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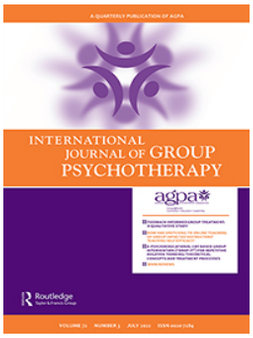

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Feedback-informed Group Treatment: A Qualitative Study of the Experiences and Needs of Patients and Therapists

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ABSTRACT

Therapists, including group therapists, can systematically gather feedback from patients about how their group members are responding to treatment. However, results of research on using feedback-informed group treatment (FIGT) are mixed, and the underlying mechanisms responsible for positive patient changes remain unclear. Therefore, the present qualitative study examined the perceptions and experiences of

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both (a) group therapists and (b) group members regarding using feedback in their therapy groups to gauge treatment progress, across five different therapy groups. Specifically, three interpersonal psychotherapy groups and two cognitive-behavioral therapy groups used a FIGT tool in which treatment progress updates were provided to patients and therapists. Observational data were collected in the form of feedback discussions in these therapy groups, as well as during interviews conducted with patients and therapists. Data were analyzed using thematic analysis and a grounded theory approach. Overall, patients were mostly positive about their experiences with FIGT, but therapists also expressed concerns about FIGT. Results indicated that FIGT is useful for gaining insight and strengthening the working alliance. In addition, specific group processes were also found to be important, especially interpersonal learning, cohesion, and social comparison. Practical implications are discussed.

Although psychotherapy is effective for most patients, approximately 20% of patients drop out (Swift & Greenberg, 2012) and 5–10% experience a decrease in functioning (Lambert & Ogles, 2004). In general, effects of group psychotherapy are comparable to individual therapy for the treatment of mental disorders (Burlingame et al., 2016) and rates of deterioration at the end of treatment are also similar (Schuman et al., 2015; Slone et al., 2015). Unfortunately, therapists are poor at predicting these negative treatment outcomes and tend to overlook worsening during treatment (Chapman et al., 2012; Hannan et al., 2005; Hatfield et al., 2010; Walfish et al., 2012). Feedback-informed treatment (FIT) is designed to reduce negative outcomes by making therapists and their patients aware of treatment progress to make timely adjustments to treatment (Lambert et al., 2018). In FIT, patients complete standardized measurement instruments on a regular basis throughout treatment, typically measuring symptom severity or functioning, thus monitoring the patients' progress during treatment. The scores of these measurements are fed back to the therapist and/or the patient.

The past two decades have shown that FIT indeed appears to be a promising addition to individual psychotherapy to improve outcomes (Lutz et al., 2015), especially for patients who benefit less from treatment than expected (Lambert et al., 2018). The effectiveness of FIT in enhancing treatment outcomes increases when both

therapist and patient receive feedback, compared to solely informing the therapist, and it increases even more when therapists receive additional treatment suggestions in case of deterioration (Shimokawa et al., 2010). A recent multilevel meta-analysis showed that FIT has a positive effect on symptom reduction for all patients and reduces dropout rates by 20% (De Jong et al., 2021). Despite its promising results, the quality of FIT studies is typically low due to the high risks of performance and attrition biases (Kendrick et al., 2016). Moreover, implementing FIT can be challenging and takes time, and ongoing training and supervision of therapists is required to maintain its effectiveness (Boswell et al., 2015; Brattland et al., 2018). In sum, FIT research shows that feedback can be a useful addition to psychotherapy, but that there are still challenges.

Until now, FIT has largely been studied in individual psychotherapy settings and less is known about its use in group psychotherapy. Feedback-informed group treatment (FIGT) has been developed, in which the method of FIT is adapted to a group treatment setting. This means that therapists receive feedback on treatment progress from all group members, with the possibility of discussing the feedback in the presence of all group members (Gleave et al., 2017). Eight controlled studies on the effect of FIGT have been published. Results of four studies showed beneficial effects for the sample as a whole (Hutson et al., 2020; Koementas-de Vos et al., 2018; Schuman et al., 2015; Slone et al., 2015) and two studies described improved outcomes only for patients who were not on-track during treatment (Burlingame et al., 2018; Newnham et al., 2010). One study found no effect at all, probably because of organizational factors (Davidsen et al., 2017): The therapists wanted more time to use the feedback and adjust therapy accordingly, but this was not possible due to the standardization of group psychotherapy. Only one study assessed long-term effects of FIGT. Byrne et al. (2012) found that FIGT was associated with fewer readmissions six months after treatment for patients who remained on track during therapy. Overall, results from FIGT studies showed that feedback has the potential to improve outcomes in group psychotherapy when there is sufficient flexibility to use the feedback actively, but it is not clear how FIGT works and how feedback can be optimally used in a group setting.

In individual psychotherapy settings, studies have been conducted focusing on the experiences and needs of therapists and patients to gain a better understanding of how feedback can be used effectively. There have not yet been any comparable studies in group psychotherapy. In individual psychotherapy studies it was found that patients and therapists appear to differ in their experiences and needs in using feedback. Therapists seem more negative about using feedback tools because they can be too time-consuming and difficult to use, and they prefer training and supervision. Patients seem to have a more optimistic view of the use of feedback: they appreciate the visual representation of their therapy progress and experience benefits when feedback is integrated into therapy (Callaly et al., 2006; Thew et al., 2015; Unsworth et al., 2012; Walter et al., 1998). Moltu et al. (2018) also found that feedback can strengthen patient–therapist collaboration. In addition to experiences with FIGT, patients and therapists also have different needs for a useful feedback system: patients prefer a holistic outcome measure with attention to general functioning and early changes, while therapists want technical information about planning and managing the therapeutic process with monitoring of risks and symptoms (Moltu et al., 2018).

Similar to individual psychotherapy, patients and therapists in group psychotherapy also may have different experiences of and needs for using feedback. Moreover, the dynamics of a group of patients can lead to different experiences of and needs for feedback than in individual therapy. It is also likely that feedback influences the group and its specific therapeutic factors, such as group cohesiveness, which is an important predictor of group psychotherapy outcomes (Burlingame et al., 2003; Yalom & Leszcz, 2020). It is unclear if and how specific group therapeutic factors and the use of feedback are related.

The current study was undertaken to address the lack of knowledge about the working mechanisms of FIGT. The first aim of this study was, therefore, to learn from experiences and needs of patients and therapists using FIGT. The following research questions concerning this first aim were formulated: (1) How is feedback used in a group psychotherapy setting? (2) What do patients and therapists experience when they receive and use feedback in group psychotherapy? (3) Do patients and therapists think that the

working alliance between them is influenced by feedback, and if so, how? (4) Regarding group factors, do patients and therapists experience changes in cohesion and engagement because of the use of feedback? (5) What are the needs and preferences of therapists and patients for an effective feedback instrument? To answer these questions, we collected and analyzed data from feedback discussions in psychotherapy groups, and interviews with patients and therapists in those groups, using thematic analysis. The second aim was to articulate a theory about the circumstances in which FIGT might be used effectively, and thus provide practical implications. To this end, three research questions were asked: (1) How does feedback work in group psychotherapy? (2) Which theoretical constructs from the group psychotherapy literature play a role? (3) Given the theoretical constructs identified in the data as being important, what are the practical considerations that flow from these? The data collected from the observations and interviews were analyzed using the grounded theory approach to gain a deeper understanding of the use of feedback in group psychotherapy.

METHOD

Design

The current qualitative study used observational data collected from feedback discussions in therapy groups, as well as during semi-structured interviews conducted with patients and therapists. The study was part of a larger research project on FIGT at GGZ Noord-Holland-Noord, a medium-sized mental health care institution in the Netherlands. In an earlier study (Koementas-de Vos et al., 2018), a FIGT tool had been developed which was used in the current study. The current study is based on the Standards for Qualitative Primary, Qualitative Meta-Analytic, and Mixed Methods Research in Psychology by the APA Publications and Communications Board Working Group (Levitt et al., 2018). The research protocol was approved by the internal research committee of the mental health institution. The organization's privacy-protocol, based on the General Data Protection Regulation 2016/679, was followed.

Participants

Therapy Groups. For this study, three Interpersonal Group Psychotherapy groups (IPT-G) and two Cognitive Behavioral Group Therapy groups (CBT-G) using FIGT were selected for observations between June and November 2019. IPT-G is a semi-open group for patients with a major depressive disorder. The group psychotherapy consists of treatment blocks of eight sessions with a frequency of one 1.5-hour session per week. Patients could follow IPT-G for up to three blocks, which means that the duration of IPT-G varies between eight and 24 sessions. CBT-G is a closed, semi-structured group psychotherapy for patients with depressive or anxiety disorders, with a maximum duration of 14 sessions and a frequency of one 1.5-hour session per week. This means that the duration of the group therapies, depending on the type of therapy, can vary between eight and 24 sessions. For both IPT-G and CBT-G, the minimum number of participants in each group was three and the maximum was nine.

Patients. Patients in the group therapies had been classified with depressive and/or anxiety disorders, based on the criteria of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5; American Psychiatric Association, 2013). Inclusion criteria for participation in the group therapies were a motivation for following group psychotherapy and the ability to formulate a treatment goal. Exclusion criteria were: age below 18 years or above 65 years, IQ below 80, substance abuse or dependence, psychotic symptoms, acute (hypo)manic symptoms, and a severe suicide risk. The reason for exclusion of subjects older than 65 years was that the department of the institution was organized for patients 18 to 65 years of age. Patients over 65 years of age were referred to a department specializing in the treatment of elderly patients.

A total of 23 patients were eligible for the interviews and seven patients were interviewed. The composition of the patients in one group was still the same in November as in June. These patients were therefore not asked for an interview again. Our goal was to interview an equal number of patients and therapists. Since each group had two therapists, our aim was to interview two patients per group. To do so, a randomized list of the group members was drawn up. Therapists

asked the patients in the order of the list. If two patients were willing to participate, the therapists did not approach the rest of the patients. In one group no patients were invited for interviews, because these patients had already participated in an earlier study. In another group, only one patient was willing to participate in the interviews. Reasons for refusal of other patients were limited time, as well as concerns about the confidentiality of data processing.

The mean age of the interviewed patients was 43.7 years (range: 24–62 years), six were men and one was a woman, all were of Dutch origin. Regarding DSM-5 classification, six out of the seven patients had a depressive disorder and one an anxiety disorder as their main diagnosis. Four patients followed IPT-G and three CBT-G. Their experience using the FIGT tool in group psychotherapy varied between five and 20 sessions.

Therapists. Each therapy group was led by two therapists, and one therapist was group leader of two groups. All nine therapists were asked to participate and they all agreed. The mean age of the therapists was 35 years (range: 27–43 years), eight were women and one was a man; seven were of Dutch origin, one of Caribbean origin, and one of Turkish Dutch origin. All therapists were psychologists with at least a master's degree, three were licensed psychologists with a postgraduate degree, four were licensed psychologists in training for a postgraduate degree, and two were in training for a specialized postgraduate degree. The mean work experience was 8.0 years (SD = 5.0 years) and the mean experience in performing group psychotherapy was 5.3 years (SD = 4.1 years). Their total experience utilizing feedback in group psychotherapy varied between six and 16 sessions. No therapist had used group therapy feedback prior to this study and all therapists received similar instructions.

Researchers. Two researchers conducted the interviews and data analysis. The first author, M.K., is a Ph.D. candidate who studies the effects of progress feedback in group psychotherapy and works as a clinical psychologist at GGZ Noord-Holland-Noord. The second author, M.D., also works at GGZ Noord-Holland-Noord and is experienced with qualitative research methods. Because M.K. was expected to be biased about the research topic, it was decided to

actively involve M.D. in the project to reduce the potential for bias in the analysis and interpretation of the results. M.D. had no previous experience with FIGT and therefore had no potential biases toward it, nor was she expected to benefit from the results.

Measure

FIGT Tool. The FIGT tool is a web-based application that provides a dashboard for patients and therapists involved with group psychotherapy. It can be used on any device with internet access and has a two-step verification to ensure privacy. In this study, the Dutch version of the Outcome Questionnaire-45 (OQ-45, De Jong et al., 2008; Lambert et al., 2013) was chosen as the feedback instrument. It is a 45-item self-report questionnaire that is widely used and is validated in different populations (Amble et al., 2014; Raz Gross et al., 2015; Wennberg et al., 2010). It measures the past week's level of functioning and symptoms, and it takes approximately five to ten minutes to complete. Four domains are measured within the Dutch version of the OQ-45: symptom distress (SD), interpersonal relationships (IR), social role performance (SR), and anxiety and somatic distress (ASD). Items are scored on a 5-point rating scale from never (0) to almost (4). The minimum score on the questionnaire is 0 and the maximum score is 180, with higher scores indicating more psychological problems. The OQ-45 contains five risk items in the questionnaire about substance abuse, suicide, and violence. An example item is, "After heavy drinking, I need a drink the next morning to get going." If a patient scores one or higher on a risk item, the therapist is alerted in the web-based tool. The OQ-45 has good psychometric properties in general and is validated in the Dutch population (De Jong et al., 2007). Internal consistency rates for the subscales and total score were sufficient, except the social role performance subscale. Also, the test-retest reliability was sufficient. The OQ-45 is sensitive to change, whereby the scores remain stable in untreated patients, and it is therefore a good instrument for progress feedback.

Within the FIGT tool, the OQ-45 was activated one day before every group psychotherapy session and patients were asked to complete it.

After completing the questionnaire, patients immediately saw the results in a graph with additional colored dots (red = deterioration, orange = no change, and green = improvement) and texts, compared to the previous and the first session. The FIGT tool was designed to allow patients to click on a measurement point in the graph to view their responses to items, as well as their progress within the four subscales. The degree of change was categorized as deterioration, no change, or improvement using the reliable clinical change index of the Dutch OQ-45, with a cutoff point of 18 points (Timman et al., 2017). For therapists, the dashboard provided a visual graph of the total scores for each group member (see, Figure 1 for an example). Additional colored dots and texts depicted comparisons with the

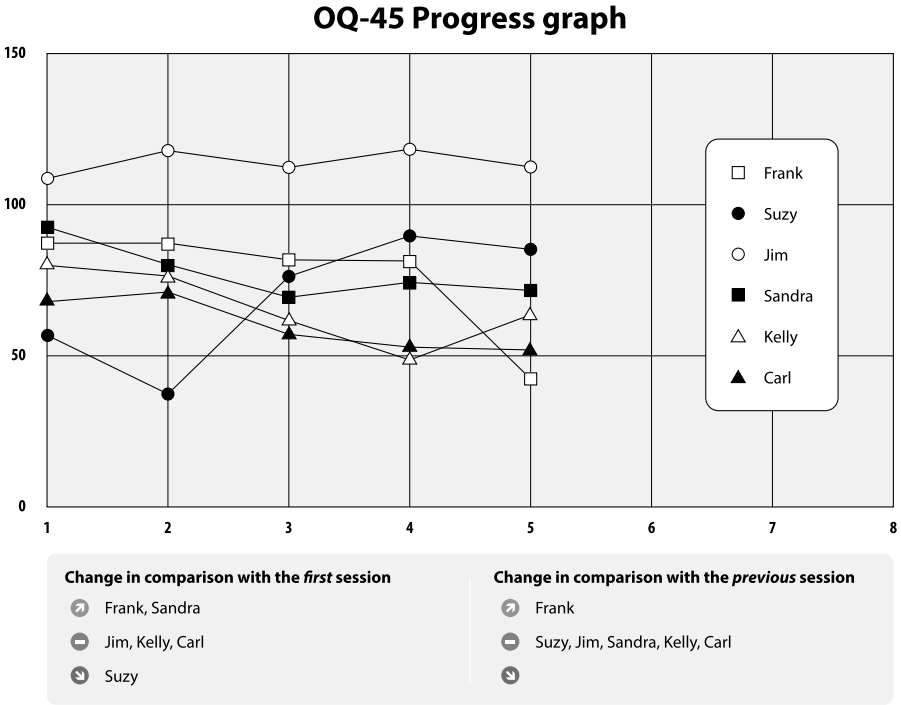

Figure 1. An example of a dashboard of the FIGT tool for therapists, also shown during the feedback discussion in the group.

previous and first session. By clicking on a measurement point it was possible to see the patient dashboard with the graph of the total score, specific scores on each item, and critical items of the OQ-45 and the progress within the subscales.

Procedure

Prior to using the FIGT tool, therapists were individually instructed by the first author (M.K.) for 45–60 min. Therapists were asked to use the tool actively by looking at the results prior to each session and discussing the results in the group for 10–15 min at the start of each session. Patients were given written instructions on how to use the FIGT tool, describing how to log in, which browser to use, and how to contact the therapists and researchers if they had any questions.

Data Collection

Observations. To examine external (behavioral) aspects of using FIGT, five feedback discussions were observed. Two video recordings were made in an IPT-G and two in a CBT-G setting. In one IPT-group, patients did not agree to a video recording for privacy reasons, but they did agree to an observation by a researcher who also took notes. Only sessions of groups in which patients and therapists had already used the FIGT tool for more than two sessions were selected for the observations to ensure that all participants were familiar with the tool. Only if all patients in the group agreed and signed an informed consent form, observations of the feedback discussions were made. In the case of the video recordings, therapists placed a video camera with a wide-angle lens in the therapy room. Recordings of 10–15 min of the feedback discussion were made. Therapists stopped the recording after the feedback discussion and asked all participants if they still agreed with participation. Video recordings instead of direct observations of the group psychotherapy setting were chosen for two reasons. First, the observed situation could be viewed in more detail because rewinding recordings is possible. Second, multiple researchers could code the same situation, which improves the reliability of the coding.

All feedback discussions were transcribed. Different aspects were noted: verbal statements, duration of the feedback discussion, the number of group members, the location of each group member and therapist, the use of a laptop or special software to show the feedback results and salient behaviors, for example, if the therapist sits next to each patient to show the results on a laptop.

Interviews. To study the internal (thoughts and emotions) aspects of using feedback, seven patients and nine therapists were interviewed. A topic list with a funnel model was designed for the semi-structured interviews, one for patients and one for therapists (see Appendices 1a and 1b). Each interview addressed three topics: (1) experience with the use of feedback in the last group psychotherapy session; (2) comparability of this experience with previous experiences, and (3) propositions for adjustments or specific feedback elements to further improve FIGT. The second topic of comparability was chosen because it was hypothesized that subjects could be influenced by the presence of a video camera or observer. However, this assumption turned out to be unnecessary, as none of the respondents indicated that their experience was different from previous sessions.

After the last topic of the interview, patients were asked more specifically whether monitoring personalized treatment goals could be useful, because in their meta-analysis Solstad et al. (2019) found that patients preferred personalized treatment goals in a shared decision-making context over general feedback questionnaires. Therapists were also asked if additional intervention suggestions would be appreciated or helpful, since research findings in individual psychotherapy settings indicate that the effectiveness of feedback increases when additional treatment suggestions are provided to therapists (Lambert et al., 2018).

The interviews took place at most two weeks after the video recordings. The duration of each interview was approximately one hour, and each interview was audiotaped. Patients received a gift card of €25 for participating. All interviews were audio recorded and transcribed.

Analysis

MAXQDA 12 (VERBI Software, 2016) was used for organizing and coding data. For the first aim of the study, namely learning from

experiences and needs of patients and therapists using FIGT, data were analyzed using thematic analysis (Braun & Clarke, 2006). This means that the researchers went through six phases, from getting acquainted with the data to making a report based on themes, in order to address the first five research questions. In the first stage of analysis, the data were read and re-read. In the second stage, initial codes were formed (e.g., "Therapist asks about causes of change"), while in the third stage, we attempted to identify themes among the codes that could address our research questions (e.g., the code "Therapists ask about causes of patient change" helped to address the first research question of how feedback is used). The fourth stage of analysis includes reviewing the themes, while the fifth stage involves further defining the identified themes (e.g., "Therapists use feedback differently"). Finally, the sixth stage involves organizing the themes into narrative form to determine how they address the five research questions.

For the second aim of the study, namely, to form a first theoretical understanding of how FIGT works, a grounded theory (GT) approach (Corbin & Strauss, 1990; Creswell & Poth, 2016) was used. GT typically involves three stages of coding: (1) open coding, in which the researcher codes the data for its major themes of information; (2) axial coding, which emerges when the researcher identifies themes in the open codes; and (3) selective coding, in which the researcher develops propositions that fits the constructs in a model, which (hopefully) leads to an emergent theory grounded in the data. As an example of our coding process, feedback sessions were first transcribed, and then small segments of data were open-coded (e.g. "Therapist checks results with patient individually") (this stage of analysis was similar to initial coding stage of the thematic analysis). Next, in the axial coding phase, general themes were formed across open codes. For example, themes about how feedback works in group psychotherapy and an initial proposal of theoretical constructs were described (e.g., the open code "Therapists checks results with patient individually" fit into the theoretical construct of social comparison, as therapists were concerned about the negative effects of social comparison). The interrelationships of these constructs were then tested in the final phase of selective coding through analysis of the data and following interviews.

Initially, data collection was planned to occur in a single phase of observations and interviews. Afterward, the first and second authors thoroughly evaluated whether data saturation had been achieved. Because they still had specific questions about the themes (first five research questions) and the working mechanisms of FIGT (last three research questions), a second round of three observations, four interviews with patients and five interviews with therapists took place in September-October 2019. In this round, all participant data were randomly selected to be read and re-read, themes and theoretical constructs were tested in the interviews with patients and therapists, and new themes, constructs and interrelations were formed. After this phase, the researchers no longer found any new themes or constructs and concluded after consultation with the other authors that saturation had been reached.

Results

After the second round of data collection, we found four main themes and seven subthemes among the main themes (Level 2), and then 17 lowest level themes (Level 3), as shown in Table 1. Some themes emerged in both the observations and the interviews, there were themes that were unique to the interviews. In the following, the three main themes with their subthemes are described. The main themes were use of feedback, effects of feedback-informed group treatment, and needs for using FIGT: preconditions and preferences of patients and therapists.

Use of Feedback

How Patients Use Feedback. All patients indicated in the interviews that they completed the OQ-45 every week and that the results were discussed in the subsequent group psychotherapy session. Therapists noted that patients were more faithful in completing the feedback questionnaires in the group than in individual therapy settings. A therapist said, “It is easier to use feedback in the group than in individual therapy. Filling out the questionnaire and discussing the results became a standard and I noticed that patients faithfully completed the feedback over time.”

Table 1. Overview of Main and Subcategories Coded From the Data Material

Main category	Level 2 subcategory	Level 3 subcategory	Patient interviews	Therapist interviews	Observations
1. Use of FIGT	1.1 Patients	All fill-out the OQ-45	X	X	X
		Variations in use before each session	X		
	1.2 Therapists	All discuss the feedback	X	X	X
		Variations in use before and during sessions		X	X
2. Effects of FIGT	2.1 Insight	Patient: insight and goal-directedness	X	X	
		Therapist: insight and think critically		X	
	2.2 Working alliance	Collaboration	X	X	X
		communication	X	X	
	2.3 Group processes	Engagement and cohesiveness	X		
		Social comparison	X	X	
3. Needs for using FIGT	3.1 Preconditions	User-friendly	X	X	
		Technically stable	X	X	
		Reflect actual progress	X	X	
		Linked to sessions	X	X	
	3.2 Preferences	Additional personalized feedback	X	X	
		More group involvement	X		
		Extra support		X	

Before each session, two patients looked extensively at the results on their private dashboard to understand why they were or were not making progress. In contrast, four other patients quickly scanned their scores on the dashboard to monitor treatment progress. One patient did not look at all: "I don't need to look at the scores. I'm fine with the therapist discussing it with me during the session."

How Therapists Use Feedback. Among therapists, the observations and interviews showed that each feedback discussion was led by one group therapist who presented the results of the FIGT tool on a desktop computer, laptop, or tablet. The group therapist asked each patient in the group whether the feedback results matched the patients' experience from their previous week. In all feedback

discussions, patients answered the therapist's questions and there was no further interactive discussion between the patients. The duration of the feedback discussions ranged between 10 and 15 min.

There were also differences in the extent to which the feedback was used between co-therapists before and within each session. One therapist said she never looked at the feedback results before each session because her co-therapist always discussed the feedback results with the group. The other eight therapists looked at the results prior to each session, four of them discussing the results with their co-therapist and four looking at them separately without discussing the results because of a lack of time. It also appeared that therapists discussed the feedback in different ways in the group. Two therapists felt that for privacy reasons patients should not be allowed to see results of other group members. As a result, the therapist sat close to each group member to discuss the results shown on a laptop so that other group members could not see them. Seven other therapists spoke openly about the results and displayed them for the group-as-a-whole using a projector, laptop, or desktop computer.

Therapists also differed in asking additional questions about the feedback results. Two therapists asked questions about cause-and-effect relationships, such as: "Do you have an idea why your scores changed?" And two therapists also linked the results to the group psychotherapy: "Do you think this result is caused by the fact that you are in group psychotherapy?" or "Could it be that you are still avoiding difficult feelings?" The other therapists only asked whether the feedback results matched the patients' experience from their previous week. Four patients who participated in the groups where therapists only asked whether the results were recognized experienced the feedback conversation as short and fleeting and saw it as a separate part of the session. The other three patients were generally satisfied with the feedback discussion, because their therapists asked more in-depth questions about treatment progress and cause-and-effect relationships.

Effects of Feedback-informed Group Treatment

FIGT and Insight. All patients experienced the FIGT tool as a means to gain insight into their treatment progress. They also mentioned that using FIGT helped them to work toward a goal. For example, one patient noted, "It is nice and helpful to see a graphic view of my progress" and another said, "It is helpful to see where I want to go." No specific drawbacks of using feedback were mentioned. Therapists also mentioned that patients seemed to experience more ownership and control over their progress.

All therapists also saw the FIGT tool as an instrument for gaining insight into the treatment progress of their patients. One therapist said, "It is helpful to know how my patients are doing before the session. Treatment progress is now measurable and specific." Another therapist mentioned that feedback helped them to think more critically about treatment, saying, "It helped me to figure out why the treatment was not working properly. Partly because of this, I started to study the method of group psychotherapy thoroughly and I registered for a training."

FIGT and the Working Alliance. Patients said that feedback was helpful for improving openness and communication about their process with their therapists. For example, one said, "For me it is the starting point of the session. I am not very talkative, and this helps me to tell my therapist how I am doing." Another patient said, "It forces me to be honest about my progress. I can't play hide and seek with my therapist anymore, which is good."

Therapists noted that feedback helped them to collaborate with the patient and to make patients feel more seen. One therapist said, "The feedback helps to take a closer look at the recovery process together with the patient and creates extra personal attention for each patient." Some patients indeed experienced that their therapist paid extra attention to them. For example, one said, "By using feedback I get the impression that my therapist is involved in my therapy process." The observations showed that each group member received individual attention in the group from the therapists when discussing the feedback. In one group, one therapist sat close to each patient to view the results together on a laptop and examine the treatment progress.

Furthermore, therapists enjoyed feeding back positive results to their patients, but struggled with what to do when there was no change over time. Therapists did not know how to discuss stagnation with their patients and feared it would negatively affect their motivation. Conversely, patients did not experience the feedback as demotivating, even when there was no treatment progress. A patient said, "Of course I know when I am not progressing in therapy, I do not need a graph for that. The main thing is that I can learn from it."

FIGT and Group Processes. Patients mentioned that discussing feedback in the group compelled them to be honest about their own progress, that it was nice to hear how others did in a similar situation, and that it motivated them to work on their own recovery. Patients said, "I am very happy when someone makes progress and is doing well," "It helps me when someone who is in the same situation and gives me suggestions," and "You become more connected to the people in the group. If people do better and you don't, it's an extra incentive to work on your progress." Both therapists and patients mentioned that discussing feedback results in the group leads to social comparison. All therapists were concerned about the effects of social comparison and thought that it would lead to negative feelings of competition. In one group, the feedback was therefore discussed strictly per person, without other group members being allowed to see the results of the FIGT tool. Patients indicated that they indeed compare their own score with that of others, but not in a negative competitive way. A patient said, "I do compare my scores to others' [scores], but the feedback is a tool to gain insight into your own process. It is not a competitive instrument." Another patient said, "When others see my results, they can support me. In addition, I would also like to see the progress of the others so that I can learn from them." In their opinion, it mattered how the results were discussed. One patient noted, "It is important that the therapist explains that it is not about competition, but about learning from each other."

Needs for Using FIGT: Preconditions and Preferences by Patients and Therapists

Preconditions. Patients and therapists noted several essentials for a feedback system to be effective. Regarding user-friendliness, all participants indicated that the FIGT tool should be easily accessible and have a clear visual display of the results for both patients and therapists. The time needed to fill out the feedback instrument should be acceptable for patients. In this study, patients needed between five and 25 min for filling out the OQ-45, which they found acceptable. Technical problems should be limited.

Participants also mentioned the importance of validity of the feedback instrument; that is, it should reflect actual therapy progress. In both observations and interviews, it was found that results on the OQ-45 were in line with the patients' and therapists' actual experience of treatment progress. Some examples of discrepancies between the results and the actual experience were mentioned, but this did not lead to questioning the scores.

All participants believed that feedback should be provided before every session and should be discussed at the start of each session. Patients said, "If the results are not discussed in the group, it makes no sense," "I think the results should be discussed weekly in the group so that you can link the results to the therapy," and "I don't want to fill out questionnaires more frequently, because that would be too much work. Weekly on a session-by-session basis is perfect." Therapists also indicated that discussing feedback per session improved patients' motivation to complete the questionnaires and thus helped to properly monitor the therapy process.

Preferences. The FIGT tool was rated as satisfactory by both therapists and patients. Patients gave an average mark of 7.2 (SD = 0.9) on a scale of 0–10 and therapists gave an average mark of 6.8 (SD = 0.5). Both patients and therapists indicated that they would like to see three additional changes

First, both patients and therapists wanted to use personalized feedback in addition to the OQ-45. Patients suggested that feedback is optimal when it is tailored to their own personal situation and the stage of their recovery progress. One patient said, "I think it would help me to have the possibility that questions can be changed during

the treatment. When I am doing better, I would like to monitor other aspects of my life instead of symptoms." Six of the nine therapists also thought the OQ-45 results could be too generic and that measuring additional specific symptoms, such as anxiety or depression, would be valuable. Both patients and therapists were unanimously enthusiastic about the suggestion for monitoring personal treatment goals. Patients thought that it would help them to focus on their goals, it would motivate them to reach their goals and be easy to understand. Therapists responded in a similar way. In their opinion, attaining treatment goals is the essence of therapy and monitoring helps patients to keep their goals actively in mind.

Second, all patients indicated that they would like more involvement from the group members in discussing the feedback results. None of the therapists in any of the groups actively involved other group members in the discussion, but patients wanted to have the opportunity to empathize with others and learn from them. All patients mentioned the value of involvement of their peers in discussing the feedback. Moreover, patients indicated they would like to see the results displayed on a big screen in the therapy room, so that the scores can be seen by the whole group and discussed openly. This would increase engagement by group members. Patients suggested the use of a projector to project the progress of all group members instead of a laptop or personal computer.

Third, five therapists wanted additional instructions on how to use feedback in group psychotherapy, how to discuss feedback results, and how to cope with insufficient change in treatment. Training, instruction videos, and written instructions were mentioned. Therapists noted that it takes time for feedback to be embedded in group psychotherapy and that they need knowledge and experience to use feedback effectively. Only one patient noticed inexperience of therapists and thought that they might need more training in the use of the feedback. Most therapists were positive about the idea of adding treatment suggestions in case of deterioration or no change. One therapist said that suggestions should always be given, even if a patient is improving. Therapists indicated that they would like to receive advice on how to link the results to treatment, how to work positively on the treatment goals and how to improve the group climate.

A First Theoretical Understanding of FIGT

During the thematic analysis, a theory about using feedback in group psychotherapy was formed using a grounded theory approach. Based on our data, the theme "Effects of FIGT" with the subthemes insight, working alliance, and group processes was designated as the basis for the theory, because these aspects appeared to be the main factors for the effectiveness of feedback in the group, as can be seen in Table 1. When analyzing these three subthemes, it was found that the use of feedback in group therapy involves processes that occur on three levels: the individual level, patient–therapist level and group level.

According to our results, both the patient and the therapist each have their own opportunity to gain more insight into the therapeutic process: the individual level. At the same time, both patient and therapist experience improvements in communication and collaboration in the working relationship when the feedback results are discussed together: the patient–therapist level. The benefits at the patient–therapist level can influence the insight into the therapy process and vice versa. The individual and patient–therapist processes also occur when feedback is used in individual psychotherapeutic settings and may explain why feedback works (Alldredge et al., 2021; Flückiger et al., 2018; Hovland et al., 2020; Jennissen et al., 2018; Solstad et al., 2019).

An obvious difference with individual settings is that feedback in group psychotherapy is discussed in and (sometimes) with the group. In this way, processes at the group level are obviously influenced as well. Based on our data, insight through interpersonal learning, engagement and group cohesiveness, and social comparison seem to be play important roles. These three subthemes are explained in more detail in the following section, in which the analyzed data are linked to preexisting literature so that a theory can be further developed.

Insight Through Interpersonal Learning. Unique in group psychotherapy is that patients experience insight through interpersonal learning in the group. For example, patients in this study indicated that discussing the feedback helped them to be honest about their treatment progress, to learn to deal with feedback by observing others, and to learn from other group members how they improve

in therapy. Yalom and Leszcz (2020) describe that patients in group psychotherapy obtain insight on at least four different levels: (1) gaining a more objective perspective on their interpersonal presentation, (2) experiencing some understanding of complex interpersonal patterns, (3) learning about underlying motives, and (4) understanding the deep roots of behavior. It is found that obtaining insight in current relationships is especially related to change (Yalom & Leszscz, 2020). The use of feedback appears to be related to this process of gaining insight: discussing the feedback in the group enables patients to compare their own view of their progress with how others see them, to receive feedback and support, and to learn how others face their problems.

Engagement and Group Cohesiveness. Another aspect of using feedback in group psychotherapy is that it can enhance group cohesiveness. In the interviews, patients mentioned that they were forced to be honest with themselves and the group when therapy progress results were discussed: "There is no hide and seek anymore and saying you are fine." By seeing and discussing the group graph, patients receive feedback from others, compare their scores to those of other group members, learn how others cope with similar problems and have the possibility of helping others as well. As a result, patients report more empathy and closeness to other group members. All these aspects are part of engagement with the group, which is related to group cohesiveness, the most central therapeutic factor in group psychotherapy (Bernard et al., 2008, Burlingame et al., 2011; MacKenzie, 1983).

Social Comparison. It appears that the use of feedback is experienced as having a positive impact on the group therapeutic factors. This is noteworthy since the therapists were concerned about a possible negative impact. They feared competitive feelings among group members that could lead to negative treatment outcomes. Indeed, previous research has shown that patients with mood disorders tend to compare themselves more negatively to others (Wheeler, 2000). Patients in this study mentioned that they did compare their results, but did not experience negative effects of this comparison because they saw feedback as an instrument to learn from.

Overall, using feedback in group psychotherapy is more than informing the patient and the therapist to gain insight (individual

level) and strengthen their working alliance (patient–therapist level). Group dynamics are influenced as well, and this can have positive effects on treatment outcome. It is therefore important that a positive group climate with engagement and group cohesiveness is created, so that patients are encouraged to use feedback effectively in the presence of other group members without negative competitive feelings.

DISCUSSION

This is the first qualitative study of feedback-informed group treatment (FIGT) with the aim of learning from experiences and needs of patients and therapists, and to formulate a first theoretical understanding of the working mechanisms of FIGT. We found three main themes that are important in understanding FIGT: (1) use of feedback, (2) effects of FIGT, and (3) needs for using FIGT. Regarding the first theme, all patients faithfully completed the feedback questionnaire each session, but patients used the feedback results differently before each session. Similar results were found between therapists. The second theme showed that the use of feedback is related to increasing insight, strengthening the working alliance and influencing specific group processes. While patients were only positive about its effects, therapists were also concerned about negative effects of FIGT because of social comparison. According to the third theme, patients and therapists generally had similar needs for an effective feedback system and they preferred additional personal, flexible and specific feedback to the OQ-45. Furthermore, patients wanted more group involvement in discussing the feedback results and therapists asked for more training and supervision in using feedback effectively. Finally, it was possible to form a first theoretical understanding of FIGT in which the use of feedback influences three levels that interact with each other: the individual, patient–therapist and group levels.

Many of the results are consistent with results found in earlier studies in individual FIT settings. For instance, in both FIT and FIGT studies, feedback appears to be seen as a tool to improve insight and focus (Hovland et al., 2020; Solstad et al., 2019). It is also found that feedback can enhance collaboration between the patient and therapist (Moltu et al., 2018), that personal, specific and flexible feedback is preferred instead of only standardized questionnaires

(Solstad et al.), that patients have more positive attitudes toward feedback than therapists (Thew et al., 2015; Unsworth et al., 2012) and that therapists need more guidance in using feedback effectively (e.g., Hutson et al., 2020).

Although there are similarities with individual therapy settings, there are specific group processes in FIGT that play a role as well, namely obtaining insight through interpersonal learning, engagement and group cohesiveness, and social comparison. Patients mentioned that the feedback discussion enabled them to self-disclose, learn from others, and to experience more closeness to other group members. Patients even preferred more group involvement when the feedback results are discussed. Therapists, in contrast, seemed concerned about negative competitive feelings and did not stimulate any group interaction during the feedback discussion. Consistent with research on social comparison (Gerber et al., 2018), it is not surprising that therapists expected negative competitive feelings. It has been found that people generally tend to compare themselves to similar people, upwards ("the other is better than me") or downward ("*t*he other is worse than me"). People with depression and low self-esteem are particularly sensitive to social comparison and have a stronger tendency to make an upward comparison in case of perceived threats to self-worth, which leads to self-devaluation (Wheeler, 2000). Most of the patients in this study had a major depressive disorder and said they were aware of differences with other patients, but they did not experience these differences in a competitive way. No upward comparison was reported or observed. A possible explanation is that the purpose of using feedback was clear, so that the feedback discussion was not perceived as threatening, but rather as useful. Indeed, patients in this study indicated the importance of how the feedback is discussed, that it is not about competition, but about learning from each other.

Interestingly, therapists in this study showed a lot of variation in using feedback, even though the instructions were the same for each therapist. Similar variations were found in the study by Hutson et al. (2020). Moreover, in all FIGT studies, therapist instructions ranged from no specific instructions (Schuman et al., 2015) to encouraging the use of feedback (Davidsen et al., 2017; Hutson et al., 2020; Koementas-de Vos et al., 2018; Newnham et al., 2010), one hour of

training (Slone et al., 2015) and two hours of training (Burlingame et al., 2018), which probably led to variation of feedback use between FIGT studies. It is possible that differences in instructions and subsequent differences in the use of feedback could be an important explanation for the mixed results in FIGT research.

This study has several limitations. Firstly, this study specifically examined CBT and IPT group psychotherapy and it is assumed that these symptom-focused treatments are probably better suited to the use of feedback. Certainly with CBT, it is standard practice to monitor behavior, emotions and thoughts (Janse et al., 2020). It is possible that our findings may not apply to other types of group psychotherapy, for example, psychodynamic or integrative groups. Another limitation is that predominantly male patients diagnosed with a major depressive disorder participated in the study, causing a selection bias. So far, there are no studies on gender differences in the use of feedback, but our study could not rule out a gender bias. Furthermore, some studies have found that patients with mood disorders benefit more from feedback (Janse et al., 2017), while patients with personality disorders can experience adverse effects from feedback (De Jong et al., 2018). It is possible that patients with disorders other than a mood or anxiety disorder have different experiences with the use of feedback in group psychotherapy. A third limitation is that we could not rule out a response bias. It is possible that patients felt they should only mention positive aspects of using feedback, despite it being explained that participation in the study does not affect their therapy. Therapists could also feel a kind of loyalty because the researchers were colleagues at the same mental health care institution. Another limitation is that the experience with the use of feedback in group psychotherapy by therapists was still relatively short between six and 16 sessions. In addition, it is unclear to what extent the therapists already had experience with feedback in other settings, such as in individual therapy, and had training and supervision on this. In general, it has been found that the degree of confidence, skills, and knowledge about the use of feedback is related to how often feedback is used by therapists and whether they have received training (Bear et al., 2021). The possible differences in feedback experience between therapists may explain the variations found in the actual use of feedback, as well as the feelings of uncertainty and worry. Finally, the

researchers may have been biased because of their experience studying the use of routine outcome monitoring in a variety of settings, which could also have led to overly positive results. To overcome this observer bias, an additional researcher with no history in FIGT was asked to conduct more than 1/3 of the interviews and was actively involved in the data analysis.

Future research should include other therapy and patient groups, to allow the drawing of conclusions about the use of feedback in group psychotherapy in mental health care in general. Furthermore, FIGT research should also focus on the effects of using feedback on specific group therapeutic factors such as group cohesion and group climate, as these are important predictors of treatment outcome (Bonsaksen et al., 2013; Burlingame et al., 2003, 2011; Ogrodniczuk & Piper, 2003). So far, it remains unclear what the effect of feedback on these factors is. In addition, specific adjustments of FIGT can be further explored: more extensive feedback discussions with stimulation of group interaction and the use of a visual display, extra support for therapists in the form of supervision and the possibility for feedback with personal goals and specific measures adjusted to the treatment phase.

The current study has several implications for practice. For the implementation of feedback in a group psychotherapy setting, a computerized feedback system is desirable that is simple to use, technically stable and whereby the administration of questionnaires must be linked to the therapy sessions. In addition to standardized feedback questionnaires, it is also recommendable to use flexible feedback instruments that can be adapted to the patient's personal situation and the therapy phase. It is also advisable to provide supervision and support for therapists. Therapists should monitor and stimulate the five aspects that are influenced by a feedback system in group psychotherapy as described in Table 2. These specific recommendations are based on the scientific literature concerning stimulating insight in therapy, improving the working alliance, and promoting group therapeutic factors.

In conclusion, this study has contributed to a better understanding of the use of FIGT by patients and therapists. It appears that the use of feedback in group psychotherapy helps patients and therapists increase their awareness of treatment progress and enhances the

Table 2. Recommendations for Therapists Using Feedback in Group Therapy

1 Insight	Discuss with each group member how the feedback tool can be useful to gain insight. Do the same with your co-therapist: how can the feedback tool improve your work? Evaluate during therapy whether adjustment is necessary (Jennissen et al., 2018).
2 Working alliance	Regularly evaluate whether there is agreement on the goals, task and bond and how feedback can support the working alliance (Alldredge et al., 2021; Flückiger et al., 2018; Stinckens et al., 2009).
3 Insight through interpersonal learning	Inform the group members that the feedback tool is an instrument to learn from each other and can be a starting point for giving each other feedback. Regularly check that patients are able to learn from the results of the group feedback and gain insight into their interpersonal functioning, and if not, promote interpersonal learning (Yalom & Leszcz, 2020).
4 Group cohesion	Check whether there is sufficient group cohesion (feelings of trust, belonging and togetherness experienced by the group members) so patients make optimal use of the feedback results in the group (Burlingame et al., 2011; Yalom & Lezcz). Use specific interventions at the level of group structure, verbal interaction and emotional climate as mentioned in the practical guidelines for group psychotherapy (Bernard et al., 2008) and/or the more recent Dutch guidelines for group psychotherapy (Koks et al., 2021).
5 Social comparison	Explain that the feedback tool is not a competitive instrument, but a means to learn from each other. Check whether group members feel safe to discuss results with each other and explore possible negative competitive feelings (Gerber et al., 2018; Wheeler, 2000)?

working alliance, like individual psychotherapy settings. But even more remarkable is that feedback has the potential to favorably influence group psychotherapeutic factors. The use of feedback in group psychotherapy therefore requires therapists to have specific knowledge and experience, not only about therapeutic methods to stimulate individual change, but also about group dynamics, so that patients in group psychotherapy can optimally benefit from feedback.

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APPENDIX 1A. INTERVIEW TOPIC LIST PATIENT VERSION

Minutes	Description
5	Introduction study, goal of the interview, informed consent
20	Question 1: "Describe your last experience with the progress feedback tool" The interviewer checks following questions: • What did you think about feedback before the start of the group psychotherapy? What did the therapist explain about feedback? • What is your current opinion on the use of feedback in group psychotherapy? • What was your experience with completing the questionnaire? • What do you think about the results of the individual progress feedback? • Tell me your experience on the feedback discussion in the group. • In which way do you think feedback influences the working alliance between you and your therapists? • In which way do you think the feedback tool influences your relationship with the other group members? • Do you feel that the use of progress feedback influences your actual progress in therapy? • Satisfaction scale: What rating would you give the use of the progress feedback tool on a scale from 0–10? Why? • Which elements of the progress feedback tool are helpful? Which not? And which are even impairing?
20	Question 2 "Is your last experience comparable to previous experiences with the feedback?" The interviewer checks following questions: • In which way was it the same or different? • Could you give an example? • Was it a more positive or negative experience for you? Why? • Did you notice other consequences of the feedback?
20	Question 3 "Imagine that the progress feedback tool has been improved to support you and your therapists even more in group psychotherapy. What has changed?" The interviewer checks following questions: • Please describe the difference and why this supports you even more? • I would like to propose a number of options for change to you and then I am curious what you think about it. What would you think if: 1. The questionnaire for monitoring the progress of the treatment has changed, what kind of questionnaire would you prefer? 2. The frequency of administration of the questionnaire is changed, which frequency would be better? 3. If it is possible to track your personal treatment goals in the progress feedback tool, would this make a difference?
5	Thank the participant, check informed consent

APPENDIX 1B. INTERVIEW TOPIC LIST THERAPIST VERSION

Minutes	Description
5	Introduction study, goal of the interview, informed consent
20	Question 1: "Describe your last experience with the progress feedback tool" The interviewer checks following questions: • What did you think about feedback in group psychotherapy before this research? What did the researcher explain about progress feedback? • What is your current opinion on progress feedback in group psychotherapy? • Tell me about your experience with the progress feedback for the group-as-a-whole and for the individual results. • Describe your experience with the feedback discussion in the group. • In which way do you think the feedback tool influences the working alliance between you and your patients? • In which way do you think the feedback tool influences the group process? • Do you feel that the use of progress feedback influences actual treatment progress in therapy? • Satisfaction scale: What rating would you give the use of the progress feedback tool? Why? • Which elements of the progress feedback tool are helpful? Which not? And which are even impairing?
20	Question 2 "Is your last experience comparable to previous experiences with the feedback?" The interviewer checks following questions: • In which way was it the same or different? • Could you give an example? • Was it a more positive or negative experience for you? Why? • Did you notice other consequences of the feedback?
20	Question 3 "Imagine that the progress feedback tool has been improved to support you and your patients even more in group psychotherapy. What has changed?" The interviewer checks following questions: • Please describe the improvements and why they help you and/or the patients • I would like to propose a number of options for change. What would you think if: 1. The questionnaire for monitoring the progress of the treatment has changed, what kind of questionnaire would you prefer? 2. The frequency of administration of the questionnaire has changed, which frequency would be better? 3. It is possible to monitor personalized treatment goals of each patient in the progress feedback tool, would this make a difference? 4. You received additional treatment suggestions, would this help you even more?
5	Thank the participant, check informed consent