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Personalization of Psychotherapy Based on Client Preferences vs. Routine Outcome Monitoring With PCOMS: A Naturalistic Study

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ABSTRACT

Taking client preferences into account and conducting routine outcome monitoring are components of evidence-based practice. The objective of this study was to compare the effectiveness, on the one hand, of adjusting therapeutic processes to clients' role or activity preferences, and on the other, of routine outcome monitoring using PCOMS. Method: experimental design with three groups of therapists randomly assigned through random number tables. Sample: Therapists N = 9, Clients N = 101. Evaluations were conducted at intake, in the third, eighth, and final treatment session. Data analysis. Generalized estimating equation (GEE) models were used to analyze the effects of adherence to different therapeutic approaches on the dimensions of the CORE-OM scale. Results. Psychotherapy monitored with PCOMS achieved better results, with a significant difference, compared to standard treatment and treatment adjusted to client preferences. In the second evaluation (third treatment session), the results of the two experimental treatments were similar. Conclusions: Routine outcome monitoring is a strategy that yields better results than usual treatment in the Mar del Plata context. Adjusting treatments to client preferences is a promising area for good outcomes.

Personalización de la Psicoterapia Basada en las Preferencias de los Pacientes vs. Monitoreo Rutinario de Resultados con PCOMS: Un Estudio Naturalístico

RESUMEN

Tener en cuenta las preferencias de los pacientes y realizar un monitoreo rutinario de resultados son componentes de una práctica basada en evidencia. Objetivos: comparar la efectividad, por un lado, de ajustar los procesos terapéuticos a las preferencias de rol o actividad de los pacientes, y por otro, del monitoreo rutinario de resultados utilizando el PCOMS. Método: diseño experimental con tres grupos de terapeutas por asignación aleatoria mediante tablas de números aleatorios. Muestra: Terapeutas N = 9, Pacientes N = 101. Las evaluaciones se realizaron en la admisión, en la tercera, octava y última sesión de tratamiento. Se utilizaron modelos de ecuaciones de estimación generalizada (GEE) para analizar los efectos de la adherencia a diferentes enfoques terapéuticos sobre las dimensiones de la escala CORE-OM. Resultados: La psicoterapia monitoreada con el PCOMS obtuvo mejores resultados, diferencia significativa, que el tratamiento estándar y el tratamiento ajustado por las preferencias de los pacientes. En la segunda evaluación (tercera de tratamiento) los resultados de los dos tratamientos experimentales fueron similares. Conclusiones: El monitoreo rutinario de resultados es una estrategia que produce mejores resultados que el tratamiento habitual en el contexto marplatense. Ajustar los tratamientos a las preferencias de los pacientes es un área prometedora de buenos resultados.

Palabras clave:

Monitoreo rutinario de resultados

Preferencias terapéuticas

Personalización del tratamiento

PCOMS

Retroalimentación

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Introduction

Evidence-based practice is defined as the integration of three core components: client values, which include individual characteristics, culture, and preferences; the best available research evidence; and clinical expertise. One of these key components is client preferences. Actively incorporating these into the therapeutic process has been associated with improved treatment outcomes (McLeod, 2015; Swift et al., 2019). Evidence indicates that attending to and accommodating client preferences enhances positive effects, reduces premature dropout rates, strengthens the therapeutic alliance, and increases engagement in psychotherapy (Calsyn et al., 2000; Hess, 2017; Swift & Callahan, 2009; Swift et al., 2011; Tompkins et al., 2013).

Another central element of evidence-based practice is Routine Outcome Monitoring (ROM) (APA Presidential Task Force on Evidence-Based Practice, 2006). In recent decades, studies have evaluated the benefits of its implementation. ROM has demonstrated statistically significant effects on psychotherapy outcomes, serving as a complement to standard treatments and offering the advantage of low implementation cost (Barkham et al., 2023).

Routine outcome monitoring (ROM) generally consists of three stages: (1) collecting client data on a regular basis; (2) providing feedback to the therapist and, in many cases, also to the client; and (3) when appropriate, adapting the therapy process or approach in response to the feedback (Barkham et al., 2023). The use of feedback is gaining increasing interest and, in some countries, is even required as part of high-quality care (Connors et al., 2024). Feedback provided to therapists and clients is a core component of measurement-based care, as it allows progress monitoring to be integrated into the therapeutic process in real time, thereby facilitating data-informed clinical decision-making (Barber & Resnick, 2023).

One of the most widely used monitoring and feedback systems, recognized as an evidence-based practice by SAMHSA, is the Partners for Change Outcome Management System (PCOMS). PCOMS is a client feedback system that utilizes two four-item scales to gather input from users: the client evaluates progress using the Outcome Rating Scale (ORS) and the quality of the therapeutic alliance using the Session Rating Scale (SRS). These scales can be applied regardless of the therapist's theoretical model or the issue being treated. PCOMS fosters a transparent discussion with clients about their results and is one of the few systems that routinely measures the therapeutic alliance. A distinctive feature is that all scoring and interpretation of the assessments are conducted together with the clients, providing them with a new way to reflect on and discuss their experience of progress and their perception of the therapeutic relationship. In this way, the assessment process becomes an integral component of therapy. (Duncan & Sparks, 2019).

PCOMS has been shown to be effective in couples therapy (Anker et al., 2009; Reese et al., 2010), group psychotherapy (Schuman et al., 2014; Slone et al., 2015), individual psychotherapy with adults (Bovendeerd et al., 2022; Brattland et al., 2018; Reese et al., 2009), children (Cooper et al., 2021; Cooper et al., 2013), adolescents living in poverty (Kodet et al., 2019), and integrated healthcare settings (Duncan et al., 2021). Studies have also been conducted outside the United States and Europe, including in China (She et al., 2018).

In line with this client-centered approach characteristic of PCOMS, another key aspect for optimizing treatment effectiveness is the consideration of client preferences. These are defined as specific types of treatments, activities, or therapist characteristics that clients want to be present in the psychotherapy environment (Swift et al., 2018), can be summarized into three types: 1) preferences related to therapists (personal characteristics they should have, such as gender, age, or religion); 2) treatment preferences (desires for a particular type of psychotherapy, such as cognitive-behavioral therapy or a person-centered approach); 3) preferences regarding activity or role (specific behaviors and intervention styles within the therapeutic work, such as the use of tasks, more or less directiveness) (Cooper et al., 2019).

Meta-analyses indicate that clients who receive therapy aligned with their preferences or chosen by them exhibit better clinical outcomes and significantly lower premature dropout rates compared to those who do not have the opportunity to choose (Delevry & Le, 2019; Lindhiem et al., 2014; Swift et al., 2018; Swift et al., 2011). Specifically, the meta-analysis by Swift et al. (2018) indicates that clients whose preferences do not align with the psychotherapy they are provided are almost twice as likely to prematurely terminate the process. Along similar lines, though with some differences, a systematic review and meta-analysis including 5,294 participants diagnosed with mental disorders found that clients who received their preferred treatment exhibited lower dropout rates and a stronger therapeutic alliance. However, no significant association was found between preference matching and clinical outcomes (Windle et al., 2020). As Faye Jacobsen et al. (2024) state, most studies in both reviews investigated treatment preferences. These findings underscore the need to advance research on the “preference-matching effect”—the alignment between client preferences and treatment characteristics—particularly with respect to preferences concerning the therapist's activity or role. Such preferences have received comparatively limited attention in empirical studies, despite their potential significance for the effectiveness of the psychotherapeutic process.

In the Argentine context, this issue acquires particular relevance. The healthcare system is characterized by significant heterogeneity, with the coexistence of public, private, and social security sectors, resulting in marked disparities in access to, continuity of, and quality of psychological care. Moreover, the implementation of approaches such as Routine Outcome Monitoring (ROM) and the systematic incorporation of patient preferences remains incipient in local clinical practice. This is partly due to structural limitations—such as a lack of technological resources, high patient loads, and insufficient training in ongoing assessment—as well as cultural factors that shape how clients perceive the therapist's role, with a historical tendency toward less directive models. These circumstances call for empirical inquiry into how ROM- and preference-based approaches can be effectively implemented and adapted within the specific conditions of the Argentine healthcare system.

Given this background and the lack of naturalistic studies in Argentina to assess the effectiveness of ROM, specifically PCOMS, and the results of adjusting psychotherapy to client role preferences, this study aims to compare the effectiveness of two types of treatments: ROM-based psychotherapy using PCOMS and psychotherapy adjusted to client role preferences. These two psychotherapy modalities are expected to yield better outcomes than standard psychotherapy.

Method

This was a clinical study, where three groups of therapists were formed randomly. Group 1 (G1) conducted standard psychotherapy, Group 2 (G2) worked with PCOMS, and Group 3 (G3) adjusted the treatment to the role preferences of the clients. They sought therapy spontaneously and were not recruited. Nor did they choose the type of intervention. The inclusion and exclusion criteria for both clients and therapists were those established by the Psychotherapy Training and Education Program, and were not determined by the research. There was no control over client assignment, and the only control applied to therapists was the randomization of groups. For these reasons, we understand this to be a naturalistic study. Four evaluations were performed throughout all therapeutic processes (Figure 1).

Participants

Therapists

The therapists, 9 women, had no more than 3 years of experience, with an average age of 30 years. The therapists in G1, none of the three had experience in client care, while in G2, one had two years of experience in psychotherapy, another with 6 months, and the third with 2 months. Finally, the therapists in G3, one had two years of experience in psychotherapy, another with 17 months, and the third had no experience.

They predominantly had psychoanalytic undergraduate training (Fierro, 2020), but all had taken postgraduate courses with a cognitive and/or systemic orientation before starting the research project. All therapists were part of the Psychotherapy Training and Formation Program (Santangelo, 2020), in which they provided therapy to individuals with violated rights who sought care on a self-referral basis. The average number of clients attended to by each therapist was 8.62 ($SD = 2.32$). The professionals participated in two parallel 90-minute sessions: one for group supervision and another in which various activities were alternated, such as clinical seminars, presentation of topics selected by the therapists, and deliberate practice. Additionally, the therapists were required to attend two postgraduate courses.

Clients

The sample consisted of G1 ($N = 30$), G2 ($N = 35$), and G3 ($N = 36$). They received psychological care in the aforementioned program during the year 2021. The treatment provided is evidence-based (Santangelo, 2020), free of charge, and available for individuals over 18 years old without medical coverage.

Exclusion criteria, in addition to age and lack of medical coverage, included not presenting any severe disorder, such as schizophrenia, eating disorders, or problematic use of psychoactive substances. These criteria are specific to the aforementioned program. The descriptive data are shown in Table 1. Most of the participants were women, and the most frequent educational levels were completed secondary education and ongoing university studies. The most common reason for consultation in all three groups was anxiety and/or depression, 47% in G1, 71% in G2, and 45% in G3. Only one person declined to participate in this study.

Instruments

CORE-OM

The Spanish version available on the University of Barcelona's website (<https://www.ub.edu/terdep/core/>) was used. It is a self-administered scale composed of 34 items that explore 4 subscales: 1) subjective well-being (4 items), 2) symptoms/problems (12 items assessing anxiety, depression, physical problems, and trauma), 3) functioning (12 items, including general functioning, close relationships, and social relationships), and 4) risk (4 items for self-harm and 2 for acts of aggression toward others). Each item assesses the frequency of distress over the past seven days and is rated on a 5-point Likert scale according to the chosen response (0 = *Never*, 4 = *Always or almost always*). Most items reflect negative reactions; therefore, the score obtained from these items is reversed. Scores are obtained for each subscale and for the total test; higher scores indicate greater problems or symptoms. For the total score of the instrument, all subscales are summed except for the Risk subscale (T-R), as it is considered supplementary to the instrument, and any of its items that score above 0 are used as a clinical indicator of the presence of suicidal ideation, self-harm, or acts of aggression toward others. This scale was used as an outcome measure.

Outcome Rating Scale (ORS)

The ORS is a brief scale that evaluates client progress globally from four areas of functioning: individual, interpersonal, social, and general. Items are answered using a 10-centimeter visual analog scale, where the client must place only one cross or mark on a 10-centimeter line to indicate how poorly or well they are in each area. The closer the mark is to the left end, the greater the distress. It provides a score in each area from 0 to 10 and a total score based on its average. The original study was conducted in the U.S. in English, with the sample consisting of a clinical population ($n = 435$) over 18 years old and a non-clinical population ($n = 86$), aged between 22 and 65; gender, socioeconomic level, and ethnicity were mixed. Internal consistency was $\alpha = .93$, and concurrent validity between the total scores of the ORS and OQ-45.2 was $r = .59$ (Miller et al., 2003).

Figure 1
Distribution of CORE-OM Assessments by Group and Treatment Session

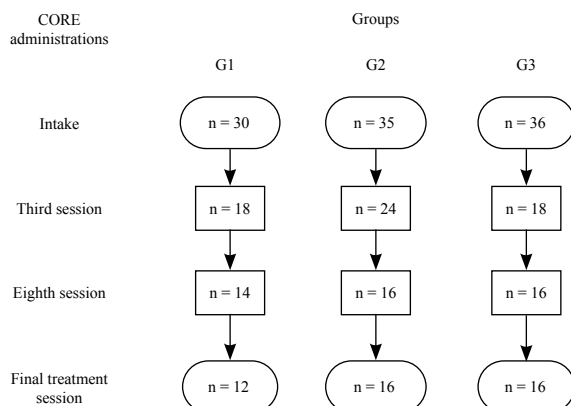


Table 1*Descriptive Data of Patients Treated Within the Framework of the Psychotherapy Training and Formation Program , Faculty of Psychology, UNMDP, Mar del Plata, 2022*

	G1 n (%)	M (SD)	G2 n (%)	M (SD)	G3 n (%)	M (SD)
Gender						
Female	25 (83)		26 (74)		25 (69)	
Male	5 (17)		9 (26)		11 (31)	
Age		32.97 (10.93)		31.54 (10.40)		28.89 (7.92)
Socioeconomic level						
Low	6 (20)		9 (26)		7 (19)	
Lower middle	8 (27)		17 (48)		15 (42)	
Middle	16 (53)		9 (26)		13 (36)	
Upper middle					1 (3)	
Marital status						
Single	18 (60)		23 (65)		30 (83)	
Married or Cohabiting	11 (37)		10 (29)		5 (14)	
Divorced			2 (6)		1 (3)	
Widowed	1 (3)					
Occupation						
Student	3 (10)		7 (20)		14 (39)	
Self-employed	6 (20)		7 (20)		5 (15)	
Employee	6 (20)		10 (29)		11 (31)	
Professional	2 (6)				1 (3)	
Unemployed	5 (18)		4 (11)			
Retired	1 (3)		1 (3)			
Administrative worker	3 (10)					
Homemaker			5 (14)		2 (6)	
Teacher	3 (10)		1 (3)		2(6)	
Not working	1 (3)					
Educational level						
No data			1		1 (3)	
Incomplete primary			1		1 (3)	
Complete primary	2 (7)					
Incomplete secondary	4 (13)		1 (3)		6 (16)	
Ongoing secondary	1 (3)		2 (6)		1 (3)	
Complete secondary	3 (10)		11 (31)		7 (19)	
Incomplete tertiary			6 (17)			
Ongoing tertiary	6 (20)		1 (3)		7 (19)	
Complete tertiary	2 (7)		5 (14)		1 (3)	
Incomplete university	2 (7)		1 (3)		2 (6)	
Ongoing university	10 (33)		6 (17)		9 (25)	
Complete university					1 (3)	
CORE-OM		135.44 (47.18)		138.59 (42.81)		128.38 (48.71)

Note: CORE-OM= Clinical Outcomes in Routine Evaluation Outcome Measure. Comparison at baseline for CORE-OM was non-significant, $p = .706$.

The psychometric properties of the Argentine adaptation were very similar to the original (Santangelo et al., 2021). The mean total score was 22.06, $SD = 9.88$, for the Individual scale 4.96, $SD = 2.59$, Interpersonal 5.66, $SD = 2.63$, Social Role 5.97, $SD = 4.31$, General 4.49, $SD = 2.66$. No differences were found regarding gender, nor was there a relationship between the scores and the age of the clients ($r = .09$, $p > .05$). The Reliable Change Index was set at 5.61. The

reliability of the scale was acceptable, with internal consistency across four different assessments: Session 1 $\alpha = .8$, Session 3 $\alpha = .89$, Session 8 $\alpha = .88$, and Final Session $\alpha = .92$. The test-retest correlation between Session 1 and Session 3 was moderate and significant ($r = .55$, $p < .001$), as was the correlation between Session 3 and Session 8 ($r = .51$, $p < .001$), and between Session 8 and Final Session ($r = .69$, $p < .001$). Concurrent Validity: The

correlation between the totals of the ORS and OQ-45.2 for each administration was moderately strong in all administrations. The coefficients were negative because lower scores on the OQ-45.2 indicate greater well-being, and the opposite is true for the ORS. The correlation coefficients between the dimensions and the totals of the ORS and OQ-45.2 were generally high. Regarding Sensitivity to Change, significant differences were found between the pre-test ($S1, M(SD) = 22.94 (9.19)$) and the post-test ($SF, M(SD) = 26.19 (8.07)$), $t(198) = -4.53, p = .042, d = -.37, 95\% \text{ CI } [-.69, -.04]$, indicating that the test is capable of detecting changes over time.

Session Rating Scale (SRS 3.0)

The SRS 3.0 is a brief instrument that evaluates the therapeutic alliance globally from four dimensions: relationship, goals and topics, approach or method, and overall. Items are answered using a 10-centimeter visual analog scale, where the client must place only one cross or mark on a 10-centimeter line to indicate how their experience was in the session. The closer the mark is to the left end, the worse the client rates the experience. It provides a score in each area from 0 to 10 and a total score based on its average. The original study was conducted in the U.S. in English, with the sample composed of three groups selected from different health agencies and intervention programs. Group one ($n = 81$), with an age range of 18 to 74 years. Group two ($n = 100$), ages ranged from 18 to 83 years. Group three ($n = 156$), age was not specified. Internal consistency was $\alpha = .88$, test-retest reliability was $.64$, and concurrent validity between the total scores of the SRS and HAQ II was $r = .48$ (Duncan et al., 2003).

The psychometric properties of the Argentine adaptation were very similar to the original (Santangelo et al., 2021). No differences were found regarding gender (women: $n = 52, M(SD) = 36.77(3.91)$, men: $n = 36, M(SD) = 36.87(4.40)$, $t(86) = -.11, p = .913, d = -.02, 95\% \text{ CI } [-.45, .40]$), nor was there any association between the scores and the clients' age ($\rho = .09, p > .05$). The reliability of the scale showed optimal results, with internal consistency in session 3 of $\alpha = .91$, in session 8 of $\alpha = .94$, and in the final session of $\alpha = .93$. The test-retest correlation was high ($\rho = .71, p < .001$) between session 3 and session 8, and non-significant between session 8 and the final session ($\rho = .39, p = .07$). Regarding Concurrent Validity, the correlation between the total scores of the SRS 3.0 and the WAI for each administration was moderate to strong in all administrations (Session 3, $\rho = .48, p < .001$; Session 8, $\rho = .67, p < .001$; Final Session, $\rho = .59, p < .001$). The correlation coefficients between the dimensions and the totals of both scales in session 3 were generally moderate to low, and all were significant.

The ORS and SRS 3.0 scales were used to provide therapists with feedback on patient progress and the quality of the therapeutic alliance. The Spanish (Argentine) translations of the ORS and SRS 3.0 scales are published on Scott D. Miller's website, <https://www.scottmiller.com>.

Psychotherapy Preferences and Experiences Questionnaire for the Client (PEX.P1)

It consists of 25 items evaluated on a 6-point Likert scale (*Not at all* = 1, *Very little* = 2, *Moderately* = 3, *Quite a bit* = 4, *Very* = 5, *Completely* = 6). Since the items illustrate interventions occurring in

psychotherapy, the client is asked to mark the response option that best expresses the degree to which they accept each intervention as helpful in their treatment. It consists of five dimensions: (1) External Orientation (EO); (2) Internal Orientation (IO); (3) Expression of Affection (EA); (4) Suppression of Affection (SA); (5) Support (SUP). The EO dimension refers to interventions focused on practical techniques to address specific problems and symptoms, consisting of five items, one of which is "It would help me to learn practical solutions to concrete problems." The IO dimension refers to interventions focused on personal reflection, understanding, and awareness of internal processes such as fantasies, memories, and dreams. It consists of five items, such as "It would help me to put feelings into words." The EA dimension refers to interventions related to the experience and expression of feelings and emotions, consisting of five items such as "It would help me to talk about painful memories." The SA dimension refers to interventions related to the suppression of feelings and emotions, as well as avoiding confrontations with actions or thoughts that lead to anxiety. It consists of five items, including "It would help me to learn to forget painful memories." The SUP dimension refers to interventions and the therapist's style based on warmth, advice, encouragement, and empathy. It consists of five items, such as "It would help me to work with a therapist who speaks with initiative and is active" (Clinton & Sandell, 2014).

Regarding the psychometric properties of the Argentine adaptation (Santangelo & Conde, 2023), the total scale showed an internal consistency of $\alpha = .90$, and for the dimensions EA $\alpha = .77$; SUP $\alpha = .80$; EO $\alpha = .90$; SA $\alpha = .64$; IO $\alpha = .76$.

Adherence to the Provider Scale for PCOMS. The ten skills (Duncan & Sparks, 2019). It consists of 10 items evaluated on a 5-point Likert scale (*Never* = 1, *Sometimes* = 2, *Often* = 3, *Regularly* = 4, *Always* = 5). The items illustrate whether therapists adhered to the PCOMS modality. The authors of the scale consider that, out of a total possible of 50 points, adherence would be considered acceptable at 40 or more.

Adherence to Treatment Based on Client Preferences Scale. An ad hoc scale was created consisting of 5 items evaluated on a 5-point Likert scale (*Never* = 1, *Sometimes* = 2, *Often* = 3, *Regularly* = 4, *Always* = 5). It evaluates whether the therapist worked with the client on the scale, whether they considered the scores when planning interventions, and whether they considered the scale useful. It was considered that out of a possible total of 25 points, adherence would be considered acceptable at 20 or more.

Procedure

The randomization of psychotherapists ($N = 9$) into the three groups ($N = 3$) was carried out using the Research Randomizer software (Urbaniak & Plous, 2013).

The therapists took a 9-hour course taught by the first author, G2 on how to implement PCOMS and G3 on how to assess and adjust treatments based on client preferences.

All treatments were evidence-based and equivalent, except for G2, which worked with PCOMS, and G3, which assessed client preferences and adjusted the treatment accordingly. They included an intake (between 3 and 4 interviews), where the client was evaluated through open interviews and a structured interview in which psychological tests (CORE-OM) were administered. Once

the intake process was completed, when there was an agreement on goals and the means to achieve them, the psychological treatment itself began, lasting no more than twelve sessions. Additionally, three evaluations were conducted, each lasting approximately 10 minutes, in which the CORE-OM was administered: in the third treatment session, the eighth session, and the twelfth (final session). Clients and therapists were given general information about the study and researchers' contact details, and written informed consent was requested, which was not a requirement for accessing treatment. The research had the ethical approval of the Research Ethics Committee of the Interdisciplinary Thematic Program in Bioethics (PTIB) under the Secretariat of Science and Technology of the National University of Mar del Plata. All subjects participated voluntarily and did not receive any form of compensation. Anonymity and confidentiality of responses were ensured.

The therapists' adherence to treatment was assessed on three occasions through access to a link where the questionnaires were available, throughout the year, in May, September, and December. The evaluation of clients was blind, meaning that the evaluators did not know which group and therapist each client belonged to. Therapists submitted the intake protocols to a member of the team, who subsequently forwarded them to the evaluators. Once the research was completed, the first author of the study interviewed the therapists to reflect on the modality they had been assigned, also considering possible modifications for a future project.

Intervention

Standard Psychotherapy – G1

Intake and treatment process of no more than 12 sessions. It is the usual treatment offered to clients consulting in the Psychotherapy Training and Formation Program (Santangelo, 2020). Therapeutic preferences were not evaluated, and the PCOMS system was not implemented.

Intervention Group (PCOMS) – G2

At the beginning of each treatment session and in the second session of the intake, the client completed the adapted Outcome Rating Scale (ORS) (Santangelo et al., 2021), where they rated their current state in each of four 10-centimeter lines associated with four domains (individual, interpersonal, social, and global), obtaining a total score out of 40. Lower scores reflect a higher degree of severity, with the cut-off point for the Argentine clinical population being a global score lower than 25.2 (Santangelo et al., 2022). From the first administration of the ORS, clients were instructed to base their responses on the agreed therapeutic goals. The ORS was introduced as a tool to guide therapy according to their perspective and to track session-by-session changes (Duncan & Sparks, 2019). The therapist scored the questionnaires and shared the information with the client.

At the end of each treatment session and in the second intake session, the client completed the adapted Session Rating Scale (SRS) (Santangelo et al., 2021), using a similar procedure to the one used for the ORS in the four domains (relationship, goals and topics, approach or method, and overall). The cut-off point for this scale is 36, meaning clients who score below this are at risk of deteriorating the therapeutic alliance. Whether the client scores below or above

the cut-off point, the therapist should thank them for their feedback and share the information. If the score is below the cut-off point or less than 9 in any of the dimensions, the therapist should address the issue to improve the situation. The SRS provides a structure to discuss the alliance and any problems that may have arisen (Duncan & Sparks, 2019). A feedback system based on raw scores was used (Barkham et al., 2023). Therapists facilitated feedback from clients by informing them that these scales do not provide bad news. If negative scores appear, they are exactly what is being sought to improve the therapeutic process. The more honest the clients were, the more reliable the information would be to improve the results.

Psychotherapy Adjusted to Client Preferences – G3

In the intake process, specifically during the second session, the client completes the adaptation of the PEX.P1 scale (Santangelo & Conde, 2023), which assesses role or activity preferences. Based on the responses, the psychotherapist adjusts the interventions. For example, if the client scored high on the External Orientation dimension, the therapist's interventions were more directive, aimed at addressing and resolving specific problems and symptoms. If the client's preferences did not align with the evidence-based knowledge regarding how to address the issue they brought to the consultation, the therapist would work on that topic by explaining why the intervention(s) that would be used would not align with their preferences, and then explain the most appropriate way to proceed with the work.

Data Analysis

We use Kruskal-Wallis's test to assess baseline differences among groups. To evaluate the effects of the different therapeutic modalities on clinical outcomes, Generalized Estimating Equations (GEE) models were employed. GEE is a statistical method suitable for analyzing longitudinal data with repeated measures, as it accounts for within-subject correlations and handles missing data efficiently. It also provides robust standard error estimates, even if it does not perfectly reflect the true correlation. In our case, GEE models were used to examine the interaction effects between the intervention groups (represented by the groups G1, G2, and G3) and time on the CORE-OM dimensions (Table 3). An exchangeable working correlation structure was specified to account for within-subject dependence over time. Missing data were handled using listwise deletion. All statistical analyses were conducted using SPSS version 20, with a significance level set at $p < .05$ and 95 % confidence intervals reported.

Additionally, effect sizes were calculated using Cohen's d coefficient to estimate the magnitude of the differences between conditions at the end of treatment. For the interpretation of effect sizes, the following cut-off points were used: small ($d = 0.20$), moderate ($d = 0.50$), and large ($d \geq 0.80$).

Results

In the Well-being and Symptoms dimensions, G2 showed significant improvements compared to G3 and G1 (see Table 2 and Table 3). Overall, the analyses revealed significant effects of the interaction between therapy type and time on several CORE-OM

Table 2

Descriptive Statistics by Group and Assessment Time Point for CORE-OM Dimensions (CORE All Items, CORE Non-Risk Items, and Risk)

Time	Groups		<i>n</i>	Minimum	Maximum	Mean	<i>SD</i>
1	G1	Risk	27	.0	10.0	3.000	3.4194
		CORE All	27	13	230	135.44	47.178
		CORE All-R	27	17	290	170.22	56.097
	G2	Risk	32	.0	10.0	2.531	3.1621
		CORE All	32	53	230	138.59	42.813
		CORE All-R	32	70	280	176.09	51.923
	G3	Risk	34	.0	10.0	2.000	2.6285
		CORE All	34	15	210	128.38	48.709
		CORE All-R	34	20	263	164.26	58.958
2	G1	Risk	18	.0	8.0	1.944	2.2874
		CORE All	18	50	200	115.39	41.087
		CORE All-R	18	67	240	147.11	49.000
	G2	Risk	24	.0	14.0	1.833	3.3188
		CORE All	24	30	220	106.13	45.779
		CORE All-R	24	37	247	135.21	53.585
	G3	Risk	18	.0	4.0	.889	1.2783
		CORE All	18	45	208	104.61	41.385
		CORE All-R	18	60	267	136.11	51.607
3	G1	Risk	14	.0	7.0	2.214	2.7225
		CORE All	14	23	163	115.79	46.702
		CORE All-R	14	30	210	146.71	57.354
	G2	Risk	16	.0	11.0	1.563	2.9432
		CORE All	16	18	178	86.31	50.488
		CORE All-R	16	23	230	109.56	61.087
	G3	Risk	16	.0	3.0	1.125	1.1475
		CORE All	16	30	175	106.94	35.320
		CORE All-R	16	40	223	138.44	45.608
4	G1	Risk	12	.0	4.0	.917	1.6765
		CORE All	12	38	163	101.67	41.829
		CORE All-R	12	50	217	132.00	54.124
	G2	Risk	16	.0	6.0	.813	1.6820
		CORE All	16	10	135	66.25	40.096
		CORE All-R	16	13	180	85.50	50.442
	G3	Risk	16	.0	6.0	1.063	1.9822
		CORE All	16	18	183	96.13	43.851
		CORE All-R	16	23	230	124.19	54.763

Note: CORE All = CORE-OM All items. CORE All-R = CORE-OM Non-risk items. G1 = Standard Psychotherapy. G2 = Feedback-Informed Psychotherapy. G3 = Preference-Based Psychotherapy.

dimensions. In particular, a greater reduction in general distress scores was observed when there was an interaction between the type of therapy and the passage of time.

The evaluation of the Functioning dimension also showed significant differences between groups. Participants in G2 demonstrated significant improvements in overall functioning compared to G3.

In the Well-being and CORE All items' measures, the interactions between time and the PCOMS model of the G2 group were significant. This indicates that the change observed in these variables depends both on the passage of time and the type of intervention, generating an additional effect when both factors interact. In contrast, no significant interaction was found between time and the type of intervention in the Functioning dimension.

No major differences were found between treatments or significant interactions over time in the Risk dimension, suggesting that time is the main factor in improving the reduction of perceived risk.

Dispersion can be observed across the four measurement points (Figure 2).

The scores of G1 show a slight decrease in the mean over time, which suggests a possible improvement in the clients' symptoms. However, the interquartile range remains relatively wide at each time of measurement, showing considerable dispersion of the scores within the group.

CORE All items for G2 also show a decrease over time, which could indicate an improvement in symptoms. Additionally, the range of scores gradually narrows, suggesting greater consistency in treatment responses at the later time points.

In G2, a decrease in scores is observed at the second time point (third treatment session), followed by stabilization at subsequent times. The interquartile range remains moderately wide, although the group shows less variability than G1.

This trend can also be observed in the total CORE scores without the Risk items (Figure 3).

G1 shows a mild decrease in average scores over time, with a more noticeable reduction in final measurements. G2 also scores decrease over time, with less dispersion by the third and fourth administrations.

These results suggest greater consistency in outcomes in these approaches compared to G1.

Figure 2

Total CORE-OM Scores for G1, G2, and G3 Across Four Time Points

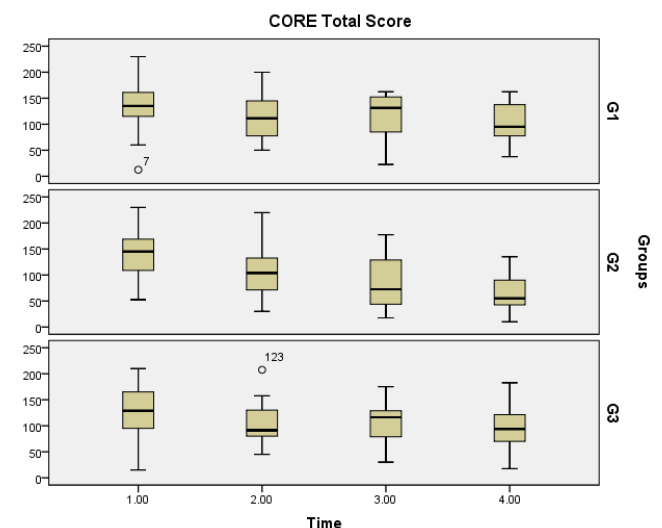
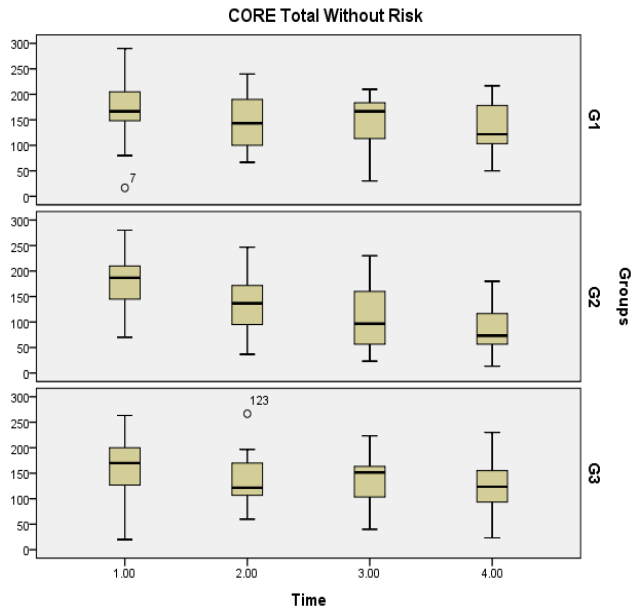


Figure 3
CORE-OM Scores for G1, G2, and G3 Across Four Time Points (Excluding Risk Items)



Comparison of Effects Between Conditions

Effect sizes (Cohen's d) were calculated to compare clinical outcomes between groups. The comparison between G2 and G1 showed a large effect ($d = -0.87$), indicating substantial clinical improvement in G2. The comparison between G2 and G3 yielded a moderate-to-large effect ($d = -0.71$), also favoring G2. In contrast, the difference between G3 and G1 was very small or negligible ($d = -0.13$), suggesting clinical equivalence between these two conditions.

Treatment Adherence Routine Monitoring of Results – G2

PCOMS Provider Adherence Scale. Ten Skills (Duncan & Sparks, 2019). The items illustrate whether therapists adhered to the PCOMS modality. The authors of the scale consider adherence acceptable with a score of 40 or more out of a possible 50 points. All evaluations, three from each therapist, scored over 40 points, except for one which scored 38. This indicates adherence to treatment.

Therapeutic Preferences – G3

Treatment Adherence Based on Client Preferences Scale. Adherence was considered acceptable with a score of 20 or more out of a possible 25 points. Adherence was acceptable for one of the

Table 3
Descriptive Statistics by Group and Time Point for CORE-OM Dimensions (CORE All Items, CORE Non-Risk Items, and Risk)

Predictors	Well-being			Symptoms			Functioning			Risk			CORE Total Score			CORE Total Score Without Risk		
	Wald χ^2	B(SE)	IC 95 %	Wald χ^2	B(SE)	IC 95 %	Wald χ^2	B(SE)	IC 95 %	Wald χ^2	B(SE)	IC 95 %	Wald χ^2	B(SE)	IC 95 %	Wald χ^2	B(SE)	IC 95 %
Model 1. PP vs. Standard y PCOMS																		
Standard (ref. PP)	.02	.01 (.09)	-.18 to .21	.04	-.24 (.11)	-.25 to .20	.56	.09 (.13)	-.15 to .34	1.18	.44 (.41)	-.35 to 1.24	.19	.05 (.11)	-.17 to .26	.06	.03 (.10)	-.18 to .23
PCOMS (ref. PP)	8.44**	.26 (.09)	.08 to .43	2.05	.16 (.11)	-.06 to .39	4.8*	.23 (.19)	0.02 to 0.43	.63	.28 (.35)	-.41 to .96	4.52*	.21 (.10)	.02 to .40	4.72*	.2 (.09)	.02 to .38
Time	6.80**	-.06 (.02)	-.11 to -.01	15.30**	-.12 (.03)	-.19 to -.06	10.1**	-.09 (.03)	-.14 to -.03	8.59**	-.30 (.10)	-.51 to -.10	16.65**	-.11 (.03)	-.16 to -.06	15.48**	-.10 (.03)	-.15 to -.05
Standard*time (ref. PP*time)	.19	-.02 (.04)	-.11 to .07	1.16	.04 (.04)	-.04 to .13	.004	-.003 (.05)	-.10 to 0.09	.19	.07 (.17)	-.26 to .40	0.17	.02 (.04)	-.06 to .10	.17	.02 (.04)	-.06 to .10
PCOMS*time (ref. PP*time)	9.84**	-.1 (.05)	-.26 to -.06	5.40*	-.12 (.05)	-.23 to -.02	4.32*	-.10 (.05)	-.19 to -.006	.66	.10 (.13)	-.15 to .36	5.67*	-.11 (.05)	-.21 to -.02	6.47*	-.12 (.05)	-.21 to -.03
Model 2. PCOMS vs. Standard																		
PCOMS (ref. Standard)	6.22*	.25 (.1)	.05 to .44	2.9	.19 (.11)	-.03 to .40	1.45	.13 (.11)	-.08 to .35	.17	-.16 (.39)	-.94 to .61	2.46	.16 (.10)	-.04 to .36	3.29	.18 (.10)	-.01 to .38
Time	4.26*	-.08 (.04)	-.16 to -.01	7.2**	-.08 (.03)	-.13 to -.02	5.12*	-.09 (.04)	-.17 to -.01	3.06	-.23 (.13)	-.49 to .03	7.73**	-.09 (.03)	-.15 to -.03	6.86**	-.08 (.03)	-.15 to -.02
PCOMS* time (ref. Standard * time)	5.34*	-.14 (.06)	-.26 to -.02	10.72**	-.17 (.05)	-.28 to -.07	2.94	-.09 (.05)	-.20 to .01	.04	.03 (.15)	-.27 to .33	648*	-.13 (.05)	-.23 to -.03	7.22**	-.14 (.05)	-.24 to -.04

Note: PCOMS= Partners for Change Outcome Management System. PP= Psychotherapeutic Preferences. CI= Confidence Interval. ** $p < .01$. * $p < .05$.

therapists in all three evaluations, while for the other two, adherence was acceptable only in the first administration, but not in the second or third.

Interviews with Therapists. Therapists from G2 found no difficulties in implementing PCOMS, only mentioning that it took a bit of time as the administration was on paper, but it was not a significant issue. Therapists from G3 stated that client preferences were mainly considered in the early sessions of treatment, but less so afterward. They found it important to also evaluate these preferences during the course of treatment.

Discussion

This study aimed to compare the effectiveness of two types of treatments: psychotherapy based on Routine Outcome Monitoring (ROM) using PCOMS (G2) and psychotherapy adjusted to clients' role preferences (G3). It is the first study conducted in our context evaluating these treatment modalities. The findings show that psychotherapy monitored with PCOMS, from G2, produced better results than psychotherapy adjusted to client preferences, from G3, and the standard treatment, from G1.

To evaluate the results, the CORE OM was used, taking into account each of its dimensions and the total score. In all its dimensions, namely Symptoms/Problems; Well-being, and Functioning, the results show a significant superiority psychotherapy monitored with PCOMS, as does the total scale. Furthermore, time would amplify the treatment effects.

In the only dimension where no significant differences were found between the treatments nor noteworthy interactions with time, it was in the risk dimension, suggesting that time is the main factor in improving the reduction of perceived risk. One reason this might have occurred is due to characteristics of the sample.

The results of the present study align with those reported in the meta-analysis by Østergård et al. (2020). They found that PCOMS had a moderate effect in counseling settings with less severely affected clients, a similar population to the one worked with in this study. However, they argue that the results of studies on PCOMS in counseling settings could be influenced by bias due to researcher loyalty and the use of the ORS as the sole outcome measure. The eight studies in the meta-analysis, conducted in counseling settings, used the ORS as the only outcome measure, and seven of them were carried out in cooperation with the "Heart and Soul of Change Project" (2017), with B. L. Duncan and/or R. J. Reese as coauthors (cited in Østergård et al., 2020). However, the present study provides evidence of the superiority of PCOMS without the previously mentioned biases, the use of ORS as an outcome measure, or researcher loyalty. Although the ORS and SRS scales were completed in front of the therapist, the CORE OM was used to evaluate the results, avoiding the social desirability bias suggested by Østergård et al. (2020).

One possible explanation for the results related to ROM is that a measurement-based approach, with feedback as a central psychotherapeutic process, enhances therapist interventions (Lutz et al., 2022). Additionally, ORS and SRS are brief scales, and clients prefer short measures to monitor treatment progress (Thew et al., 2015). We hypothesize that ROM was more effective because patients were informed about the rationale behind its implementation and understood that the ORS is not a symptom-focused scale, but rather a tool designed to assess progress based

on collaboratively established goals. This may have contributed to clients feeling more empowered and actively engaged in the therapeutic process. Furthermore, both the ORS and the SRS were likely used as instruments to facilitate clinical dialogue and to foster greater involvement in treatment. This hypothesis aligns with the meta-themes proposed in the work of Solstad et al. (2019). Additionally, data were reviewed collaboratively with clients, as suggested by some authors (Hepner et al., 2019). In a recent meta-analysis, Jonášová et al. (2024) reported that monitoring serves three main purposes: (1) providing valuable information that might otherwise be overlooked; (2) acting as a communication tool for clinically essential conversations; and (3) offering a structure to help therapists and clients stay focused on therapy goals while promoting a flexible and dynamic approach to care. These principles may have played a role in G2 outcomes in the present study, as both the ORS and SRS aim to facilitate clinical dialogue by focusing on relevant information and centering on goals agreed upon with clients.

The literature suggests that preference-based personalization can optimize the therapeutic alliance and outcomes when applied continuously (Li et al., 2024). In our study, intermittent adherence (focused only on the initial sessions) resulted in a treatment that, from the fourth session onward, resembled the standard approach. This inconsistency helps explain why, despite an early positive effect, sustained advantages were not observed.

In other words, the therapist's lack of adherence to the treatment may be one of the reasons why the use of Routine Outcome Monitoring with feedback was superior. It is important to highlight that in the second assessment (third treatment session), there was a significant improvement in this group, which was not sustained in later evaluations. One explanation for this phenomenon is that when therapists considered client preferences, better results were achieved in the second assessment (third session), but these improvements did not persist throughout the treatment due to the therapists' lack of adherence. This aligns with findings from a qualitative study (Li et al., 2024), where clients found the personalization of treatment more useful than a generic approach. Therefore, rather than questioning the value of preferences, our data highlight the importance of support mechanisms—such as protocols, electronic reminders, or focused supervision—that help therapists incorporate preferences throughout the entire treatment.

Considering the final outcome of treatments based on client preferences, the findings of this study align with recent research that used PEX-1 to assess therapeutic preferences and found no statistically significant matching effect for the five activity types measured by the scale (Faye Jacobsen et al., 2024). Similarly, a recent study on 470 outpatients found no relationship between role or activity preferences and psychotherapy outcomes (Cooper et al., 2022). These results are also consistent with the meta-analysis conducted by Windle et al. (2020), which found no significant effect of client preference on clinical outcomes, and the recent study by Eigenhuis et al. (2024), which also found no significant effect on outcomes in clients with symptoms of depression and anxiety; the most frequent presenting problems among participants in the present study.

Limitations and Strengths

Due to the naturalistic design of this study and the difficulty in accessing the clinical population, *a priori* statistical power

analysis was not conducted. However, post hoc power analyses are often discouraged in the literature because they can yield misleading results, particularly when based on observed effect sizes. Instead, our analyses used Generalized Estimating Equations (GEE), which are robust for small to moderate sample sizes and suitable for repeated measures with missing data. Nevertheless, we acknowledge that the relatively small sample size is a limitation and recommend that future studies include larger and more diverse samples to strengthen statistical power. The therapists' gender was exclusively female, although previous studies suggest that this does not impact psychotherapy outcomes (Wampold & Imel, 2015). Due to the characteristics of the care system, clients were not randomly assigned to groups. While this implies less control over variables, it also increases the generalizability of the findings. The PCOMS system was used as a clinical tool to facilitate dialogue with clients, but no algorithms were employed to determine the expected response for each client. Another limitation was that therapists in the G3 group considered client preferences during the initial treatment sessions, but after the fourth session, the degree of attention given to these preferences was not consistent. To ensure adherence to the assessment of preferences and to tailor interventions accordingly, the following are recommended: specific training on how to collect, update, and apply role preferences throughout the process; use of technological supports that remind the therapist to review preferences and co-plan goals; and clinical supervision that includes session review and feedback on the consistent use of preference information.

In the previously mentioned meta-analysis (Østergård et al., 2020), the authors highlighted those prior studies had a high risk of bias due to the lack of blinding in outcome assessments and the use of the ORS as both an intervention tool and an outcome measure. A key strength of the present study is that it involved blinded evaluators and used a different scale from the ORS to assess psychotherapy outcomes.

Another strength is that this work is framed within the Practice-Oriented Research Paradigm (POR) (Castonguay et al., 2021). Providing high ecological validity by more accurately reflecting what happens in the real world, since it involves neither selected patients nor artificial settings, but rather clinical practice as it occurs daily. The participation of actual clinicians, with treatments delivered by therapists working under typical conditions—not by expert researchers specially trained for the study. It incorporates the complexity of clinical work; instead of controlling all variables, it accepts the diversity of clients, therapist styles, and dynamic changes as part of the process. This makes it more faithful to clinical reality.

The therapists in this study implement the usual evidence-based treatment with the incorporation of client preference assessment and routine monitoring. The research was conducted in a real consultation context, the sampling was naturalistic, the exclusion criteria were those of the intervention program, and as mentioned earlier, clients sought consultation on a voluntary basis and were not randomized. Additionally, therapists were interviewed at the end of the project to assess how the work had turned out, with a focus on future research.

In addition to the strengths and limitations previously discussed, it is important to consider certain cultural and systemic aspects of the Argentine context that may have influenced the

observed outcomes. First, the mental health system in Argentina is marked by considerable heterogeneity, with the coexistence of diverse theoretical orientations (psychoanalytic, humanistic, cognitive-behavioral, systemic), and a historical predominance of psychoanalysis in both undergraduate and postgraduate training. However, the therapists participating in the Psychotherapy Training and Development Program were not psychoanalysts, but rather professionals who deliberately chose an evidence-based training path, which may have shaped their conceptualization of psychotherapy. This may have fostered greater openness to assessment models such as PCOMS, which provide an external and objective tool to guide the clinical process. Moreover, data-informed feedback may be perceived as more persuasive and legitimate within a professional framework that values technical and measurable components, potentially accounting for its greater impact in this sample. Therefore, the results observed may be at least partially mediated by these cultural and training-related specificities. Future research should further explore how such factors modulate the relative effectiveness of different client-centered strategies.

In Argentina, the implementation of measurement-based care using PCOMS has not been evaluated until now. Furthermore, there is no local precedent for adjusting psychotherapy treatments according to clients' role or activity preferences.

This study provides novel local evidence: psychotherapy informed by ROM with PCOMS improves clinical outcomes compared to standard treatment and preference-tailored psychotherapy when therapists' adherence to those preferences is not sustained. For Argentine practice, these findings highlight the usefulness of integrating continuous feedback systems and the need for training and technological strategies that keep preference-based personalization active throughout the therapeutic process. Future research should include larger samples, client randomization, and support mechanisms to validate the independent impact of sustained preferences on psychotherapy effectiveness.

Conflict of Interest

Los autores no tienen conflictos de interés.

Declaration of Authorship

Pablo R. Santangelo: Project administration, methodology, supervision, conceptualization, and writing. Karina Conde: Data curation, formal analysis. Gabriela Millaman Rickert: Data curation, formal analysis, writing. Marcos Mattiello: Drafting, writing, and data collection. Germán Lao: Review, editing, and data collection. Victoria Pocorena: Review, drafting, and data collection.

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