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Using Formal Client Feedback to Improve Retention and Outcome: Making Ongoing, Real-time Assessment Feasible

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Research has found that client change occurs earlier rather than later in the treatment process, and that the client's subject experience of meaningful change in the first few sessions is critical. If improvement in the client's subject sense of well-being does not occur in the first few sessions then the likelihood of a positive outcome significantly decreases. Recent studies have found that there are significant improvements in both retention and outcome when therapists receive formal, real-time feedback from clients regarding the process and outcome of therapy. However, the most used instruments in these feedback studies are long and take up valuable therapy time to complete. It has been found that most therapists are not likely to use any feedback instruments if it takes more than five minutes to complete, score and interpret. This article reports the results of an evaluation of the use of two very brief instruments for monitoring the process and outcome of therapy, the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS), in a study involving 75 therapists and 6,424 clients over a two year period. These two instruments were found to be valid and reliable and had a high use-rate among the therapists. The findings are discussed in light of the current emphasis on evidence-based practice.

"The proof of the pudding is in the eating."
Cervantes, *Don Quixote*
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Outcome research indicates that the general trajectory of change in successful psychotherapy is highly predictable, with most change occurring earlier rather than later in the treatment process (Brown, Dreis, & Nace, 1999; Hansen & Lambert 2003). In their now classic article on the dose-effect relationship, Howard, Kopte,

Krause, and Orlinsky (1986) found that between 60-65% of people experienced significant symptomatic relief within one to seven visits—figures that increased to 70-75% after six months, and 85% at one year. These same findings further showed, "a course of diminishing returns with more and more effort required to achieve just noticeable differences in patient improvement" as time in treatment lengthened (p. 361, Howard et al., 1986).

Soon after Howard et al.'s (1986) pioneering study, researchers began using early improvement—specifically, the client's subjective experience of meaningful change in the first few visits—to predict whether a given pairing of client and therapist or treatment system would result in a successful outcome (Haas, Hill, Lambert, & Morrell, 2002; Lambert, Whipple, Smart, Vermeersch, Nielsen, & Hawkins, 2001; Lueger, 1998; Lueger, 2001). Continuing where they had left off, Howard, Lueger, Maling, & Martinovich (1993) not only confirmed that most change takes place earlier than later, but also found that an absence of early improvement in the client's subjective sense of well-being significantly decreased the chances of achieving symptomatic relief and healthier life functioning by the end of treatment. Similarly, in a study of more than 2000 therapists and thousands of clients, Brown, et al. (1999) found that therapeutic relationships in which no improvement occurred by the third visit did not on average result in improvement over the entire course of treatment; this study further found that clients who got worse by the third visit were twice as likely to drop out of treatment than clients who reported making progress. More telling, variables such as diagnosis, severity, family support, and type of therapy were, "not . . . as important [in predicting eventual outcome] as knowing whether or not the treatment being provided [was] actually working" (p. 404).

By the mid-nineties, researchers were using data generated during treatment to improve the quality and outcome of care. In 1996, Howard, Moras, Brill, Martinovich, and Lutz showed how measures of client progress could be used to "determine the appropriateness of the current treatment…the need for further treatment…[and] prompt a clinical consultation for patients who [were] not progressing at expected rates" (p. 1063). That same year, Lambert and Brown (1996) made a similar argument using a shorter, and hence more feasible, outcome tool.

Other researchers had already found that clients' early ratings of the alliance, like progress, were "significant predictors of final treatment outcome" (Bachelor & Horvath, 1999, p. 139). Building on this knowledge, Johnson and Shaha (1996, 1997; Johnson, 1995) were among the first to document the impact of outcome and process tools on the quality and outcome of psychotherapy as well as demonstrate how such data could foster a cooperative, accountable relationship with payers.

Several recent studies have documented significant improvements in both retention in and outcome from treatment when therapists have access to formal, real-time feedback from clients regarding the process and outcome of therapy (Duncan & Miller, 2000; Duncan, Miller, & Sparks, 2004). For example, Whipple, Lambert, Vermeersch, Smart, Nielsen, and Hawkins (2003), found that clients whose therapists had access to progress and alliance information were less likely to deteriorate, more likely to stay longer, and twice as likely to achieve a clinically significant change. Formal client feedback has also been shown to be particularly helpful in cases at risk for a negative or null outcome. A meta-analysis of three studies by Lambert, Whipple, Hawkins, Vermeersch, Nielsen, and Smart (2003) found that cases informed by client ratings of progress were, at the conclusion of treatment, better off than 65% of those without access to such data (Average ES = .39).

The present study was designed to assess the impact of two simple and brief, client-completed, rating scales of alliance and outcome on retention in and outcome from therapy. Research and clinical experience indicate that the length and complexity of the measures employed in the studies to date hinder their application in real world clinical settings (Miller, Duncan, Brown, Sparks, & Claud, 2003). Indeed, Brown et al. (1999) found that the majority of practitioners are unlikely to use any measure or combinations of measures that took more than five minutes to complete, score, and interpret. Therapists, it is clear, not only require valid and reliable but also *feasible* tools for inviting client feedback. As Lambert, Hansen, and Finch (2001) pointed out in a special issue of the *Journal of Consulting and Clinical Psychology* on client feedback, "treatment systems cannot tolerate expensive and time-intensive markers of change, especially when used as a start up procedure or where patient (sic) progress is reported to therapists on a weekly schedule" (p. 160).

Method

Participants

The participants in the study were clients of Resources for Living® (RFL), an international Employee Assistance Program (EAP) based in Austin, Texas. The company employs 75 "in-house" therapists who provide telephonic-based employee assistance, information and referral, executive coaching, individual therapy, disease management, and critical incident services to 28 different corporate and organization customers. Therapists at RFL range in age from 25 to 57, with an average age of 37.4, and are predominantly female (72.2%). Average length of employment at RFL for those included in the study was 3 years, with an average of 7 years of total clinical experience. The staff comes from a variety of professional disciplines, including clinical psychology (45%), social work (35%), and marriage and family therapy (20%), and the majority of them (92%) were licensed to practice independently by their respective discipline.

The clientele of RFL is culturally and economically diverse, including people of American, European, African, Latin, and Caribbean decent. In any given year, the severity of problems presented by clients of organization is comparable to those seen in a typical mental health clinic, including anxiety, depression, alcohol and drug abuse, work and family issues, as well as chronic mental and physical health problems (Miller, Duncan, Brown et al., 2003).

The sample in the present study included 6,424 clients that received telephonic based counseling between April 1, 2002 and March 31, 2004. In order to be included in the sample, the client must have received at least two sessions and completed an outcome questionnaire by the end of each. Because callers have a right to remain anonymous, limited demographic information is available. Similar to most community mental health outpatient settings, two-thirds of the participants were female, one third male. The average age of the sample was 36, with a median age of 34, mode of 20, and standard deviation of 13. The level of distress as assessed by the outcome measure administered at intake was also similar to that found in a typical community mental health outpatient sample—in fact, it was slightly greater than the figure reported by Miller, Duncan, Brown et al. 2003 (18.6 versus 19.6).

Given that the services offered by RFL are employer funded, it can be safely assumed that all of the clients in the current study were either employed or were a family member

of someone who was working for a covered organization. The majority of clients who utilized the service during the study period fell at the lowest end of the pay scale in their respective work settings, with 68% of the sample made up of "line workers," 12% from middle and upper management, and 4% who had either retired or been terminated. Family members of a covered employee made up the remaining 16% of contacts. During the study period, the top five presenting problems were: (1) marital (24.7%); (2) depression (10%); (3) anxiety (5.9%); (4) issues related to grief and loss (4.8%); and (5) drug and alcohol problems (3.5%).

Measures

Client progress was assessed via the oral version of the Outcome Rating Scale (ORS [Miller & Duncan, 2000]), a four-item, self-report instrument (see Appendix 1). The ORS was developed as a brief alternative to the Outcome Questionnaire 45 (OQ-45)—a popular but longer measure developed by Lambert and colleagues (Lambert, Hansen, Umphress, Lunnen, Okiishi, Burlingame, Huefner & Reisinger, 1996). Both scales are designed to assess change in three areas of client functioning widely considered valid indicators of progress in treatment: individual (or symptomatic) functioning, interpersonal relationships, and social role performance (work adjustment, quality of life [Lambert & Hill, 1994]).

In a recent issue of the *Journal of Brief Therapy*, Miller, Duncan, Brown et al. (2003) reported results of an initial investigation of the reliability and validity of the ORS. Pearson product moment correlation between the ORS and the OQ-45 yielded a concurrent validity coefficient of .58, a figure considered adequate given the brevity of the ORS. Reliability of the measure, as assessed by Cronbach's coefficient alpha, was .93, test-retest reliability at the second session, .66. Independent confirmation of the reliability of the ORS was conducted by the Center for Clinical Informatics[11] using data collected at RFL. In this sample, coefficient alpha was found to be .79 (n = 15,778), while test-retest reliability at second administration was .53 (n = 1,710). With regard to the latter, it is important to note that lower test-retest reliability is expected for measures designed to be sensitive to change from week to week as research has shown both the ORS and OQ-45 to be (Miller, Duncan, Brown et al. 2003; Vermeersch, Lambert, & Burlingame, 2000).

The therapeutic alliance was assessed via the oral version of the Session Rating Scale 3.0 (SRS [Miller, Duncan, & Johnson, 2000] see Appendix 2). The SRS is a brief, four-item, client-completed measure derived from a ten-item scale originally developed by Johnson (1995). Items on this measure reflect the classical definition of the alliance first stated by Bordin (1979), and a related construct known as the client's theory of change (Duncan & Miller, 2000). As such, the scale assesses four interacting elements, including the quality of the relational bond, as well as the degree of agreement between the client and therapist on the goals, methods, and overall approach of therapy.

To test the reliability and validity of the SRS, Duncan, Miller, Reynolds, Sparks, Claud, Brown, & Johnson (2004) compared the instrument to the Revised Helping Alliance Questionnaire (HAQ-II), a widely used measure of therapeutic alliance. The reliability for the SRS compared favorably with the HAQ-II (.88 and .90, respectively). Test-retest reliability for the SRS over six administrations was .74, compared to .69 for the HAQ-II. Concurrent validity as estimated by Pearson product moment correlations averaged .48, evidence that the SRS and HAQ-II are referencing similar domains. As with

the ORS, independent confirmation of the reliability of the SRS was conducted by the Center for Clinical Informatics using data collected at RFL. In a sample of nearly 15,000 administrations, coefficient alpha was found to be .96, remarkably high for a four-item measure. Test-retest reliability was .50, comparable to that of the ORS.

Procedures

The study was divided into four distinct phases: (1) initial training (including several site visits by the first two authors over a 6-month period); (2) baseline data collection and analysis (6 months); (3) implementation of automated feedback condition (6 months); and (4) continued evaluation (12 months). During the first phase, therapists were trained on site by the first two authors in the proper administration of the ORS and SRS. Both tools were then incorporated into RFL's existing, computerized client tracking system, making the use of the scales a uniform and automatic process along with routine record keeping. In practice, the ORS was completed at the start of each session and the SRS at the end.

During the second phase, baseline data from the ORS and SRS was collected for 1,244 clients that received two or more telephonic counseling sessions. Gathering such data was a critical step in developing the clinical norms that would form the basis for the automated feedback system known as SIGNAL (Statistical Indicators of Growth, Navigation, Alignment and Learning). As the name implies, the Windows™-based system used a traffic light graphic to provide "real-time" warnings to therapists when an individual client's ratings of either the alliance or outcome fell significantly outside of the established norms.

As an example of the kind of feedback a therapist would receive when a particular client's outcomes fell outside of the expected norms, consider Figure 2. The dotted line represents the expected trajectory of change for clients at RFL whose total score at intake on the ORS is 10. Consistent with prior research and methodology (Lambert & Brown, 2002), trajectories of change were derived via linear regression, and provide a visual representation of the relationship between ORS scores at intake and at each subsequent administration. Colored bands corresponding to the 25th (yellow) and 10th (red) percentiles mark the distribution of actual scores below the expected trajectory over time. The horizontal dashed-dotted line at 25 represents the clinical cutoff score for the ORS. Scores falling above the line are characteristic of individuals not seeking treatment and scores below similar to people who are in treatment and likely to improve (Duncan, Miller, Reynolds, et al. 2003). The remaining solid line designated the client's actual score from session to session.

As can be seen in Figure 2, the client's score at the second session falls below the 25th percentile. By session 3 the score has fallen even further, landing in the red area representing the 10th percentile in the distribution of actual scores. As a result, the therapist receives a "red" signal, warning of the potential for premature drop out and an increased risk for a negative or null outcome should therapy continue unchanged. An option button provides suggestions for addressing the problem, including: (1) talking with the client about problems in the alliance; (2) changing the type and amount of treatment being offered; and (3) recommending consultation or supervision.

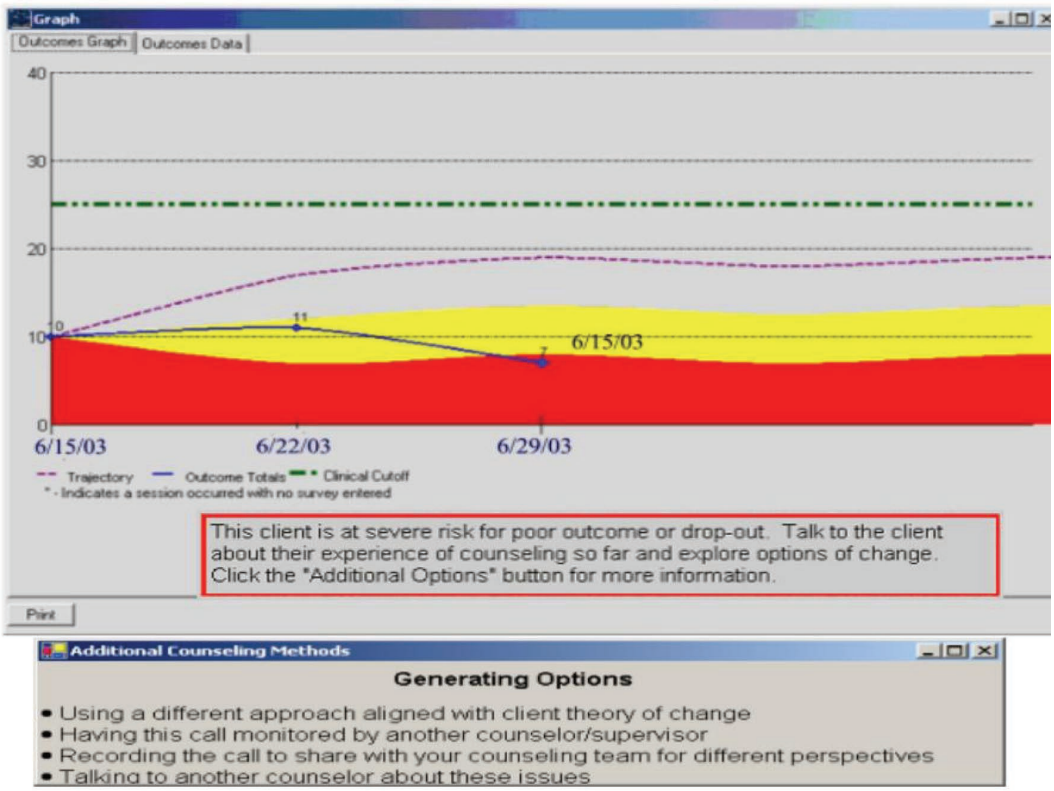

Figure 2: SIGNAL Outcome Feedback

Client feedback regarding the alliance was presented in a similar fashion at the end of each visit (see Figure 3). A solid line designates a client's actual score from session to session. Colored bands represent the 25th (yellow) and 10th (red) percentile of responders in the study sample (Duncan, Miller, Reynolds et al. 2004). In this particular example, the client scores a 34 on the SRS at the conclusion of the first visit. As can be seen, this score falls below the 25th percentile thus triggering a yellow signal. Given the relative rarity of such a score, the therapist is advised to check in with the client about their experience, express concern for their work together, and explore options for changing the interaction *before* ending the session.

Once the normative data was collected and the SIGNAL feedback system created, the study entered its third phase. Outcome and alliance scores were entered and SIGNAL feedback given for the next 1568 clients that sought services at RFL. During this time, a handful of site visits by the first two authors, plus ongoing support from administration and management at RFL encouraged a high rate of compliance with and consistency in the use of the measures and SIGNAL system. In the fourth and final phase of the study, data was collected from an additional 3,612 clients, providing a large sample by which the effect of feedback on the retention in and outcome from clinical services could be evaluated.

Data Analysis

The outcome of treatment was assessed in three ways. First, a continuous variable

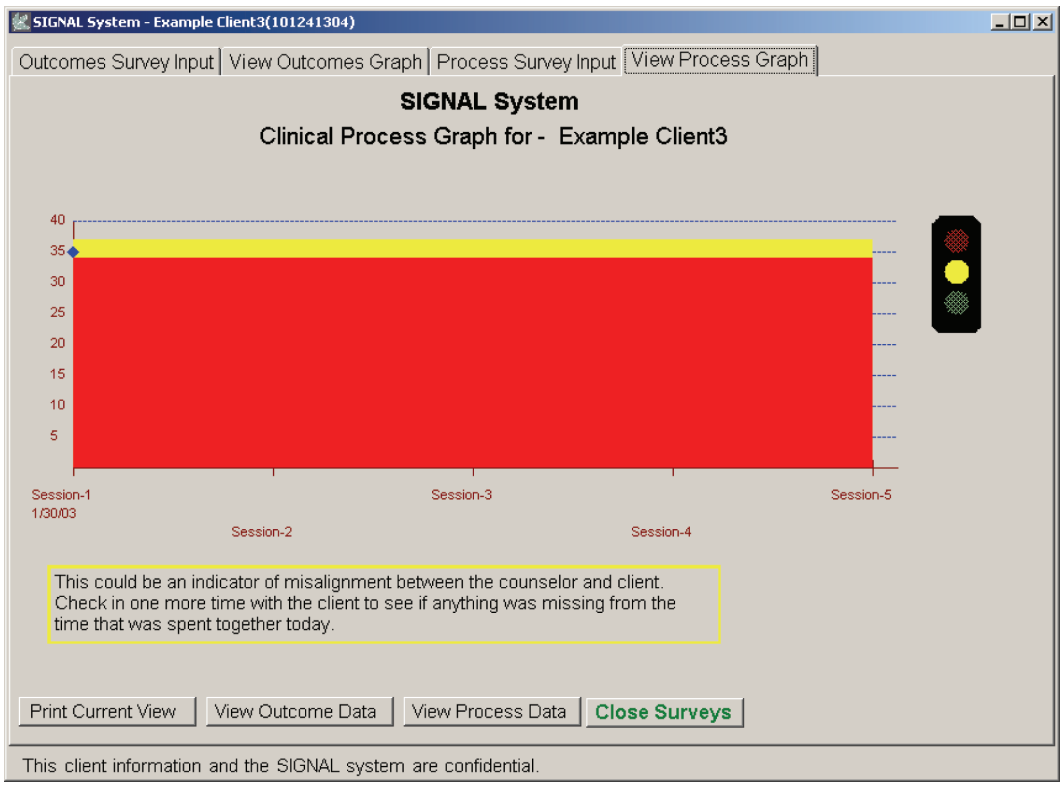

Figure 3: SIGNAL Alliance Feedback

gain score was calculated by subtracting the ORS score at intake from ORS score at the final session. Second, a residualized gain score was computed based on a linear regression model. Residualized gain scores are necessary whenever intake scores are correlated with change scores in order to control for the change in gain scores associated with differences in ORS scores at intake (Cohen & Cohen, 1983; Campbell & Kenny, 1999). Third, and finally, a categorical variable classification of outcome as "improved," "unchanged," or "deteriorated" was determined by comparing the gain score against the reliable change index of the ORS (RCI = 5; Duncan & Miller, 2004). The RCI for the ORS is 5, so cases with a gain score greater than +5 were classified as improved, -5 as worse, and those falling between + or – 4 points as unchanged.

In order to facilitate interpretation of the magnitude of improvement across phases, gain scores were converted to effect sizes (Smith & Glass, 1987). The effect sizes in the present study were calculated by dividing the gain score by the standard deviation of the ORS in a non-treatment normative sample (Miller, Duncan, Brown et al. 2003). As such, the effect sizes reported can be interpreted as an indication of how much clients in the study improved relative to a normal population.

Finally, the relationship between the alliance and outcome was also subjected to analysis. Given prior research showing that clients' early ratings of the alliance are significant predictors of final treatment outcome, simple correlations were computed between SRS scores at intake and end of treatment gain scores. To determine the effect of improving alliances on the outcome of treatment, gain scores for the SRS were computed and then correlated with gain scores on ORS. Finally, the relationship between the actual use of the

SRS and outcome from and retention in treatment the first session was also examined.

Results

Data gathered during the baseline phase of the study revealed that the majority of clients (56%) who received two or more sessions did not remain with the same therapist over the course of services. Analysis of the outcome data from this period further showed that clients who switched therapists fared significantly worse than those treated by the same therapist from session to session (Effect Size = .02 versus .79). Reflecting on the possible causes of the rampant switching, therapists and administrators identified official agency policy favoring immediate access over continuity of services. Prior to entering the third phase of the study during which SIGNAL was launched, the policy was changed. Thereafter, therapists were strongly encouraged to retain clients by setting aside a certain amount of time per week during which standing appointments could be scheduled.

By the last phase in the study, the number of clients that switched therapists had been cut in half (~27%). The outcomes for clients who stayed with the same therapist compared to those who switched can be found in Table 1. Across phases, clients who stayed with the same therapist from session to session fared significantly better. Note, additionally, that the overall outcomes of both groups improved over time. Progress was most pronounced in the group of clients that switched therapists, going from an effect size of .02 at baseline to .40 by the end of the final evaluation phase ($p < .001$). Clients who remained with the same therapist also improved significantly over the course of the study, with an initial effect size of .79 at baseline increasing to .93 during the last phase of the study ($p < .01$).

Switched therapist	Time period	Sample size	% of sample in time period	Mean ORS at intake	Mean gain score	Mean Residual gain score	Effect Size
	Baseline	695	56%	18.3	0.13	-4.6	0.02
	Intervention	689	44%	18.3	1.9	-2.9	0.28
	Evaluation	993	27%	18.3	2.7	-2*	0.40
Same therapist							
	Baseline	549	44%	18.3	5.4	0.97	0.79
	Intervention	879	56%	18.9	5.9	1.5	0.87
	Evaluation	2719	73%	19.2	6.3	2	0.93
* p<.01 when comparing result to baseline period using two tailed t-test of significance							

Table 1: Comparisons between clients that switched therapist or stayed with therapist

Table 2 presents the mean ORS intake scores, gain scores, and residualized gain scores across the various phases of the study. As can be seen, the magnitude of improvement is substantial, with the overall effect size of treatment more than doubling from the baseline period to the final evaluation phase (baseline ES = .37 versus final phase ES = .79). A one-way analysis of variance further found the difference between residualized gain scores across phases was highly significant ($p < .001$).

Time period	Sample size	Mean ORS at intake	Mean gain score	Mean Residual gain score	Effect Size
Baseline phase: (six months)	1244	18.3	2.5	-2.3	0.37
Interventional phase: 1-6 months post SIGNAL System	1568	18.6	4.2	-0.5*	0.62
Evaluation phase: 7-18 months post SIGNAL System	3612	19	5.4	1*	0.79
* p<.001 when comparing result to baseline period using two tailed T-test of significance					

Table 2: Outcomes for all cases across phases

Table 3 presents the results from the categorical variable classification of outcome. Using the RCI of the ORS as the criteria by which change was assessed, the data indicate that improvement in outcomes was due to a 13% increase in the percentage of clients reporting significant improvement and an 11% decrease in cases reporting deterioration. With regard to the latter, it is important to note that the relatively high percentage of clients that deteriorated during the various phases resulted from the inclusion of clients who scored in the normal range on the ORS (Total Score > 25) at their initial visit. Indeed, 25% of the RFL sample had intake scores at or above the established clinical cutoff for the measure. In general, clients scoring in the normal range on standardized outcome measures at intake tend to average little or no improvement or even worsen with treatment (Brown et al. 1999; Brown, Burlingame, Lambert, Jones, & Vacarro, 2001; Duncan, Miller, & Sparks, 2004). When the analysis of the data in the present study is limited to clients falling in the clinical range—as is usually the case in controlled clinical trials of psychotherapy or medications—the rate of deterioration not only decreases in the final phase to 5% but the overall effect size for the same time period increases considerably. In the final phase, for example, the overall effect size is .79. However, with the sample restricted to clinical range cases only, the effect size increases to 1.06.

Time period	% improved	% unchanged	% worse
Baseline phase:	34%	47%	19%
Interventional phase	42%	46%	12%
Evaluation phase	47%	45%	8%

Table 3: Categorical evaluation of outcomes across phases

Turning to the analysis of the relationship between alliance and outcome, scores on the SRS at intake proved to be a weak predictor of change on the ORS ($p > .05$). However, increases in SRS scores over the course of treatment were associated with better outcomes. For all cases, gain scores on the SRS correlated .13 with gain scores on the ORS ($n=4785$, $p<.0001$). As was also expected, the relationship was even stronger for clients whose SRS scores at intake fell below the clinical cutoff of 36 established for the SRS (Duncan, Miller, Reynolds, et al. 2004).

Since correlation does not imply causality, the relationship between SRS and ORS scores was examined to determine whether there was any impact of distress on clients' ratings of the alliance. The analyses showed that client ratings on the ORS and SRS were correlated both at the beginning and end of treatment ($r = .10$ and .19, respectively). Thus, clients who were less distressed were more likely to rate the alliance higher. From

the present data, it is not possible to determine whether feeling better leads to better alliances or better alliances result in feeling better. It seems plausible to assume that there is a reciprocal effect, with improved alliances leading to decreases in distress leading to improved alliance and so on.

What can be said with greater certainty is that the simple act of monitoring the alliance has a beneficial impact on outcomes and retention rates. During the baseline period, for example, 20% of the cases with ORS scores at intake did not have SRS scores for that visit. Such cases were three times *less* likely to have an additional session than those for which alliance data was present (6% versus 19%, respectively). Failure to complete the SRS was also associated with less change on the ORS at the end of treatment. Among clients who remained with the same therapists throughout treatment, those that completed the SRS at intake averaged 3.3 points more change (residualized gain score) than those that did not ($p < .01$; two tailed t-test). By the final evaluation period, utilization rates for the SRS by therapists at RFL had improved so much that failure to complete the measure was no longer predictive of drop out after the first session. Even in this phase, however, failure to complete the SRS was associated with less change by the end of treatment (Mean residualized change score = 1, $p < .05$; two tailed t-test).

Discussion

The present study found that providing formal, ongoing feedback to therapists regarding clients' experience of the alliance and progress in treatment resulted in significant improvements in both client retention and outcome. To summarize briefly, access to the client's experience of progress in treatment effectively doubled the overall effect size of services (See Figure 1). And while high alliance scores were only weakly related to outcome, improving a poor alliance during at the outset of treatment was correlated with significantly better outcomes at the conclusion. At the same time, clients of therapists who failed to seek feedback regarding the alliance as assessed by the SRS were three times less likely to return for a second session and had significantly poorer outcomes.

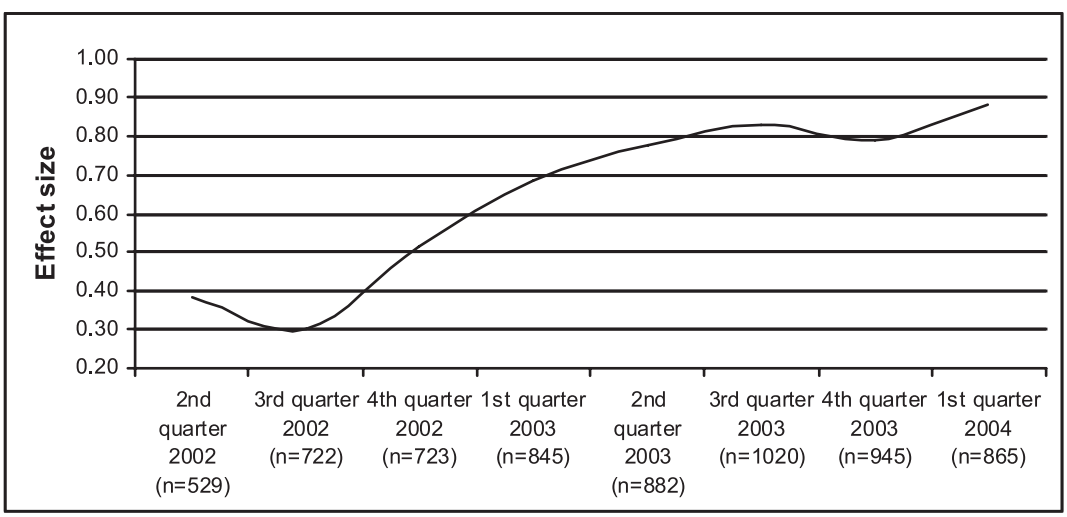

Figure 1: Effect Size

As dramatic as these results may seem, they are, as noted in the Introduction section of this article, entirely consistent with findings from similar research (Lambert et al. 2003; Whipple et al. 2003). One important difference between the current study and previous research is the simplicity and feasibility of the measures employed. Here, the results are also compelling. For example, of the thousands of sessions of treatment provided during the course of this study, only a handful of complaints were logged from clients regarding the scales. At the same time, use of the scales by therapists to inform treatment was, by the final phase of the study, exceptionally high as compared to studies that have employed longer, more complicated measures (~99% versus ~25% at 1 year [Miller, Duncan, Brown et al. 2003]).

The findings from the present study are limited by a number of factors. First and foremost is the reliance on client self-report measures (Boulet & Boss, 1991). Clearly, evaluation of outcome and alliance via the ORS and SRS is far from comprehensive and does not contain multiple perspectives (e.g., therapists, outside judges, objective criteria, etc.). At the same time, however, both measures are similar in scope to those being used in "patient-focused" as opposed to traditional efficacy types of research studies (Lambert, 2001).

A second issue to consider when determining the generalizability of the results is the type of treatment services examined in the present study. Although the sample did not differ either demographically or in terms of measured levels of distress at intake, all services were offered via the telephone. Provision of clinical services via the telephone and other technologies (e.g., internet, video-conferencing) has increased dramatically over the last two decades. Although fewer studies have been done overall, research to date finds such services work for the same reasons as (Bobevski & McLennan, 1998) and produce results roughly equivalent to face-to-face treatment for a number of presenting conditions, including the promotion of health related behaviors, anxiety and depression, obsessive-compulsive disorder, medication and case management, and suicide prevention (Gold, Anderson & Serxner, 2000; King, Nurcombe, Bickman, Hides, Reid, 2003; Ko & Lim, 1996; Liechtenstein, Glasgow, Lando, Ossip-Klein, et al. 1996; Reese, Conoley & Brossart, 2002; Salzer, Tunner, Charney, 2004; Taylor, Thordarson, Spring, Yeh, Corcoran, Eugster, & Tisshaw, 2003; X Day & Schneider 2003). Still, more studies involving direct comparisons are needed in order to better establish equivalence. On a positive note, research on feedback derived from the ORS and SRS is currently underway in a number of settings that provide face-to-face services, including residential and intensive-outpatient substance abuse treatment, outpatient community mental health, and a college counseling center.

One final issue that merits discussion is the drop out rate of clients served by RFL. Although the average number of sessions for clients who returned for at least two visits was similar to national retention rates (Mean = 3.5), the percentage of clients having only one treatment contact was significantly greater (~ 80% versus 30% [Talmon, 1990]). In order to understand the reasons for and any impact of this difference on client satisfaction and outcome, a survey was conducted (Sorrell, Miller & Chalk, in press). Follow up phone calls were made to a random sample totaling twenty percent of clients who had contacted RFL for services a single time during July 2002 (n = 225). The average length of time between contact and follow up was 58 days, with a range from 37 to 77.

During the interview, each former client was asked to complete the ORS and answer two opened ended questions regarding the services received. Interestingly, scores on the

outcome measures showed that that the large majority of those attending a single session (80%) had made positive change (average effect size = 1.3) while the remaining 20% experienced either no change or had deteriorated. Table 4 summarizes the responses clients gave when they were asked why they had not sought out further care with RFL. Consistent with the results on the ORS, clients who rated improved were much more likely than those reporting a negative or null outcome to cite "lack of need" as the major reason for not seeking further services. On other hand, clients reporting a negative or null outcome were four times more likely than those rating improved to cite "counselor unhelpfulness"—a result also consistent with results on the ORS.

Outcome	No reason to call back	Too busy to call back	Counselor didn't help	Wanted to handle it myself	Getting help elsewhere	System failure
Positive	**44%**	**20%**	**6%**	**11%**	**8%**	**11%**
Negative or null	**24%**	**27%**	**23%**	**10%**	**8%**	**8%**

Table 4: Single session follow up study

When clients rating improved were asked to account for the changes they had experienced since their single session, 28% cited "talking to the RFL counselor" as the major contributor—second only to extratherapeutic factors (36%). Only 10% of such clients attributed the change to another treatment service or provider. Indeed, whether clients rated improved or had experienced a negative or null outcome, very few found it necessary or desirable to seek out treatment elsewhere (8% for both groups). Such findings, when considered together with the results from the ORS cited above, indicate that, whatever the cause, the high percentage of single session contacts in the present study cannot be attributed to poor outcome or quality of service.

Turning briefly to the implications of the present findings for the practice of therapy, the field has long sought to establish itself on solid ground through the creation of a reliable psychological formulary—prescriptive treatments for specified conditions. Such efforts have only intensified in recent years given the harsh economic climate of the American healthcare system (Duncan & Miller, 2000). Thus, phrases such as "evidence-based" practice, empirically supported treatments, and the like have come to characterize the best that clinical practice has to offer.

The assumption inherent in current efforts is that a unified or systematic application of scientific knowledge will lead to a universally accepted standard of care that, in turn, results in more effective and efficient treatment. Few would debate the success of this perspective in medicine where an organized knowledge base, coupled with improvements in diagnosis and pathology, and the development of treatments containing *specific* therapeutic ingredients, have led to the near extinction of a number of once fatal diseases. Unfortunately, for all the claims and counterclaims, and thousands of research studies, the field of therapy, in spite of a numerous years of research and development, can boast of no similar accomplishments. Indeed, available research evidences calls the validity of this entire way of thinking about, organizing, and operationalizing clinical practice into question.

To briefly summarize the data, virtually hundreds of studies conducted by different

researchers, using a variety of measures, and increasingly sophisticated research designs provide little, no, or contradictory evidence that:

- Models of therapy contain specific therapeutic ingredients or exert diagnostic specific benefits (Asay & Lambert, 1999; Wampold, 2001);
- Models of treatment differ in terms of outcome (Hubble, Duncan, & Miller, 1999; Wampold, 2001);
- Treatment manuals, when strictly adhered to by practitioners, improve the quality or outcome of therapy (Adis, Wade, & Hatgis, 1999; Beutler, Malik, Alimohammed, Harwood, Talebi, Noble, & Wong, 2004; Lambert & Ogles, 2004; Shadish, Matt, Navarro, & Phillips (2000);
- Quality assurance practices either improve the quality or the outcome of treatment (Johnson & Shaha, 1996, 1997); or that
- Training in psychotherapy reliably improves success (Atkins & Christensen, 2001; Lambert & Bergin, 1994; Lambert & Ogles, 2004; Weisz, Weiss, Alicke, & Klotz, 1987).

Despite these research findings, many therapy practitioners and researchers still find it attractive to attempt to fit the round peg of psychotherapy into the square hole of medicine. Indeed, the general acceptance of the medico-scientific perspective in Western society makes it easy to see how anything short of emulating the field's seemingly more scientifically minded and financially successful cousins in medicine is viewed as courting marginalization. As Nathan (1997) argued in the Register Report, therapists need to "put [their] differences aside, find common cause, and join together to confront a greater threat…. securing the place of psychological therapy in future health care policy and planning" (p. 5). Still, the facts are difficult to ignore: psychotherapy does not work in the same way as medicine. The improvements in outcome hoped for and promised by the identification, organization, and systematization of therapeutic process have not materialized.

In truth, however, consumers (and payers) care little about how change comes about—they simply want it and in the most accessible format possible. As such, the field's exclusive focus on the means of producing change (i.e., models, techniques, therapeutic process) has been and continues to be on the wrong track. Consider the results of focus groups conducted by the American Psychological Association (APA, 1998). When asked, 76% of potential consumers of psychotherapy identified low confidence in the outcome of therapy as the major reason for not seeking treatment, far eclipsing variables traditionally thought to deter people from seeing a therapist (e.g., stigma, 53%; length of treatment, 59%; lack of knowledge, 47%). Worse yet, a recent survey of 3,500 randomly selected subscribers of Reader's Digest rated psychologists and social workers below auto mechanics and taxi drivers and only slightly above lawyers in trustworthiness (Psychotherapy in Australia, 2000).

The present study adds to a growing literature on a different approach to effective, efficient, and accountable treatment practice. Instead of assuming that identifying and utilizing the "right" process leads to favorable results, these efforts use outcome—specifically, client feedback—to both inform and construct treatment as well as inspire innovation. Put another way, rather than evidence-based practice, therapists tailor services to the individual client via practice-based evidence; instead of empirically supported therapies, consumers would have access to empirically validated therapists. Whether the field can put outcome

ahead of process, given its historical and current emphasis on identifying and codifying the methods of treatment remains to be seen. As Lambert et al. (2004) points out, however, "those advocating the use of empirically supported psychotherapies do so on the basis of much smaller treatment effects" (p. 296).

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Appendix 1

Scripting for Oral Administration of Outcome Rating Scale*

I'm going to ask some questions about four different areas of your life, including your individual, interpersonal, and social functioning. Each of these questions is based on a 1 to 10 scale, with 10 being high (or very good) and 1 being low (or very bad).

Thinking back over the last week (or since our last conversation), how would you rate:

1. How you have been doing **personally**? (On the scale from 1 to 10)

a. If the client asks for clarification, you should say "your self," "you as an individual," "your personal functioning."
b. If the client gives you two numbers, you should ask, "which number would you like me to put?" or, "is it closer to X or Y?"
c. If the client gives one number for one area of personal functioning and offers another number for another area of functioning, then ask the client for an average.

2. How have things been going in your **relationships**? (On the scale from 1 to 10)

a. If the client asks for clarification, you should say "in your family," "in your close personal relationships."
b. If the client gives you two numbers, you should ask, "which number would you like me to put?" or, "is it closer to X or Y?"
c. If the client gives one number for one family member or relationship type and offers another number for another family member or relationship type, then ask the client for an average.

3. How have things been going for you **socially**? (on the scale from 1 to 10)

a. If the client asks for clarification, you should say, "your life outside the home or in your community," "work," "school," "church."
b. If the client gives you two numbers, you should ask, "which number would you like me to put?" or, "is it closer to X or Y?"
c. If the client gives one number for one aspect of his/her social functioning and

then offers another number for another aspect, then ask the client for an average.

4. So, given your answers on these specific areas of your life, how would you rate how things are in your life **overall**?

The client's responses to the specific outcome questions should be used to transition into counseling. For example, the counselor could identify the lowest score given and then use that to inquire about that specific area of client functioning (e.g., if the client rated the items a 7, 7, 2, 5, the counselor could say "from our responses, it appears that you're having some problems in your relationships. Is that right?) After that, the counseling proceeds as usual.

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Appendix 2

Scripting for Oral Administration of Session Rating Scale*

I'm going to ask some questions about our session today, including how well you felt understood, the degree to which we focused on what you wanted to talk about, and whether our work together was a good fit. Each of these questions is based on a 1 to 10 scale, with 10 being high (or very good) and 1 being low (or very bad).

Thinking back over our conversation, how would you rate:

1. On a scale of 1-10, to what degree did you feel **heard and understood** today, 10 being completely and 1 being not at all?

a. If the client gives you two numbers, you should ask, "which number would you like me to put?" or, "is it closer to X or Y?"
b. If the client gives one number for heard and another for understood, then ask the client for an average.

2. On a scale of 1-10, to what degree did we **work on the issues that you wanted to work on** today, 10 being completely and 1 being not at all?

a. If the client asks for clarification, you should ask, "did we talk about what you wanted to talk about or address? How well on a scale from 1 – 10?"
b. If the client gives you two numbers, you should ask, "which number would you like me to put?" or, "is it closer to X or Y?"

3. On a scale of 1-10, how well did my approach, **the way I worked, make sense and fit for you**?

a. If the client gives you two numbers, you should ask, "which number would you like me to put?" or, "is it closer to X or Y?"

b. If the client gives one number for make sense and then offers another number for fit, then ask the client for an average.

4. So, given your answers on these specific areas, how would you rate how things were in today's session **overall,** with 10 meaning that the session was right for you and 1 meaning that something important that was missing from the visit?

a. If the client gives you two numbers, you should ask, "which number would you like me to put?" or, "is it closer to X or Y?"

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