not treat her with respect. She felt this was partially her fault because she found it difficult to say "no" to men and as a result she engaged in sex sooner than she wanted, and sometimes even when she did not want to have sex at all. She reported a history of suicidal ideation and said she had been hospitalized 6 months prior for this reason. She denied ever attempting suicide but said she had "come very close."

Ellen reported that she was raised by her mother as an only child and described a fairly unstable home life (frequent moves, school changes, etc.). She stated that her life stabilized between the ages of 11 and 14 when her mother went to work for an attorney, with whom she had become romantically involved. This man proceeded to molest Ellen from ages 12–14. At age 14 Ellen became worried that this man might also molest her next-door neighbor, an 11-year-old girl whom Ellen sometimes babysat. After having a "breakdown" at school, Ellen told her teacher about the abuse. The abuse was reported and this man was arrested. He subsequently dumped and fired her mother. Ellen later learned he was convicted for abusing her and her neighbor, and while he was in prison, committed suicide. After her mother lost her job, she had was unable to find another, which lead to Ellen and her mother being evicted and forced to live in a homeless shelter for 3 months. Ellen said she felt responsible for ruining her mother's life, her 11-year-old neighbor's life, and even her abuser's life.

Psychological processes: Ellen's plan. As a result of her traumatic experiences, Ellen developed four central pathogenic beliefs that she was seeking to disconfirm in psychotherapy: (a) The world is a dangerous place and I must be constantly on guard and hypervigilant against impending catastrophe; (b) I am responsible for the feelings and actions of others; (c) I failed to protect a loved one; and (d) I do not deserve to make my likes and dislikes known, and if I do, it will have catastrophic consequences for me and my loved ones.

Ellen's particular constellation of pathogenic beliefs suggests that she is likely to test the therapist in the following ways in therapy: (a) She may present with a chronically pessimistic and anxious world-view, constantly waiting for the other shoe to drop, and often in crisis mode. She may present situations inviting the therapist to worry excessively about her. Consequently, she might benefit from her therapist remaining empathic yet calm and thoughtful during crisis; (b) She may take great care of the therapist and worry constantly about his well-being. She may benefit from a therapist who does not require care, and who takes special notice when she is taking on excessive responsibility for him or the therapy; (c) Ellen's guilt over failing to save her neighbor and her mother may mean that she feels she deserves punishment. She may be self-critical during sessions, and may unconsciously present situations where the therapist might criticize her, and may even ask the therapist for negative criticism. She may need a therapist who does not buy into this negative view of her, and who even disagrees outright with her when she is self-critical; (d) Ellen's experiences of revealing the abuse involved catastrophic consequences for herself, her mother, and the perpetrator. Therefore, she may view any form of self-assertion as highly dangerous, and will likely have a difficult time voicing criticism of the therapist. She might benefit from an attuned therapist who pays careful attention to her experience during sessions, and a therapist who actively solicits and warmly receives criticism (e.g., displaying confidence in her abilities, inviting the patient to disagree with him and resisting the urge to take over and "play the expert" during therapy).

The Clinical Error

The clinical error, or anti-plan intervention, occurred approximately 1 year into the therapy, during the 51st and 52nd sessions of weekly psychotherapy. Ellen had arrived to Session 51 stating she had been in a car accident several days before. She said no one had been hurt but she had been terrified and could no longer ride in a car. She stated she walked to therapy and began to predict the total catastrophe she was sure would occur.

Ellen: *I can't even look at a car! Why does this always happen to me! I gotta do something about this now! I can't walk over an hour to work every day! I'm gonna get fired! Won't be able to pay rent!. Will get depressed!. Then I'm just gonna kill myself!*

Ellen's dilemma felt very real to me (the first author). She was extremely upset, bordering on panic, and consequently I attempted to reassure her and problem solve by offering suggestions such as riding the bus. However, my suggestions did not seem to calm her and in fact appeared to increase her agitation. Her increased agitation resulted in my feeling an even stronger pull to find a solution to her problem. I found myself looking at this current situation as something *outside* her original reason for seeking therapy. As such, I ceased to consider the situation and her response to it from within the context of her plan, and instead began to think about this as something separate that we (or I) needed to "fix" before we could return to the "real therapy." I had recently attended training on the use of cognitive–behavioral exposure therapy for the treatment of specific phobias such as fear of driving and suggested this form of treatment:

Therapist: *It sounds as if you've developed a phobia of driving.*

Ellen: *I have!*

Therapist: *One thing we might try, is something known as "exposure therapy", do you know what that is?*

Ellen: *Yeah, it means you expose the person to what they're afraid of.*

Therapist: *What do you think? It might be a good idea to jump on this right now.*

Ellen: [laughs] *sounds terrible! but if you think it would help.*

Therapist: *It has been shown to be effective for this sort of thing. I think it might.*

Ellen: *All right, I guess.*

I informed Ellen of the specifics of the treatment, which among other things would involve her riding as a passenger in my car as I drove us once around the block of the relatively quiet residential neighborhood where my office was located. We agreed that we would commence the exposure therapy at our next session, unless she felt differently or changed her mind.

The following session (#52), Ellen stated that she continued to be terrified of riding in cars and had once again walked to our session. I asked if she was still up for our plan. She said, *I guess so*. I reminded her that she could stop at any time and that we did not have to do it today. She said she thought it would be *all right.* We then got into my car and drove around the block one time. Afterward, I parked, and we walked back into my office to debrief. She stated that it had been *difficult but ok.* I reminded her to complete her regular feedback forms following our session and leave them in the drop box in the waiting area, which she did.

Identification of the Error

Following this session, I reviewed Ellen's ratings on the OQ-45.2 and the PEAR scale. On the OQ-45.2 (outcome measure) she endorsed one of the highest levels of distress since beginning treatment (112). On the PEAR scale (process measure) she gave the lowest endorsement since beginning therapy (62). Historically, Ellen tended to give high PEAR ratings (around 80). At our next session (#53), I asked Ellen if I could check in with her about the previous session. I said that I had gone over her ratings on the PEAR scale and that it seemed like last session had been very difficult and that her experience of me seemed to be that I had not been *getting her* as well as I usually did. I told her I was very interested in exploring her feelings, and that I thought they were very important. Ellen immediately told me that the last session had indeed been quite difficult. She reported that being in the car *with me* was what had been difficult, far more difficult than simply *being in a car.*

Ellen: *I've been able to put you in the box of 'therapist' and kept you out the box of 'man'. As soon as we left the office and got into your car, you became a man to me.*

I immediately understood that I had made a mistake and the way in which it was an error with Ellen. I told her that it made perfect sense that she would feel this way and that I had really *missed the boat on this one.* I thanked her for her candid, honest response. Ellen immediately waved off my apology as unnecessary and began attempting to take the blame for her discomfort during the previous session. She stated that it had really been her fault; that I had thoroughly explained the treatment, and that she had agreed to it. She reminded me that I had told her repeatedly that she could stop at any time and that she had not done so. I interrupted Ellen, and said that I wondered if something else was going on right now. I said that I had found her description of the way her experience of me had changed from "therapist" to "man" incredibly insightful. I added that I believed it was important to consider this process here in therapy. I brought up the multiple instances over the past year where she had discussed feeling like she could not assert herself, particularly with men. We discussed how she had repeatedly blamed herself after each of these instances as well.

This led to a further discussion of how her experience with me during the previous session was a repetition of a familiar situation where she feels paralyzed and unable to stop something that she truly does not want to happen. I took accountability and responsibility for having failed to be more attuned to her experience and said that as her therapist, it was my responsibility to protect her and provide interventions that felt right and helpful. There was some protest on Ellen's part to this, as she said she did not think it was fair to expect me to read her mind. I said that I did not think it was so much a matter of reading her mind as much as it was a matter of paying close attention to her experience. We discussed her historical experiences of molestation as well as sexual experiences with men who chose not to pay attention to her experience. Indeed, she and I had previously discussed that an attentive sexual partner, while not always able to tell *exactly* what is going on for the other, can at least pick up on instances when the other person is not happy about what is going on, or not "into it."

As the therapist, my personal reaction to the error was a combination of embarrassment, guilt, and remorse at having committed what in hindsight seemed like a foolish error. I ultimately sought consultation and support regarding this error. However, at the time, I felt like a neophyte who had acted hastily, and was disappointed in myself. I also felt some amount of defensiveness associated with the thought that I had checked in with Ellen several times before and during the intervention. However, I had returned to thinking about this situation within the context of Ellen's plan, which allowed me to recognize my defensiveness as a form of countertransference, and a test. One thing I knew about Ellen was that she was prone to taking on excessive guilt and responsibility. This view of the event served to mitigate my own guilt and in fact led me to consider that I needed to model for Ellen, my own capacity to experience an *appropriate* amount of guilt and accountability for my actions, without overdoing it, or completely slamming myself. Indeed, to completely "fall on my sword" would likely have felt intolerable for Ellen owing to her own tendency toward excessive responsibility. This formulation guided my above-described response. Ellen's feedback ratings immediately following this session indicated that she experienced me as far more attuned and responsive to her needs (PEAR = 85), and showed a marked decrease in her level of distress (OQ-45.2 = 61).

Recommended Alternative Intervention

On reflection, this clinical error ultimately provided an opportunity to engage in a meaningful rupture-repair process. Nevertheless, my initial intervention was clearly an error, and not one that I would want to make again. Even though she had been physically unharmed in the car accident the week before, it had understandably frightened Ellen and had activated her pathogenic beliefs that catastrophe is always about to happen; the world is a dangerous place, and that she must be constantly on guard. Consequently, she felt panicked and began catastrophizing during our session. In hindsight, what Ellen needed from me was to feel validated and empathized with in her fear,

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and for me not to buy into her panic and her catastrophic vision of the future. An example of a better approach to Ellen's statement that her fear of driving would ultimately lead to catastrophe might have been:

Therapist: *That accident was terrifying.*

Ellen: *It was! I just don't know what I'm going to do.*

Therapist: *It's hard for you to imagine ever feeling safe in a car after something like that.*

Ellen: *I just don't know how I could ever!*

Therapist: *I am so relieved that neither you nor anyone else was injured.*

Ellen: *Someone could've been.*

Therapist: *You're absolutely right. I'm so relieved that was not the case. You've experienced a lot of tragedy in your life, haven't you?*

Ellen: *I have. Sometimes I feel like I just couldn't take one more thing.*

In this hypothetical alternative intervention, the therapist disconfirms Ellen's pathogenic belief that the world is one big catastrophe waiting to happen by not accepting the invitation to join her in the view that "something has to be done right now!" Instead he validates Ellen's legitimate fear over a frightening experience, while remaining calm and thoughtful, acknowledging his own feelings of relief at the reality; that Ellen was in fact unharmed. The therapist does not tell Ellen that she *should* feel relieved. He merely expresses and models his own ability to feel relief. The therapist also acknowledges that this frightening event occurred within the context of many other tragic historical events in Ellen's life. This alternative intervention would likely be proplan for Ellen because the therapist resisted the pull toward crisis and the idea that catastrophe was eminent. It was this feeling of crisis that, in the case of the clinical error, led me to feel like I "have to do something now!" Unfortunately, I gave into this feeling, leading to my hasty suggestion that we try exposure therapy, recreating a familiar situation with a man where Ellen felt unable to assert herself and say "no."

Implications

Clinical practice. This case example shows how measure-based feedback was used to identify and address a clinical error in Ellen's treatment, thereby allowing for a clinically meaningful repair to the relationship. Providing therapists with feedback regarding their patients' experience of attunement and responsiveness might be particularly helpful for agreeable and compliant patients like Ellen, and could be used to guide therapists to make adjustments in subsequent sessions (Haskayne, Larkin, & Hirschfeld, 2014). The reported benefit of measure-based feedback in the context of Ellen's plan formulation fits with the literature demonstrating that tracking progress session-by-session helps therapists to predict and identify therapy ruptures (Safran et al., 2011), increases patient retention, and enhances treatment outcomes (Berking et al., 2006). Also, measure-based feedback on therapy process and outcome could potentially be used to improve supervision (Swift et al., 2015). Indeed, the first author used feedback in this way during subsequent consultation regarding the clinical error described in this article. Similarly, trainees could be instructed to prioritize cases for supervision if a patient goes off-track, allowing supervisors to join with trainees in analyzing the reasons for predicted failure (Friedlander, 2015).

Finally, while the above patient formulation was based on control-mastery theory and the clinical error could be described as a behavioral exposure technique applied within a broad psychodynamic approach, the patient's feedback response indicates a clinical error that transcends theoretical approach. The patient's experience of attunement and responsiveness is a trans-theoretical concept that can be used to evaluate therapy process and outcome regardless of theoretical orientation.

Research. Future research should investigate the utility of feedback measures such as the PEAR scale in the identification and correction of therapeutic errors. Using measure-based feedback to link the patient's experience of attunement and responsiveness to therapeutic outcome goes some way toward correcting psychotherapists' blindsidedness (Macdonald & Mellor-Clark, 2015) and can be used to guide therapists to become more responsive to their patients, by predicting, identifying, and responding to clinical errors, with the aim of ultimately improving therapy outcomes (e.g., rupture repair strategies for therapists, Safran et al., 2011).

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