How to make the most of routine outcome monitoring (ROM) a multitude of clinical decisions and nuances to consider

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COMMENTARY

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How to make the most of routine outcome monitoring (ROM): A multitude of clinical decisions and nuances to consider

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Abstract

Routine outcome monitoring (ROM) involves the use of patient-reported standardized outcome measures to monitor progress throughout the course of treatment, followed by feedback of the patient's scores to the therapist. The potential benefits of ROM have been established, however, from our own experiences, we know that the implementation in clinical practice can be challenging. We therefore wanted to explore in more detail exactly how we might be able to apply ROM in difficult clinical contexts. The inspiring case illustrations in this issue of Journal of Clinical Psychology: In Session highlight the heterogeneity in ROM systems, and the way in which ROM can be used in treatment. Just as there are many ways of interpreting a survey data-point, there are also many ways in which ROM may be used to complement the treatment and supervision. Whether or not ROM is implemented may partly be determined by clinic policies and routines, but there remain a multitude of clinical decisions that require careful consideration by the individual therapist. To complement the evidence supporting the benefits of using ROM, further empirical support and clinical guidance is needed on how exactly therapists are to use ROM in their work and how ROM may be used in evidence-based practice. We make suggestions for additional uses of ROM for deliberate practice, and teletherapy practice, and look toward novel ways of assessing progress in the near future.

KEYWORDS
deliberate practice, ROM, therapeutic failures, video

1 | INTRODUCTION

Several terms have been used to describe the practice of using patient-reported standardized outcome measures to monitor progress throughout the course of treatment, including routine outcome monitoring (ROM), clinical feedback, patient feedback, progress monitoring, and measurement-based care. Importantly, the measurement is followed by immediate, frequent, and systematic feedback of the patient's scores to the therapist. Numerous research teams have developed measures and computerized systems to help collect and make sense of the data by providing normative feedback on patient progress. Though various definitions appear in the literature, implementing ROM commonly includes three core elements: (1) regular monitoring of relevant outcomes (e.g., symptoms and functioning) using repeated administration of patient self-report measures; (2) therapists who use this data to inform treatment decisions; and (3) share measurement data with patients and/or supervisors.

In the introduction of this issue of Journal of Clinical Psychology: In Session, we wrote about the research evidence that supports the use of ROM in clinical practice. We emphasized how ROM research is moving from effectiveness-research toward the challenges of implementing ROM, highlighting the need for case illustrations on how ROM may be usefully applied. Now, considering our reading of the case studies we realize we cannot speak of the implementation of ROM, as if it were one thing. The authors provided a wide range of clinical examples of how ROM may be used to aid treatment, illustrating the use of different ROM systems, in a variety of international contexts and treatment settings, across different theoretical approaches, and patient populations. The studies thus highlight the versatility of ROM across treatments (e.g., cognitive behavioral therapy [CBT] and dialectical behavioral therapy [DBT]), services (e.g., outpatient and inpatient), ROM systems (e.g., OQ-analyst and Trier Treatment Navigator), as well as perspectives on its usefulness (from a beneficial tool to not reflecting a patient's experiences). Just as there is no one way of interpreting the ROM data, there is also no one way of implementing ROM in clinical practice.

As regard the application of ROM when multiple patients are involved, Terje et al. illustrate the implementation of ROM within a family therapy context (Mary & Ed and their two children). They reported on the Systemic Therapy Inventory of Change system and illustrated how the discussion of session-by-session outcome measures positively impacted the treatment at an individual level and systemic level. They, for example, reported that ROM appeared to serve as a mediating tool for the couple to interact and become curious about themselves and each other, and continually informed and helped refine the working hypothesis related to the prioritized/presented problem. This implicates that ROM may be usefully applied within the context of a family treatment, as a tool that facilitates communication and mentalization, and helps to focus the therapeutic task. This paper provides an example that, unlike previously thought, ROM may not only be used in individual treatments, but may also be very useful in treatments that involve multiple patients, such as couples and family therapy.

Ogles et al. (2022) qualitatively examined an interview with a patient called John, to gain his perspective on the deterioration indicated by the outcome questionnaire (OQ)-Analyst (OQ-45 measure) in a brief treatment at a university counseling center. The patient reported several benefits of the treatment and appeared relatively unphased by the increase in self-reported symptom scores over time. This suggests that for some patients, an increased symptom rating may not reflect increased suffering per se but may reflect a patient's increased awareness of their internal experiences (e.g., Dimaggio et al., 2020). It is thus important to be open to possible inconsistencies between symptom scores and the subjective experience of the patient.

Gomez et al. (2022) also used the OQ system but used a briefer version of the OQ measure (OQ-30). They reported on a Cognitive Integrative therapy for Sandra, a patient who suffered from obsessive compulsive disorder. They noted that the use of the OQ-30 in treatment and supervision helped the patient and therapist to identify the

different factors that could hinder treatment progress, and thus helped to build a more collaborative relationship. This case illustrates how the use of ROM might facilitate the achievement of agreement on the task and goals of treatment, not only in treatment but also in supervision.

Schaffrath et al. (2022) describe Ms Daun's CBT treatment for depression in an outpatient clinic. They used several patient self-report measures (BSI/PHQ-9/GAD-7) as part of a ROM system called the Trier Treatment Navigator. In their case illustration they highlighted the importance of treatment personalization in the form of choice of self-report measures and making treatment changes because of the data collected. The therapist gained confidence by tracking the patient's progress relative to clinical benchmarks and progress expectations and was able to identify a potential risk of dropout early on in treatment. The patient also benefited from the ROM feedback in that the patient was able to actively engage in therapy and was able to gain a new perspective on her problems. This suggests that ROM allows both therapist and patient to be more actively engaged in the treatment process and changes over time.

Demir et al. (2022) also report on a CBT treatment within a university outpatient clinic. Sarah, a patient who suffers from social phobia, is asked to complete a short transdiagnostic scale for symptom severity, including motivational involvement, intersession process, and suicide warning via the Greifswald Psychotherapy Navigator System. They highlight that discussing the feedback with patients seems to support a more collaborative process in therapy, which proves especially important for those patients who may be reluctant to share more personal information or feel easily ashamed. Similar to the case study by Schaffrath et al. this case illustration highlights the benefits, not just of the collected datapoints, but the collaborative process of tracking itself. The use of ROM is an intervention; a communication that the patient's experience is center point, and that the therapist aims to adjust the treatment to the individual needs of the patient.

Finally, Hooke et al. (2022) describe the application of a session-by-session brief Distress Index and Well-being index within a hospital setting and an outpatient setting. They describe the case of Tracey, who is offered DBT for her borderline personality disorder symptoms. In their clinical report they highlight that ROM helps to demonstrate the value of the substantial progress made by this patient, to herself, to the hospital staff, and to funding agencies. This highlights an important benefit of ROM, in that it helps to make the patient's progress more concrete, and thus makes it easier to communicate about treatment gains to people outside the treatment process.

All in all, these case illustrations highlight the potential therapeutic benefits of using different types of ROM. All case studies mentioned that the therapist explicitly shared the ROM results with the patients, however, none of the studies explained exactly how this was done (e.g., "discussed the lack of progress with the patient" in [Gomez et al., 2022]; "the therapist showed the profile" in Gomez et al., 2022). Although Terje et al. (2022) mention that their therapists were trained and supervised in how to implement ROM, the other studies did not refer to therapist training in the use of ROM. This is especially relevant because in the recent meta-analysis by de Jong et al. (2012, 2021), training in the implementation of ROM was a moderator of the efficacy of ROM. The studies in which therapists had received training in the respective feedback system had larger effect sizes than studies in which no ROM training was provided. The training set up for therapists might vary widely across services and countries and may affect the results of implementing ROM.

Some of the papers reported on the discussion of ROM in supervision (e.g., Hooke et al., 2022; Schaffrath et al., 2022), but how exactly data was shared, discussed, and reflected on by the supervisor remained relatively unclear. One of the studies reported that ROM was required (Schaffrath et al., 2022), the other studies did not explicitly mention if therapists and/or patients were free to choose to use ROM, or if this was mandated by the clinic policies.

None of the case studies described a psychodynamic approach. This might not be surprising, because most aforementioned literature on ROM has occurred within the context of relatively short-term manualized treatments, such as CBT (e.g., Levy et al., 2020) and the unique psychodynamic clinical context remains largely unexplored. That said, a handful of studies report on the implementation of ROM in psychodynamic treatments (e.g., Brattland et al., 2018; Errázuriz & Zilcha-Mano, 2018; Tzur Bitan et al., 2018), Notably, some of these studies alluded to discomfort

and resistance experienced by PDT therapists and supervisors (e.g., Bantjes et al., 2018; Lemma et al., 2011). It is likely that psychodynamically oriented therapists and their supervisors are more skeptical of ROM, and symptom measurement more generally. The idea of measurement and quantifiable answers may be seen as contradicting the psychodynamic goal of creating space and tolerance for the unknown (Aafjes-Van Doorn & Meisel, 2022). However, ROM does not need to be restricted to symptom measurement, as several ROM systems also measure treatment processes, and these types of ROM systems might fit better with a psychoanalytic way of working than symptom measurement alone.

Although most studies focused on the benefits and potential of ROM, some authors expressed more critical perspectives on ROM. For example, a deterioration on the symptom measures might not suggest a treatment failure (Ogles et al., 2022). Gomez et al. (2022) highlight the discrepancy between the patient's verbally reported progress during the sessions and the results of the self-reported outcome measures and wonder how well standardized measures can correctly reflect a patient's experiences and progress. A particular outcome measure might not provide the most useful feedback, because it might not capture information that would help the psychologists understand the reasons for treatment. Higher levels of symptoms might reflect higher levels of self-awareness, and not improvement or deterioration per se (Knapp et al., 2012). This case study highlights the limitations of using standardizd outcome measures that might not reflect the patient's experience or therapeutic goals per se. For example, a brief screening measure of depression might not be a relevant outcome measure for a patient who is suffering from anxiety or trauma-related distress.

Terje et al. (2022) similarly state that not all the questions in a standardized ROM questionnaire fit perfectly to the individual patient. This raises the question if the items of a ROM measure are required to fit perfectly with the patient's presentation in that moment, or whether is sufficient for a ROM measure to have an acceptable coverage to be able to function as a thermometer of the progress made by the patient. For example, most generic ROM instruments capture common mental disorders like anxiety and depression well but will not perform equally well with some specific disorders, such as psychotic disorders, eating disorders, or autistic spectrum disorder. In the latter situation, it might be better to use a disorder-specific instrument to measure treatment progress.

2 | IMPLEMENTING ROM: A MULTITUDE OF CLINICAL DECISIONS

Most of the cases presented in this issue demonstrate how the use of ROM can facilitate positive change. The therapists of Mary, Sandra, Tracey, Sarah, and Ms Daun were able to make therapeutic use of the ROM results. We can learn a lot from the theorized post hoc understanding of the authors on how ROM contributed to the effectiveness of the treatment. That said, we know from experience,—and from reading John's case (Ogles et al., 2022)—that interpreting ROM is not that easy. To complement these inspiring case descriptions, it is important to reflect on the nuances of the clinical decision-making process along the way. The exact way ROM was used in each of these cases appears to be based on a multitude of implicit clinical decisions, that was not explicitly mentioned by the authors, but that warrant more nuanced discussion.

Maybe the most imminent question that arises is: What exactly does it mean to apply ROM in our treatments? Specifically, how, and when should we introduce the patient to ROM? How often and when should we collect ROM measures? How do we decide which ROM system, and which measures to use with which patient? What should we do when a patient does not complete the measure as requested? How often, when and with whom should we review the ROM data? What should we share with our patient? The individual scores, the trajectories over time, or the full screen of the feedback system? How do the different ROM systems compare with each other, are they all equally effective for all patients? How can a supervisor best review the ROM data of our patients? Similarly, the clinical interpretation of the data that is gathered by the ROM measures also warrants careful reflection. Does a decrease in symptoms always mean an improvement, and if not, how do we ensure ROM is not used as an evaluative tool for therapist competency and effectiveness?

3 | THE IMPLEMENTATION OF ROM: A CONCERTED EFFORT

These ROM success stories almost make it seem like ROM is easy to initiate. However, it is important to realize that these case studies took place within the context of an existing clinic, a larger frame that facilitated the implementation of ROM. Many have written about the difficulties with implementation of ROM in a therapy or training clinic (e.g., Aafjes-Van Doorn & Meisel, 2022; Cooper et al., 2019; de Jong, 2016; Mellor-Clark et al., 2014; Minieri et al., 2015; Peterson & Fagan, 2017). It requires an organizational change that includes an intensive process of training, engagement, monitoring, and service support, in which common problems are preempted as much as possible, and genuine feedback on the implementation process is provided. The successful implementation of ROM likely requires flexibility, time, and effort from therapists and patients alike, as well as a thorough implementation model (see quality implementation framework; Meyers et al., 2012), such as described by Mellor-Clark et al. for the CORE Outcome Measure (CORE-OM) in the National Health Service in the United Kingdom (Mellor-Clark et al., 2014).

Several strategies might help clinics overcome these challenges of implementing ROM. First, clinics should be prepared to try multiple versions of ROM to determine which systems best meet their needs and should collect and critically consider feedback from therapists, supervisors, and patients about the application process (Cooper et al., 2021). It may even be important to provide therapists with opportunities to try out different ROM systems because choice in the type of ROM system likely improves their sense of agency, engagement, and attitudes toward ROM. For example, some therapists may prefer a longer, multidimensional ROM measure that also captures topics like psychosocial functioning and treatment processes such as the therapeutic alliance (i.e., when working with personality disorders), whereas others may prefer a short unidimensional instrument (i.e., when working with major depression disorders in a depression clinic). In addition, there is no reason why only one ROM measure should be used in a particular treatment. It might be clinically relevant to supplement standardized measures with idiosyncratic measures that help to track the patients' unique treatment goals. Not only patients but also therapists appear to prefer individualized outcome measures like progress on treatment goals (i.e., "going outside alone" in a patient with panic disorder) over standardized outcome measures (Jensen-Doss et al., 2018). In their large-scale survey, Jensen-Doss et al. found that nearly all therapists who used standardized progress measures (91.2%) also used individualized tools, which means that we might not have to choose one or the other and could benefit from using both. Also, these metric evaluations should be uses as a tool that is supplemented with qualitative information on the rich, lived experiences of individual patients (McLeod, 2010).

Moreover, it may be useful to expose therapists to the use of ROM early in their career. It is good to see that both Keiser et al. and Schaffrath et al. (2022) have implemented ROM systems in a training clinic setting. It may also be helpful to become aware of ambivalent feelings around its implementation, especially since research suggests that therapists' attitude toward ROM is predictive of their active use of the measures in treatment (de Jong et al., 2016). Open reflections on the pushes and pulls toward the implementation of a ROM system are few and far between (for an exception, see Aafjes-Van Doorn & Meisel, 2022). Just like with other new advancements in the field (video-recording of therapy sessions; Aafjes van-Doorn et al., 2022; teletherapy; Békés et al., 2022) therapists' experience of using ROM over time likely will reduce their anxiety and discomfort. The trainees' experiences in training clinics likely affect their ROM adoption later (Batty et al., 2013; Unsworth et al., 2012) and thus offers a valuable starting point.

4 | THE IMPLEMENTATION OF ROM: CONTEMPORARY CLINICAL TRAINING

In addition to the clinical uses of ROM as highlighted in the case studies, there are two other ways in which ROM may be used which is particularly fitting with contemporary clinical training: deliberate practice (DP), and evidence-based practice (EBP).

4.1 | ROM and DP

Recent research suggests that therapists who obtain better patient outcomes engage in more DP than the therapists whose patients demonstrate lower levels of change (e.g., Chow et al., 2015; Goldberg et al., 2016). DP refers to individualized training activities designed to improve specific therapeutic skills through focused review, repetition, and successive refinement. More specifically, a DP exercise may consist of watching a video of a challenging moment in a psychotherapy session while tracking ones' inner experiences and avoidance responses. DP may, for example, include the practice of tolerating silence, reflecting meaning, asking about suicide risk, or assigning homework. For the practice to truly be deliberate, experiential exercises of microskills must be followed by immediate feedback (Bennett-Levy, 2019; Lewandowsky & Thomas, 2009). This means that the effective use of DP thus requires a capacity for self-evaluation; an openness to be guided by results. As Terje et al. (2022) touch on in their case illustration, ROM-data are very useful for the purpose of monitoring therapist's facilitative interpersonal skill development (Anderson et al., 2016) within the concept of "deliberate practice" (Chow et al., 2015; Clements-Hickman & Reese, 2020).

The use of ROM aids the process of DP in two ways. (1) ROM helps to identify particular sessions that might warrant a closer look. It might be hard to identify what to work on (McLeod et al., 2021). Some areas of growth might arise from personal self-reflection on situations in therapy that were experienced as difficult. Therapists might also use implicit or explicit feedback from the patient, facilitated through ROM. For example, a low alliance score after a session might indicate that the therapist was mis attuned or that the therapist was less skilled in dealing with the situation at hand; (2) When tracking patient-reported outcomes regularly, a therapist may be able to see if a particular change in technique, or improved skills, actually influences the patient. It is not always easy to know when you have practiced a skill enough, when you become proficient, or sufficient in a certain skill, or when it might require further work (McLeod et al., 2021). Thus, ROM may help the therapist to gain feedback on what skills to work on and when a skill has been sufficiently mastered. This way, therapists do not have to rely on the words of colleagues, a supervisor, or their own inner critic to self-evaluate their skills but can be guided by patient-reported outcomes.

When measuring outcomes with ROM for a period of time and keeping track of those results together with some characteristics of the cases, we can also start to see patterns in which patients we get good results with and which patients we struggle with (also see Miller et al., 2020). For example, if I (K. d. J.) notice in my ROM outcomes that I struggle with patients who are dominant, I could use DP exercises that target setting boundaries with dominant patients. After DP, I could use ROM again to see if I improved outcomes with these patients.

Similarly, I (K. A. V. D.) have used ROM alliance data to identify sessions with relatively lower alliance ratings. I noticed that that were also the sessions in which patients were crying. When I showed my recordings of these sessions in supervision, it became clear that I was uncomfortable with the overwhelming sadness of my patients, and tended to withdraw, look away and change the topic. To improve my therapeutic skills, I identified several video clips in which patients cried, and practiced more empathic responses that allowed me to stay with the patient's emotional experience, until my level of discomfort had reduced sufficiently. Indeed, in subsequent sessions the alliance ratings appeared to be higher, even in sessions where my patients cried.

As we can see from the second example, the use of ROM together with the review of videorecorded therapy sessions, may provide useful information about the session-by-session change in a patient's experiences of symptoms and alliance, and the nature of the therapists' interpersonal interactions that could potentially be targeted through DP exercises (Rousmaniere, 2016). A therapist may share their patient-reported outcome data in conjunction with these recorded sessions—with a supervisor. A video may be easier to translate into specific skills if it can be augmented with continuous feedback about what the therapist is or is not doing, and a safe space to reflect on and analyze the patient feedback received.

This careful review of treatment videos and outcome measures might be commonplace for therapists in training, but it is a lot less common among seasoned therapists. The unwarranted over-confidence of experienced

therapists means that they are less likely to be motivated to take actions (e.g., obtain and use critical feedback) that would enhance their actual expertize (Pintrich, 2003). Many therapists do not yet collect objective treatment information and do not know how to use the information that does exist to improve their performance over time (Tracey et al., 2014).

4.2 | ROM and EBP

Given the benefits of ROM, it is not surprising that ROM is increasingly being recognized as a critical component of Evidence-Based Practice (EBP; APA Presidential Task Force on EBP, 2006; Dozois et al., 2014; The Joint Commission CTS, 2020). EBP can be described as a three-legged stool that rests on a combination of seeking empirical evidence to support the use of specific treatments, clinical judgment and expertize, and patient preferences (Spring, 2007). Based on clinical guidelines, there is knowledge of which treatments are most likely to be effective for the average patient or most patients, but there is still a substantial number of patients (30%–50%) that does not benefit from treatment. ROM can provide information on whether the treatment is progressing well, and thus, whether the evidence-based intervention that was selected for treatment also is effective in the context of this specific patient. This is where clinical judgement and patient preferences become relevant. As was highlighted by Ogles et al. (2022) and to some extent also by Gomez et al. (2022), a signal from ROM that a treatment is not-on-track, does not always mean that the treatment selected is not effective for the patient. There might be several reasons why patients report higher levels of symptoms in treatment over time. For example, patients may change in their own awareness of symptoms over time, they might develop skills that helped them to cope with their symptoms, or possibly, the constructs that were important for their sense of improvement in therapy might not have been captured by the ROM measure.

The use of ROM may also play a role in emancipating the patient in therapy. For example, in shared-decision making and value-based care models, ROM results are actively discussed between the patient and the therapist and result in mutual decisions about the course of treatment. Research suggests that if applied well, this can lead to fewer decision conflicts and better treatment outcomes (Metz et al., 2018). This approach may not fit equally well with all treatment orientations, but it would fit well with most humanistic experiential therapies and cognitive behavioral therapies.

The therapist together with the patient need to make a balanced evaluation of the scores in the wider context of the ROM results. This includes demographic (e.g., being a member of a minority group) and clinical factors (e.g., having personality disorder traits), as well as process factors (e.g., motivation and working alliance) influencing the ROM results. Based on this wider evaluation, the case conceptualization may need to be adapted accordingly. In some cases, this will lead to adaptations in treatment, whereas in others the therapist and patient will need to find a way to work with or around certain factors that are unlikely to be changed (de Jong et al., in press).

In some settings there might be a risk that therapists start to rely too heavily on ROM scores. For example, in training clinics trainees might be at risk of becoming dependent on ROM feedback systems for their decision making (Fernando & Hulse-Killacky, 2005; Levine et al., 2017). Many trainees may have low self-efficacy at the start of their career and ROM might feel like an objective measurement that can reassure them in their uncertainty on how and when to act. It is important that a good balance is found in supervision, in which supervisors both recognize that a patient being not-on-track substantially increases the odds of negative treatment outcomes (Lutz et al., 2006), and are aware that scores are open to multiple interpretations in the context of the case and to actively include this context in clinical decision making. On the opposite end, there might also be therapists who disregard ROM completely because they associate it with an overly focus on EBP and manualized treatments. It is thus important to clarify that ROM does not equate research evidence, but rather is a clinical tool that has shown to be effective clinically, and that can be used for service evaluation and research purposes.

5 | WHAT IS NEXT?

Given the robust evidence that using ROM in treatment is useful, it is no longer a question of IF we need to implement is, but rather of HOW we do this in the best way in a specific setting. Therapists are often reluctant to implement ROM, and as a result, we need to develop better ways of convincing therapists of its usefulness, and also adapt ROM systems better to the needs and preferences of therapists and patients. The OQ and other commonly used ROM systems such as the Partners for Change Outcome Management System and CORE-OM only represent the initial iteration of progress monitoring tools more broadly. These current ROM systems might become outdated, but the concept of progress monitoring in psychotherapy is here to stay. In recent years, novel ways of assessing progress, and advanced feedback measures have been developed that are minimally disruptive, adaptive to each patient, and integrated into electronic health record systems (Boswell et al., 2015; Lewis et al., 2019), and that may make our current ROM feedback systems look old-fashioned. First, several new online monitoring tools are being developed that allow for individualized ROM self-report scales (Langkaas et al., 2018). For example, Norse Feedback (NF), is a relatively novel clinical feedback system developed by the Førde Hospital Trust and standardized for the Norwegian population (McAleavey et al., 2021). Different from other feedback systems, the NF aims to combine the advantages of standardized measures with idiographic approaches, to create a person-adapted system for clinical feedback (Jensen-Doss et al., 2018). To do so, the set of items that are included in the measure evolves throughout therapy, based on an algorithm that adapts the number of items to individual patients' responses. As therapy progresses, patients will receive fewer items on domains where their scores are low but continue to receive the full set of items on domains where scores are high.

Another innovative example of ROM is the Synergetic Navigation System that uses ideographically tailored items to map dynamic transitions (fluctuations that are not picked up in standardized assessments (e.g., Schiepek et al., 2016; Schiepek et al., 2019). This monitoring system starts from a detailed case formulation that is, coconstructed by patients and therapists. Based on this case formulation, associations between the most important characteristics of a patient's problem, mental and social functioning are represented in an associative network model and the variables of interest are determined together with the patient and translated into the items of an idiosyncratic online questionnaire which is then rated by the patient. As such, this method considers which clinical goal is aimed for and how it can be defined and evaluated in a clinically valid way, and allows to capture complex, individual patterns of change. These types of individualized progress measures are more flexible than standardized measures and likely are more focused on domains that are relevant to individual patients (Ashworth et al., 2009; Doss et al., 2005). As such, individualized progress measures may be more sensitive to detecting change (Lindhiem et al., 2016; Sales & Alves, 2012; Weisz et al., 2011). The use of individualized progress measures also considers individual context, emphasizes patient goals and priorities, and may promote patient engagement in treatment by eliciting their perspective on problems and progress (McGuire et al., 2014; Sales & Alves, 2012). All in all, these types of individualized ROM solutions thus appear to fit much better within psychodynamic conceptualizations of the treatment process and outcome.

Moreover, the teletherapy movement due to the COVID-19 pandemic, as well as technological advancements in nonintrusive high-quality video recordings, mean that the practice of recording therapy sessions is becoming more standard. And with regard to outcome tracking session-by-session, that is great news. In this current day and age, with scientific developments and interdisciplinary research that integrates basic psychological science, with machine learning and computer science, we will likely soon be able to track our patients' outcomes in a more comprehensive, valid, and precise way (Aafjes-van Doorn et al., 2020). Tracking facial expressions and physiological measures of change might give an additional impression of the patients' change over time. This means that in the near future we may not need to use standardized self-report scales but can automatically learn from recordings of the patient's interactions how they currently are functioning. At the same time, self-report will always be valuable to some extent in our field, as it reflects the perspective of the patient on how treatment is progressing. But more

importantly, the process of ROM and feedback is not so much about the way of measuring, but more about what you do with that information in the treatment.

6 | CONCLUSION

We are convinced that monitoring patients' progress can aid our therapeutic work. However, the question is how exactly we go about the use of ROM. And perhaps more importantly, how the information obtained should be interpreted. Whether or not ROM is required may partly be determined by clinic and national policies and routines, but regardless of the treatment setting, there are a multitude of clinical decisions that require careful consideration by the individual therapist. Thus, in addition to the outcome research supporting the benefits of using ROM, further empirical support and clinical guidance is needed on how exactly therapists are to integrate ROM in their work. In the meantime, therapists may want to continue to write about their experiences with using ROM. Especially, it might be helpful to complement these success stories of the use of ROM (as reported in the case examples in this issue), with examples in which the implementation of ROM did not go smoothly. This would allow for even more clinical learning and reflection to take place (e.g., Kealy et al., 2021; Snyder & Aafjes-van Doorn, 2016). Although Ogles et al. report on a case in which the patient's perspective was not well represented by the outcome measure trajectory, the patient did not appear to be burdened by the ROM measurements. We can imagine that there might also be cases in which the measurement process or the ROM results trigger a rupture in the therapeutic work, that may or may not be able to be repaired. But of course, it could also be that the rupture is taking place and that the ROM measurement is crucial in signaling this to the therapist.

By continuing to reflect on the therapeutic subtleties and nuances of ROM it is hoped that we will sketch a balanced picture of its therapeutic potential, as well as the likely challenges the integration of this clinical tool might entail. The future will likely bring more advanced, attuned, and less intrusive methods of tracking patients' progress that might be easier to implement within therapeutic contexts, but until then, the use and usefulness of ROM are on us.

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