

“One step up, but not there yet”:

Moving towards developing a feedback-oriented family therapy.

Peter Rober¹
Karine Van Tricht²
Rolf Sundet³

Abstract

As research points to a strong link between the quality of the therapeutic alliance and the effectiveness of psychotherapy, also family therapists should be reflect on ways to improve the quality of the alliance. The systematic use of client feedback can be a rich resource as a response to the complexity of the alliance in the family therapy setting. While a feedback-orientation can give evidence of the effectiveness of therapy, in this paper the focus is on the ways in which the client’s systematic feedback can contribute to an optimization of the therapeutic alliance. A new feedback instrument is presented to be used especially in family therapy sessions in which children are involved: the *Dialogical Feedback Tool* (DFT). It is illustrated how the feedback of clients on their experiences in therapy can help therapists to better attune to the family members’ experiences and expectations about therapy.

¹ Clinical psychologist and family therapist at Context, UPC K.U. Leuven, Belgium. Professor at the Institute for Family and Sexuality Studies, Department of Neurosciences (University of Leuven, Belgium).

Address for correspondence: peter.rober@med.kuleuven.be

² Clinical psychologist and family therapist at Context, UPC K.U. Leuven, Belgium.

³ Professor at University College of Southeast-Norway, Drammen, Norway.

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The Smits family is in family therapy because the parents are worried about their 8-year-old daughter Emma. She is described as being aggressive and difficult. At the end of the second session, invited to give feedback on the session, the 11-year-old son Fred says, “we are one step up, but we are not there yet.”

This remark puzzles the therapist, and he curiously asks Fred to help him understand what is the meaning of his words...

Based on years of psychotherapy research with randomized controlled trials (RCTs), we can conclude that psychotherapy works (e.g. Lambert, 2013). Overall we can say that about three-quarters of our clients are better off than those who did not use psychotherapeutic services. The question then can be posed, what accounts for psychotherapy success? What exactly works in psychotherapy? There is a lot of controversy around this question (e.g. Norcross, Beutler, & Levant, 2006). Still, although psychotherapy research does not lead to simple answers and it sometimes seems that any point of view can be backed up by scientific evidence (Wampold & Imel, 2015), there is substantial evidence suggesting that the non-specific factors are important to explain the efficacy of psychotherapy (e.g. Duncan, Miller, Wampold, & Hubble, 2010; Lambert, 2013). In particular, it seems that the quality of the therapeutic alliance is the most robust predictor of therapeutic change (e.g. Norcross & Lambert, 2011; Wampold & Imel, 2015), especially if the quality as experienced by the clients is taken into account (Bachelor & Horvath, 1999). The most important advice for practicing therapists seems to be: be flexible and avoid one-size-fits-all therapies (Orlinsky, Rønnestad, & Willutzki, 2004; Norcross & Lambert, 2011; Norcross & Wampold, 2011). An effective therapeutic alliance results from a process of relational attunement (e.g. Angus & Kegan, 2007) between therapist and the client. A condition for such a process to emerge in

the session is that the therapist is prepared to be open for the feedback of the client and to tailor the therapeutic relationship to the needs and preferences of the specific client (Norcross & Wampold, 2011).

In order to optimize such a process of attunement, several authors have recommended that practitioners would routinely monitor patients' feedback about their experiences of the therapy relationship and ongoing treatment, as this can lead to increased opportunities to reestablish collaboration and improve the relationship (e.g. Duncan, Miller, Wampold, & Hubble, 2010; Norcross & Wampold, 2011). In feedback-oriented therapy, session-by-session feedback from the clients is gathered with the use of simple, valid and reliable instruments. This feedback is immediately delivered to therapist and client(s) in order to fine-tune the therapy when necessary. This perspective of feedback-oriented therapy represents an important development in the field of psychotherapy (e.g. Duncan, Miller, Wampold, & Hubble, 2010; Lambert, 2010; Lutz, De Jong, & Rubel, 2015). A feedback-orientation can give additional evidence of the effectiveness of psychotherapy (e.g. Lambert, 2013; Pinosof, Tilden & Goldsmith, 2016). Research based on systematic client feedback on the progress of therapy compliments RCT research in a crucial way. It is focused on the specific unique client; while RCT research only gives us information about average group effects and does not help clinicians to answer the question *"How should I treat this unique client sitting in front of me?"* In that way, research based on systematically gathered client feedback in therapy may be useful to bridge the gap between research and clinical practice (e.g. Pinosof, Goldsmith, & Latta, 2012; Lambert, 2013).

Feedback-oriented practice is also important in another respect: It does not only give additional evidence on the outcome of therapy, but research shows that it is associated with better outcome (e.g. Anker, Duncan, & Sparks, 2009; Sapyta, Riemer, & Bickman, 2005). Furthermore, it leads to dropout reduction and a better dose/effect ratio (e.g. Shimokawa,

Lambert, & Smart, 2010). These good effects of using client feedback can probably best be attributed to the optimization of the therapeutic alliance. For instance, research suggests that it increases motivation and empowerment of clients (De Jong, Timman, Hakkaart-Van Roijen, Vermeulen, Kooiman, Passchier, & Van Busschbach, 2014). Because of the early detection of problems in the alliance, it facilitates a better working alliance (e.g. Lambert, 2010). In this article we will focus on this second aspect of feedback-oriented therapy: the opportunities it offers to optimize the therapeutic alliance. This is particularly important in multi-actors settings like a family therapy session.

THE CHALLENGE OF THE ALLIANCE IN FAMILY THERAPY

While the therapeutic alliance is important in all forms of psychotherapy, specifically in a family therapy setting therapeutic alliance is particularly complex (e.g. Pinsof & Catherall, 1986; Friedlander, Escudero, Heatherington, & Diamond, 2011). It could be said that the setting of family therapy demands a unique conceptualisation of the therapeutic alliance (e.g. Sprenkle, Davis, & Lebow, 2009; Friedlander, Escudero, Heatherington, & Diamond, 2011) because a family therapy session can be characterized as a multi-actor dialogue filled with tensions that are enacted by the family members (Seikkula, Laitila, & Rober, 2012). These tensions usually surface already in the first session. To give one example: While in individual therapy the starting point of the therapeutic process is an individual who chooses to go in therapy to address a problem he/she experiences, in family therapy usually the different family members' willingness to engage in therapy differs. Often they don't agree on the existence of a problem, or on the definition of the problem or on the necessity of family therapy to address the problem. Friedlander, Escudero, Heatherington and Diamond (2011) in this context mention for instance that sometimes one family member feels like a *therapy hostage* (p.93): "I don't want to be here, but if I don't come there will be consequences".

The therapy hostage in family therapy is often a child or a young person, as typically the parents want therapy and the children come along, with some degree of compliance.

A lot has been written about difficulty of mobilizing the voices of children in family therapy (e.g. Rober, 1998, 2008; Sori, 2006). Forming an alliance with children or youngsters often is difficult for family therapists. Qualitative psychotherapy research shows that children experience therapy as a challenge and that being heard is very important to them (Strickland-Clark, Campbell & Dallos, 2000). Furthermore, research suggests that, if the therapist does not specifically attempt to engage with children, children don't succeed in taking the conversational floor from an adult in a family therapy session (O'Reilly, 2008). Based on their interviews of children after their first family therapy session, Moore & Bruna Seu (2011) recommend that therapists should find good ways to explain their approaches to the children, in order to establish a fruitful therapeutic relationship with them and in order to make them feel heard (Strickland-Clark, Campbell & Dallos, 2000).

There is another reason why the therapeutic alliance in a family therapy setting is particularly complex. Therapeutic alliance in family therapy is not limited to the relationship between the therapist and the family members, but extends also to the relationship between the family members themselves (e.g. Friedlander, Escudero, Heatherington, & Diamond, 2011).

Friedlander, Escudero, & Heatherington (2006) speak about a *shared sense of purpose* (p. 125). This refers to the family members' history together and their allegiance that precedes the development of the alliance with the therapist. As the alliance with the therapist develops, it is the therapist's goal to also enhance the family's shared sense of purpose.

FEEDBACK-ORIENTATION IN FAMILY THERAPY

Given the complexity of the therapeutic alliance in family therapy, a feedback-orientation of the therapist is of paramount importance (Haber, Carlson, & Braga, 2014; Tilsen & McNamee, 2014). A few years ago we started to experiment with different feedback

instruments. We were looking for ways to optimize the therapeutic alliance in our family therapies.

Working as family therapists in a feedback-oriented way is a challenge as a lot of the traditional feedback instruments are in fact instruments for individual therapy, like Duncan & Miller's PCOMS, which included the well-know and widely used SRS and ORS (Pinsof, Tilden & Goldsmith, 2016). Some feedback instruments have been developed from an integrative perspective and can be applied in individual, couple and family therapy: the STIC for instance (e.g. Pinsof, Breunlin, Russel & Lebow, 2011). There are some instruments that are specifically developed with a systemic perspective in mind, like SCORE (Stratton, Bland, James & Lask, 2010), but this instrument is in fact not meant as a feedback instrument but as an outcome measure (Pinsof, Tilden & Goldsmith, 2016). Furthermore, instruments like the STIC and the SCORE, while they have been tested for their psychometric qualities, in terms of validity and reliability, are heavy instruments that are quite clumsy to use within the complexity of the multi-actor setting of a family therapy session. With one notable exception (Haber, Carlson, & Braga, 2014), we did not find any publications of feedback-oriented psychotherapy in which the specificity of the family therapy session was taken into account. Also, while some feedback instruments have a version for children and adolescents, (e.g. Duncan, Sparks, Miller, Bohanske, & Claud, 2006), we found that –in order to really invite the child's voice in the session- an instrument that was more specific for children was needed. That is why we developed our own instrument, the *Dialogical Feedback Tool* (DFT), which will be introduced later in this paper.

In order to illustrate our approach, we will describe part of the therapy with the Smits family in *Context*, a small outpatient family therapy team that's part of the *University Hospital of Leuven* (UPC KU Leuven), Belgium. The first (X) and the second authors (Y) were the therapists. The first two sessions of the therapy will be discussed in detail. Z, the third author,

working at the *Norwegian Ambulant Family Section* (AFS), commented on this work from a distance and had the role of supervisor of the project. His expertise on the usefulness of feedback instruments as conversational tools (Sundet, 2014) inspired the first two authors from the very beginning of their project on feedback-oriented family therapy. Throughout the descriptive case study we will demonstrate how the systematic use of client feedback can be a rich resource for family therapists as a response to the complexity of the therapeutic alliance in the family therapy setting. Client feedback can help the therapist to become better attuned to the family members' experiences and expectations about therapy (Haber, Carlson, & Braga, 2014; Tilsen & McNamee, 2014).

Case The Smits family (1)

Father wanted to go into therapy with his family. He talked to his wife and she agreed that something needed to be done. Then, he talked to the children. 11-year-old Fred listened but he didn't say much. "OK," was all he said. 8-year-old Emma protested: "There is nothing wrong with me. Why should I go to the therapist?" Father corrected: "We will go to the therapist together, because we fight too much, and we want us all to be happy instead of angry and sad."

This illustrates the typical complexity of the motivation to come to family therapy. Some family members (most often the parents) are worried and they think that family therapy might be useful for them. Other family members may be less worried, or are reluctant to go to family therapy for other reasons. It is clear that this multiplicity in expectations and motivations is a challenge for the family therapist who wants to develop a strong therapeutic alliance with all family members.

DEVELOPING A FEEDBACK CULTURE

One of the first things we learned when we started to work in a feedback-oriented way is that choosing the right instruments is just one aspect of the challenge. The biggest challenge

however is the development of a culture of feedback (Duncan, Miller, & Hubble, 2007): an atmosphere in which the family members are invited to give feedback and to contribute to the therapeutic process. In our way of working, the development of a feedback culture in the therapy starts from the very first moment of contact between the therapist and the client. Often this first contact is by telephone, when the person seeking help is offered an appointment for a first session. Already in such a telephone conversation the feedback orientation of the therapist should be briefly introduced as an important part of the standard care that the family can expect.

Case The Smits family (2): Father's telephone call

Father called us to make an appointment and asked how he could introduce family therapy to his daughter. I (Y) told him I understood what he meant. I agreed that the girl needed an explanation of what family therapy is and what she could expect from the session. I offered him our definition of family therapy: "A family therapist is someone who talks with family members when someone in the family is worried about something. And then we talk and listen to what everybody has to say."

This way to describe family therapy is very respectful to the family members who hesitate to come to therapy, as the main idea is not that there is an objective problem, but rather that the worries or concerns of someone is the starting point for therapy. While we validate the ones who are worried in the family (usually the parents), we also leave room for other perspectives as we make it clear that therapy doesn't start from an official diagnosis or a clearly defined problem.

Case The Smits family (3): Father's telephone call (continued)

... Our description of what family therapy is seemed to reassure father. Then he inquired who should attend the first session: "Do all family members have to be present?" he asked.

I answered: “Everyone is welcome and in general the more people the better, as all family members can help us to better understand what is going on. So we invite all family members. But of course we don’t know your family. You are the experts of your family. So we propose that you as a family decide who is going to be present in the session. We can talk more about this when you are here.”

This was acceptable for the father.

This is an example of the way in which we –from the first contact onwards- try to empower the family members and give them a voice. While we don’t deny our expertise as family therapists, we want to emphasize their expertise and invite them to talk with us from an agentic position in order to make therapy a useful process for them.

DIALOGICAL FEEDBACK INSTRUMENTS AS CONVERSATIONAL TOOLS

When we started to work in a feedback-oriented way, we experimented with the *Outcome Rating Scale (ORS)* (Miller, Duncan, Brown, Sparks, & Claud, 2003) and the *Session Rating Scale (SRS)* (Duncan, Miller, Sparks, Claud, Reynolds, Brown, & Johnson, 2003). We were certainly charmed by these instruments, especially in the way they could be used as conversational tools, rather than as measuring instruments (Sundet, 2017). Although we experienced the SRS as an excellent and useful instrument to obtain client feedback on the alliance and therapy process, we decided that we wanted to develop our own instruments specifically tailored to working with families and children. Our main goal was to invite the family members (adults, as well as youngsters and children) to give us feedback about their experiences in the session, in order to open space for dialogue about their experiences and expectations. In this article we will present one of the feedback instruments we developed: the *Dialogical Feedback Tool (DFT)*.

The DFT (see Attachment) is mainly developed to be used in therapies with families with young children, but the instrument can also be used for adolescents, young adults and adults.

There are two versions, the "*Memes*"-version (see Attachment) and the "*Smileys*"-version. It is a simple instrument. There are two figures representing characters that were present in today's therapy session, with for each figure there is a speech bubble. The left figure is looking grim, the right figure is looking happy. Each of the family members is invited to fill in the speech bubble with whatever in their view these characters might think or say about the session.

At the end of each session (approximately 10 minutes before the end of the session) all family members are invited to fill out the DFT. By means of the pictures of a smiling and an unhappy face we make room for ambivalent thoughts and feelings. Furthermore, first mentioning what was appreciated, often makes room to also mention things that were less than optimal or that were displeasing. The family members are allowed to fill in the DFT however they want. Parents often write some words or short sentences. Children may prefer to not only use words but to also add colours, symbols and drawings to provide feedback in their own way. Whatever family members fill out, it is appreciated by us as therapists and welcomed with curiosity and enthusiasm. When the DFT's of the different family members are completed at the end of the session, the therapist takes a moment to review them briefly. Friendly and curiously he/she promises the family members that in the next session issues that are raised in the DFT's will be addressed.

Case The Smits family (4): The DFT at the end of the first session

We had a first session with the Smits family. Father, mother, Emma and Fred were present. At the end of the session we invited them to fill out the DFT. Emma liked the opportunity to give feedback with the DFT. She playfully accepted the invitation to share with us, with her parents and her brother how she had experienced the session.

Emma's DFT looked like this⁴:

<Figure 1: Emma's DFT (first session)>

⁴ We translated the words she wrote and copied her drawings.

Predictably, in her DFT Emma repeated that therapy was not a good idea. But on the other hand she wrote it was a “super idea”.

This was Fred’s DFT after the first session:

<Figure 2: Fred’s DFT (first session)>

This was important feedback for us. It taught us that Fred was grateful and that hope was growing for him that therapy might lead to meaningful change in the family. Furthermore, we learned that positive change for Fred would be change in the direction of being more like friends in the family. That reminded us of what father had said; that there was too much anger and sadness in the family. What bothered us in Fred’s feedback was that he had the feeling that he had not had the chance to say what he wanted to say: “It was never my turn.” It seems that he had been waiting during the session until it was his turn to speak, but in the end had never had an opportunity to speak. This was surprising for us; we had tried so hard to make room for everybody’s voice, and now it seemed that we had not succeeded. It was clear for us that this was important feedback and that in the second session we had to talk with the family about it. Furthermore, we told ourselves to give more room to Fred to speak in the next session.

Also the parents filled out a DFT. While mother was positive and hopeful about the session, especially her remark about Fred’s not feeling part of the conversation struck us. For one thing, it reiterated Fred’s feedback of not having had the chance to participate in the session. This emphasized the importance of our resolution to talk about it with the family. Furthermore, it struck us that mother said that Emma maybe was too much the focus of the session. This is surprising in the sense that Emma was the so-called identified patient and the main source of the parents’ worries. Father’s feedback on the DFT was brief. Two words. Still, both words are important. The smiling face said “Finally”, and the grim face “Too short”. We understood “finally”

as expressing hope and relief; while we thought that “Too short” conveyed that there is more work to be done and that the family will need time because there is so much going on.

In our way of working, before the beginning of the next session we review the DFT's the clients completed in the previous session. We reflect on the way the family members' feedback might be helpful to orient the therapy in new directions. In preparing the next session, while we try to understand as best as we can all the feedback from the family, usually we choose one or two themes from the feedback as a potential starting point for the next session. In particular, the most critical or surprising feedback may be useful or interesting to start the session with.

Case The Smits family (5): The review of the DFT's before the 2nd session

What surprised us was Emma's feedback that therapy was a super idea, on the one hand and a bad idea on the other hand. It might be interesting to ask her to explain in what sense it was a good idea and in what sense it was a bad idea. But rather than burdening Emma with questions about what she meant exactly, we were happy with her response to our invitation to give feedback. We saw it as a first hesitant step towards participating in the therapy. As our main focus we chose Fred's feedback that he had not been given the chance to participate. Usually we opt for critical feedback, as this can help us to orient the process in a direction that is useful for the family. Furthermore, it shows the family that critical feedback is welcomed and valued by the therapists. We invite the family members in a warm and curious manner to elaborate on the critical remarks they made in the DFT's, and we try to understand the criticism as good as possible.

At the beginning of the session, the DFT's the various family members filled out in the previous session are spread out on the table. Despite our own hypotheses or questions, we

give the family members space and opportunity to focus on their own reflections first. We ask questions like: "Do you have any comments?", "What do you notice?" or "What surprises you?" This way of starting the session links the new session to the previous one and helps the family members to focus on what is most meaningful for them, in terms of process (e.g. the therapeutic alliance) and in terms of content (e.g. themes to talk about in the family).

Case The Smits family (6): The start of the 2nd session

We presented the filled out DFT's to the family and asked them to comment.

There was not a lot they wanted to add:

"For us, it seems the growing hope was the most important feedback we can give," father said.

We said we appreciated their feedback. Then we addressed Fred and thanked him especially for his feedback about not having enough space to participate and say what he had to say. We apologized to him and we promised him that we would take care to give him enough room to speak this session.

Further on in the session the focus was on anger and sadness; and how sometimes one can lose control over one's feelings. The family members talked about conflicts in the family and how they dealt with it. The parents talked in a very engaged and animated way, so did the children. Both children made several drawings that helped them to explain some of the things they wanted to talk about. Everybody seemed to enjoy the pleasant and playful atmosphere in the session. At the end of the session the family members filled out the DFT.

In their DFT's the parents showed concern about the participation of the children:

"Emma needed time to defrost", "Fred participated more", ... Both were pleased with the way the session had been going. Father wrote "Today a lot of things surfaced" and mother wrote "interesting ideas about conflict strategy".

The DFT's of the children were especially interesting. The way Emma filled out the DFT reflects the atmosphere in the session. She added long hair to the smiling character on the right and she said "That's me. That is how I really think about the session". She had written "It was top, top, top" in the speech bubble. Fred's feedback was also positive (see figure 3). While after the first session he had written "I hate waiting", this time he wrote "time went by very quickly".

<Figure 3: Fred's DFT (second session)>

We were especially intrigued by Fred's feedback "...we are one step up, but we are not there yet." I (X) asked him to help me understand his words: "Can you tell us a bit more about what you mean?" Fred said "Wait," and he took a drawing he made in the course of the session. It was the drawing of a house.

<Figure 4: Fred's drawing of a house (second session)>

Fred then explained that his house has several floors. Below, it's called the 'Boos verdieping' (trans. Anger-floor). That's the floor where they have been for a long time, he said. The second floor is the 'Hulpzaam verdieping' (trans. Helpfulness-floor), the third floor is the 'Vriendelijke verdieping' (trans. Friendly-floor) and all the way up there is the 'Lief verdieping' (trans. Sweet/love-floor).

Now we understood what Fred meant when he wrote on his DFT "...we are one step up, but we are not there yet." In the second session Fred's hope had further increased. This was his way to express that he felt the therapy was going fine. Also in later sessions he would refer to the house with the floors as a metaphor for the family's connection and the progress of the therapy. For instance at the end of the third session in his DFT he noted: "Through our talks we have made good progress. We are on the next floor!"

DISCUSSION

Family therapy practice is very complex, and writing about what happened in a therapy session always is a simplification. Some things are described while other things are neglected. In our description of the therapy with the Smits family we wanted to illustrate that it is interesting to systematically make room for the different family members' feedback and that the DFT is a useful instrument to do so. While we think it is not possible to be atheoretical, we think that an instrument like the DFT can be used across therapy theories as it is focused on a common therapy factor like the alliance.

Feedback instruments as conversational tools

The *Dialogical Feedback Tool* (DFT) is not a measuring instrument. A measuring instrument is directed at securing quantitative information about process and/or outcome. Its psychometric properties can be calculated. The information a measure instrument generates can be the basis of graphics and software applications. The DFT does not generate quantitative information. It is a conversational tool. In that sense, strictly speaking, it does not fit the *Routine Outcome Monitoring* (ROM) perspective (Tilden & Wampold, 2017). It is not an instrument that is aimed at monitoring progress in therapy in terms of outcome. Rather it is an instrument that is supposed to contribute to the creation of a dialogical space (Rober, 2015; Rober 2016) in which the family members and the therapist can together reflect on the process of therapy and in particular on the therapeutic alliance in all the complexity of such an alliance in a family therapy session.

What characterizes conversational tools is that they don't give answers. Rather, they offer opportunities for questions and for respectful curiosity. For example, the responses of the Smits family on the DFT were always explored through the therapists' questions and were never given any definite interpretation outside of the conversations with the family members. Furthermore, the aim of a conversational tool is not knowledge or decisions, but conversations about attunement in the therapeutic relationship and the need to re-orient the

therapy process. In the attunement with the family members the therapist's flexibility and his/her openness to change are central. Feedback instruments as conversational tools are focused on optimization of the collaboration between the family and the therapists (Sundet ea, 2016). A central part of this collaboration is that we therapists are part of the dialogue and also contribute with our perspectives and ideas.

The family members' agency

Being feedback-oriented as a therapist first of all is about making dialogical space for the feedback of clients. This feedback may be positive or it may be critical. Especially when the feedback is critical it is helpful for the therapist (Duncan, 2010). From a cybernetic perspective critical feedback actually can be seen as a positive feedback mechanism creating change, if necessary through crisis. In contrast, affirmative feedback or compliments merely function as negative feedback mechanisms establishing or maintaining homeostasis (Bateson, 1979).

However, for clients it is not easy to be critical (e.g. Hill, Thomson, Cogar & Denman, 1993; Rennie, 1994). Only if the client feels safe enough he/she will take the risk to present critical feedback to the therapist (Rhodes, Hill, Thompson & Elliott, 1994). And it is precisely this critical kind of feedback the therapist should be interested in as it can help him/her to orient the therapy in a better direction. Therefore it is important that we as therapists invest in creating a safe space in which the client can be sure that his/her feedback is respectfully invited and welcomed.

Inviting the client's feedback implies a therapeutic approach that may be at odds with the dominant discourse in the mental health field that views the client's perceptions as suspect because they may be distorted by psychopathology (Bohart & Tallman, 2010). The dominant discourse also sees clients as patients that need to undergo some treatment. However, therapy is more than the administration of intervention techniques on the clients as inert objects

(Bergin & Garfield, 1994). Research shows that the patient's contribution to the process is a crucial factor in therapeutic change (Assay & Lambert, 1999; Duncan & Miller, 2000). Clients are active self-healers, rather than submissive recipients of an intervention (Bohart & Tallman, 2010). The agency of the family members is central from the start of the therapy. The therapist engages with the family members as active, committed and responsible persons focused on finding ways to better manage their lives together. The therapist assists them with his/her knowledge and professional expertise, but especially by encouraging and supporting them in their self-healing efforts (Bohart & Tallman, 2010).

Relational attunement as central process

While most psychotherapy research focuses on the importance of static characteristics of individuals (e.g. age, gender, diagnosis, ...) in correlation to the outcome of therapy (Sprenkle, Davis, & Lebow, 2009), therapy is a complex process that is not ruled by the causal relationships between static characteristics of the treatment, therapist and clients (e.g. Lambert, 2013). Rather, in the therapy process there is a moment-to-moment interaction between the therapist and the clients. Putting the spotlight on the therapist, for instance, we can see that he/she tries to tailor the therapeutic relationship to the different family members in a process of relational attunement: the therapist is sensitive to what the clients experience and he/she is responsive.

The word *attunement* refers to the tuning of a guitar or another musical instrument; Not only with the aim that it sounds beautiful, but also with the aim that it is in tune with other instruments of the band or the orchestra to make it possible to play together. The concept is often used in the psychological sciences within the frame of attachment research, and refers to the intersubjective sharing of affective states of mother and baby (e.g. Stern, Hofer, Haft, & Dore, 1984; Hughes, 2007). It is considered the central process of attachment. Like a mother and an infant create their interpersonal world together, the therapist and the client too, through

their dialogical interactions, create their world together. Also within a dialogical frame attunement is a central concept (e.g. Linell, 2009). The process of attunement assumes differences between interlocutors and asymmetry in the dialogue; for instance, between mother and infant, or between therapist and client. Attunement then is the process of gradually, through the exchange of small verbal, but even more importantly, also bodily signals, building trust and finding a way to go on together.

In such a process the therapist is as responsive as possible to the different voices in the family (Tilsen & McNamee, 2014). He/she also tries to make more room in the session for the voices that are rather faint and difficult to hear (for instance, the voices of children). He/she is in particular attentive to voices of hesitation (Rober, 2002), as such voices often express the family members' reservations about therapy as well as their critical reflections. The family members' feedback is valued and used by the therapist as a means to orient the therapy process in directions that are more useful for the family.

Limitations

While we are enthusiastic about the DFT and about feedback-oriented family therapy in general, we also experience limitations due to the choices we made when we developed the instrument and our protocol of its use. While the instrument and the way we use it is meant to open space for dialogue and aims to invite family members to share their feedback with the therapists and with each other, it is clear that we sometimes don't reach these goals. For instance, although children often use the DFT as an invitation to make drawings, the instrument favors writing. This may leave discourage younger children who feel less comfortable with writing to share their experiences through the instrument. Furthermore, the DFT faces in the Memes version are white, which limits its usefulness. Furthermore, experience has taught us that the DFT is not so useful as an online instrument. The filling out

of the tool as a paper and pencil instrument in the session, in the presence of all family members is in our experience necessary in order to use the full potential of the instrument.

These are just a few of the limitations.

The clients' feedback to feedback oriented work

The case of Emma and her family is one of the seven pilot cases we used to test our protocol and our instruments. In these cases author X en Y formed a co-therapy team and all sessions were videotaped using two cameras. All sessions were transcribed verbatim. These transcripts are now being used for qualitative analyses (mainly content analyses of the client's feedback) and case studies. While the case study in this paper is one of them, it is clear that we could not report on all these studies and analyses in this paper.

We also interviewed several families of these families about their experiences with using feedback instruments (not only the DFT, but also our other instruments which are introduced in other publication, for instance Rober, 2017). These interviews revealed, as can be expected on the basis of the literature (e.g. Lambert, 2010), that clients generally like the use of feedback instrument on the condition that they are brief and relevant to the concerns that bring them to therapy. Furthermore, they prefer that the feedback they provided is discussed with the therapist and used to optimally adapt the process to their preferences and goals. Interestingly, for a lot of clients the feedback of the other family members is very meaningful and at the end of the session usually they are very curious of the feedback the others are giving. The discussion of the feedback in the next session is experienced by them as an important aspect of the family therapy process.

Feedback-oriented therapy as a responsibility

Feedback-oriented therapy is often framed within an ethic of accountability. Like all professionals, also therapists are accountable to the community that supports them financially, and that is counting on their services. It is expected that therapists prove their accountability

with hard data based on measurements and controls. They have to demonstrate that the psychotherapy services they offer actually work and that they contribute significantly to the quality of life of their clients.

Our practice of feedback-oriented family therapy does not fit well within such a frame of accountability. We prefer to frame it within an ethic of responsibility. However, the distinction made between an ethic of accountability and one of responsibility may not be readily understood. What is exactly the difference between an ethic of accountability and an ethic of responsibility? In an ethic of accountability there is always a triangle: there is the service user (the client), the professional (the therapist) and the controlling agent (the manager, the politician, ...) to whom the professional is accountable. While they can be useful for the optimization of the therapeutic alliance, it is specifically within the interaction between the professional and the controlling agent that objective outcome measures is crucial: With objective measurements the professional can prove that he/she does a good job and that it is a good idea for the policy maker to invest in his/her services.

In an ethic of responsibility there is no such triangle. Instead of being accountable to a controlling agent, the dialogue between the family members and the therapist is crucial: the family members suffer and the therapist tries to be responsive. While accountability is etymologically connected to "counting", responsibility is connected to "respond" or "response" (Partridge, 1961). "Response,..., grows with the capacity to respond, that is responsibility" (Haraway, 2008, p. 71). Haraway (2008) also talks about responsibility as being "...response-able.." (p. 71). Fitting with the concept of *relational attunement* we use to characterize the process of the therapeutic alliance, we can say that when we are talking about the ethics of responsibility we are in fact referring to a *relational responsibility* (McNamee & Gergen, 1999) that emerges within a continuous process of human becoming.

Although nowadays it is impossible not to be affected by the ethic of accountability that is so dominant in the field of mental health care, we have chosen to orient our work as therapists primarily by an ethic of responsibility, in line with the thinking of Levinas and Derrida (e.g. Larner, 2004; 2016; De Haene & Rober, 2016; Rober & De Haene, in press). Such an ethic has to do with our choice to be responsive to our clients (Larner, 2004), and be open for their feedback. General knowledge about the average client may be helpful in order to make the right policy decisions, but it is insufficient for the practitioner confronted with the particular suffering of the unique client who just told his/her story. In the face-to-face encounter with the client the therapist has to learn to speak the language of the other (Larner, 2016): it is only through the conversations and dialogues with that specific, unique client in front of us that we get a sense of what might be helpful in this single case. It is here that we find the use of feedback instruments handled as conversational tools clinically relevant and indispensable. While measurements with valid and reliable instruments do make sense within an ethic of accountability, within the perspective of responsibility, reliable measurements are less important as our focus is on the client rather than on the controlling agent. Therefore we prioritize the collaborative process of dialogue and exploration that therapist and clients are involved in, facilitated by feedback instruments used as conversational tools. If within an ethic of responsibility the therapist is accountable to someone, it is to the client, not to an outside controlling agent. To the contrary, orienting the therapy in response to the controlling agent's expectations, in disregard of the client's perspective, would be considered an act of violence within a Derridean perspective (De Haene & Rober, 2016; Larner, 2016). Noteworthy in this context is that research seems to suggest that the outcome of working in a feedback-oriented way is influenced by the therapist's attitude and by his/her commitment to use the client's feedback: it seems that working in a feedback-oriented way only makes sense if it is the therapist's choice (Lutz, De Jong, & Rubel, 2015). A feedback system is only

useful if the therapist is committed to work with the client's feedback; if he/she is open for the feedback and if he/she is prepared to reorient the therapy if necessary. This illustrates that working with the client's feedback in therapy is a responsibility of the therapist, rather than a form to be filled out, or a box that has to be checked.

While there are clear differences between the ethics of accountability and the ethics of responsibility, these are not necessarily mutually exclusive. It is possible, for instance, to use quantitative measures in order to monitor progress and proving effectiveness, while also using qualitative measures to allow clients a voice about their experiences in therapy. Such complimentary use of feedback instruments, while risking being a burden on the clients who have to fill in a lot of questionnaires, offers a lot of opportunities for the therapist as well as for the family to make therapy an enriching experience.

CONCLUSION

In this paper we wanted to illustrate that it is interesting to systematically make room for the client's feedback and that the DFT is a useful instrument to do so. We wanted to share our enthusiasm about working in a feedback-oriented way, to point out some of the challenges (e.g. how to make room for different voices, how to work in a child friendly way, etc.) and to show some of the ways of addressing these challenges. We used the case of Emma and her family as an illustration of our way of working, although we don't know whether the therapy would have turned out similarly with or without the use of the DFT.

As therapists we are mobilized by the client's suffering to try and be helpful. RCT research reassures us that we are (in general) helpful. A feedback-oriented way of working helps us to attune to the particular family with its unique suffering. This puts us in a frame of an ethic of responsibility; rather than within an ethic of accountability. Still, the ethic of accountability and the ethic of responsibility may not always be in opposition. Providing effective therapy for clients is both ethically accountable and responsible. But who assesses the effectiveness

of the therapist? The difference between the ethic of accountability and the ethic of responsibility is that in an ethic of accountability the effectiveness of the therapy is assessed with the dialogue with the controlling agent in mind; while within the ethic of responsibility the attunement between the family members and the therapist is the therapist's first concern. In our way of working, the latter has primacy.

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Figure 1: Emma's DFT (first session)

These 2 characters were present in the therapy session today...

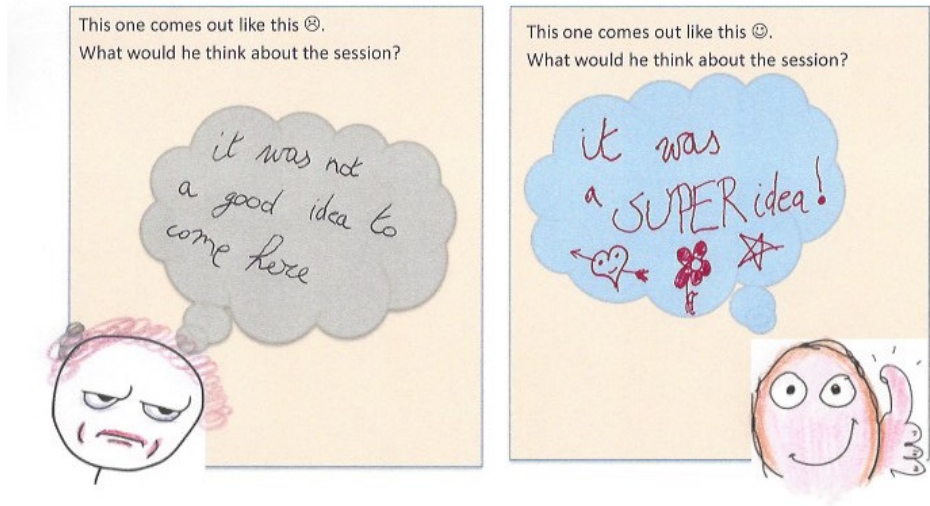


Figure 2: Fred's DFT (first session)

These 2 characters were present in the therapy session today...

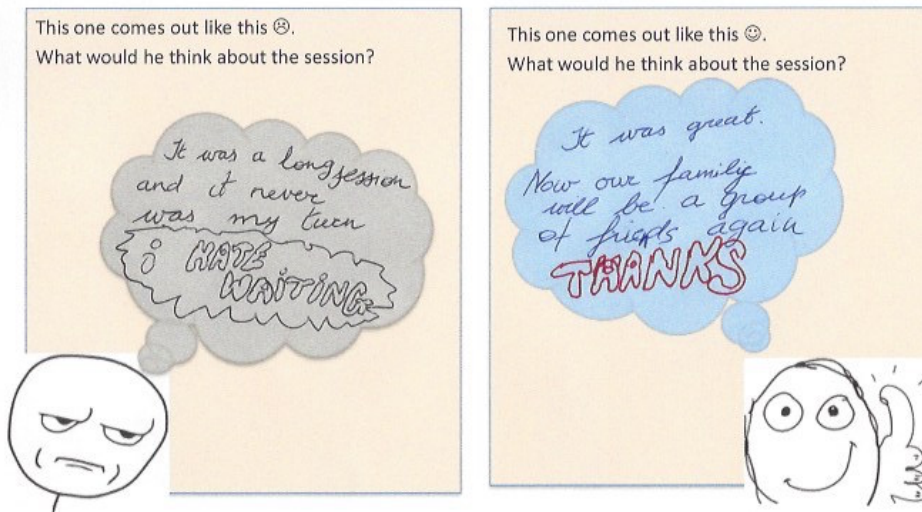


Figure 3: Fred's DFT (second session)

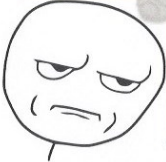
Name: FRED
Date: 2nd SESSION

Dialogical Feedback Tool
(DFT; Rober & Van Tricht, 2015)

These 2 characters were present in the therapy session today...

This one comes out like this ☹.
What would he say about the session?

*time went
by very
quickly*



This one comes out like this ☺.
What would he say about the session?

*It was fun
and we are
one step up
but we are
not there
yet*




Figure 4: Fred's drawing of a house (second session)

