Clinical Psychologist

SUBSCRIPTION INFORMATION:

Clinical Psychologist (ISSN 1328-4207, Online ISSN 1741-9552, Volume 13, 2009)

Clinical Psychologist (www.informaworld.com/cp) is a peer-reviewed journal published three times a year in March, July and November by Taylor & Francis, 4 Park Square, Milton Park, Abingdon, Oxfordshire, OX14 4BN, UK.

Institutional Subscription Rates 2009 (print and online): EU/USD/US/EU/100/140 Institutional Subscription Rate 2009 (online-only): AU$1815/US$1615/£1015 (+ VAT where applicable)/£155

Taylor & Francis has a flexible approach to subscriptions enabling us to match individual library’s requirements. This journal is available via a traditional institutional subscription (either print with free online access, or online-only at a discount) or as part of the Behavioural Sciences subject package or Behavioural Sciences full title package. For more information on our sales packages please visit www.informaworld.com/librarians/pricing/gdfs/journals.

All institutional subscriptions include online access for any number of concurrent users across a local area network to the currently available backfile and select passed online ahead of publication.

Subscriptions purchased at the personal rate are for personal, non-commercial use only. The re-selling of personal subscriptions is prohibited. Personal subscriptions must be purchased with a personal cheque or credit card. Proof of personal status may be requested.

Ordering Information: Please contact your local Customer Service Department to take out a subscription to the Journal: India: Universal Subscription Agency Pvt. Ltd, 10-102 Community Centre, Malviya Nagar East, Post Bag No 8, Saket, New Delhi 110017; Japan: Komiyama Company Ltd, Journal Department, PO Box 55, Citrozo, Tolyo 156, USA, Canada and Mexico: Taylor & Francis, 525 Chestnut Street, 8th Floor, Philadelphia, PA 19106, USA; Tel: +1 800 354 1420 or +1 215 625 9800; fax: +1 215 625 4914, email: customerservice@taylorandfrancis.com; UK and all other territories: T&F Customer Services, Informa Plc., Shepenhom Place, Colchester, Essex, CO3 3LP, UK; Tel: +44 (0) 207 197 5556; fax: +44 (0) 207 197 5598, email: tfsenquiries@informa.com.

Australian dollars apply to orders from Australia and New Zealand. Australian customers will have 10% GST added to the standard prices. Taylor & Francis’s ABN is 83 107 064 258. US dollars applies to all subscribers outside Europe. Euro rates apply to all subscribers in Europe, except the UK and the Republic of Ireland where the pound sterling price applies. All subscriptions are payable in advance and all rates include postage. Journals are sent by air to the USA, Canada, Mexico, India, Japan and Australasia. Subscriptions are entered on an annual basis, i.e. January in December. Payment may be made by standing deposit, dollar cheques, euro cheques, international money order, National Credit or credit cards (American, Visa and Mastercard).

Back Issues: Taylor & Francis retains a three year back issue stock of journals. Older volumes are held by our official stockists to whom all orders and enquiries should be addressed: Periodicals Service Company, 11 Main Street, Germantown, NY 12526, USA; Tel: +1 518 537 5490; fax: +1 518 537 5899; email: psc@periodicals.com.

Copyright © 2009 The Australian Psychological Society Ltd. All rights reserved. No part of this publication may be reproduced, stored, transmitted, or disseminated, in any form, or by any means, without prior written permission from Taylor & Francis, to whom all requests to reproduce copyright material should be directed, in writing.

Taylor & Francis makes every effort to ensure the accuracy of all the information ("the Content") contained in its publications. However, Taylor & Francis and its agents and licensees make no representations or warranties whatsoever as to the accuracy, completeness, or suitability for any purpose of the Content and disclaim all such representations and warranties express or implied to the maximum extent permitted by law. Any views expressed in this publication are the views of the authors and not the views of Taylor & Francis or The Australian Psychological Society Ltd.

Taylor & Francis grants authorization for individuals to photocopy copyright material for private research use, on the sole basis that such use is carried out directly to the requestor’s local Reproduction Rights Organization (RRO). The copyright fee is $32.40 exclusive of any change or levy. In order to contact your local RRO, please contact International Federation of Reproduction Rights Organizations (IFRO), c/o the Prince Royal, 87, B-1050 Brussels, Belgium, email ifro@jpl.Important; Copyright Clearance Center Inc., 222 Rosewood Drive, Danvers, MA 01923, USA; email info@copyright.com; or Copyright Licensing Agency, 90 Tottenham Court Road, London, W1P 0LP, UK; email cejilal.co.uk. This authorization does not extend to any other kind of copying, by any means, in any form, for any purpose other than private research.

Periodicals postage paid at Jamaica, NY, by US Mailing Agent Air Business Ltd, c/o WorldNet Shipping USA Inc., 149-35 177th Street, Jamaica, New York, NY11434. US Postmaster: Please send address changes to TCPS, Air Business Ltd, c/o WorldNet Shipping USA Inc., 149-35 177th Street, Jamaica, New York, NY11434.

For more information on Taylor & Francis’ journal publishing program, please visit our websites: www.informaworld.com/journals.

ABSTRACTING INFORMATION:

Clinical Psychologist is abstracted in: Applied Social Sciences Index and Abstracts (ASSIA); Australian Education Index; CINAHL; ERIC; Family Index Database; International Bibliography of Periodical Literature in the Humanities and Social Sciences; and PsycINFO.


Outcome Rating Scale and Session Rating Scale in psychological practice: Clinical utility of ultra-brief measures

Alistair Campbell & Samantha Hemsley

School of Psychology, James Cook University, Townsville, Queensland and Australian Institute of Health and Welfare, Canberra, Australian Capital Territory, Australia

Abstract

The validity and reliability of the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) were evaluated against existing longer measures, including the Outcome Questionnaire-45, Worthing Alliance Inventory, Depression Anxiety Stress Scale-21, Quality of Life Scale, Rosenberg Self-Esteem Scale and General Self-Efficacy Scale. The measures were administered to patients referred for psychological services to a rural primary health-care service. Participants were recruited from both current and new patients of psychologists providing the service. Both the ORS and SRS demonstrated good reliability and concurrent validity with their longer alternatives. The ORS also evidenced significant correlations with measures of self-esteem, self-efficacy, and quality of life. The SRS and SRS offered benefits such as cost-effectiveness, brevity, simple administration, and easy interpretation of results in the measurement of clinical outcomes when compared to their longer counterparts. These tests provide clear support for the adoption of brief outcome assessment measures in psychological practice.

Keywords: Clinical/consulting psychology, discipline issues, Outcome Rating Scale, Session Rating Scale, theoretical and methodological issues

Outcome assessment measures are ultimately intended to guide clinicians in tailoring treatment and to identify efficient treatment approaches (Smith, Fischer, Nordquist, Mosley, & Lodbetter, 1997). Many current outcome assessment measures lack essential components such as brevity, ease of administration, and content simplicity, all of which are vital if such measures are to be used on a session-by-session basis to enhance patient care. In recent years, two brief outcome assessment measures have been developed in an attempt to provide rapid but valid measurement. These are the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) (Miller & Duncan, 2000). Given the recentness of their arrival in the psychotherapy arena, the reliability and validity of these measures has not adequately been tested. The present study was conducted in an attempt to evaluate the use of the ORS and SRS in psychological practice against other more established measures of outcome.

Practice-based evidence and outcome assessment measures

Practice-based evidence requires that practitioners adopt a highly individualised service delivery plan for each patient, acknowledging the patient’s goals for treatment, ideas about how change occurs, and view of an effective therapeutic relationship (Miller, Duncan, & Hubble, 2004). It supports the use of regular measures of patient progress through the gathering and dissemination of patient feedback and allows therapists to monitor their work in a systematic and ongoing fashion to ensure that it continually reflects the needs and treatment goals of the patient (Saggers, 2005).

Outcome assessment measures are recognised as an excellent method to operationalise practice-based evidence through the collection and communication of patient feedback. Utilisation of standardised measures that communicate ongoing outcomes allows practitioners to predict with a high degree of certainty the value of therapy and the constancy of...
their services. The flexibility of such measures, however, also allows therapists to identify which patients are not responding to treatment and to adjust therapy accordingly (Saggsite, 2005).

The Q45, in particular, provides a number of benefits to a range of stakeholders at multiple levels. It provides practitioners with systematic needs assessment information and puts research into the hands of therapists. This improves outcomes for the generalisability problems that characterise empirically validated treatments (Asay et al., 2002). There is also a specific instrument for patients, who benefit by actively monitoring their own progress both during and after treatment (Victoria’s Mental Health Services, 2006). Finally, outcome measures simply the interaction between external agencies and health-care professionals by providing data upon which decisions can be based regarding funding, insurance reimbursement, and the cost-benefit analysis of psychological services (Saggsite, 2005).

There are problems, however, with the practicability of using such measures on a routine basis. Often, the methodological complexity, length of administration, and cost of outcome assessment measures render them infeasible because few practitioners have the time and/or resources to devote to the repeated administration, scoring and interpretation of their results (Miller, Duncan, Brown, Sparr, & Clauw, 2004). Another major factor contributing towards the poor acceptance of outcome measures is the current focus on the use of outcome information. Much of the present literature discussing the advantages of outcome measurement focuses on economic decision-making rather than potential benefits to patients and clinicians (Stedman, Yellowlees, Metiafop, Clarke, & Crake, 1997). The Outcome Questionnaire-45 (OQ-45) and Working Alliance Inventory (WAI) are two examples of current outcome assessment measures that suffer many of the feasibility issues mentioned.

The OQ-45 is a 45-item self-report scale designed to assess three domains of functioning on a sessional basis: the outcomes of psychological disturbance, interpersonal problems, and social role functioning (Lambers, Hamon, Slade, Whipple, & Hawkins, 2005, Wampold, 2001). This feedback allows clinicians to compare progress at treatment termination and to adjust therapy accordingly. The OQ-45 is reported to have good reliability and validity across groups and patient populations, and demonstrates adequate sensitivity to change (Lambert, et al., 2005). But despite its excellent psychometric properties and widespread use, the OQ-45 is often rendered impractical due to the length of time needed to complete the questionnaire, size of print, and content complexity (Miller et al., 2003).

The WAI is another self-report instrument designed to measure the quality of alliance between patient and therapist. Measures of the ORS using both a non-clinical (n = 86) and clinical sample (n = 435). Participants in the non-clinical sample received four concurrent administrations of the ORS and 32% of patients reported a reliable improvement from pre to post measure. Participants in the clinical sample realised only the ORS as part of standard treatment.

Recent evidence specifically indicated that the ORS possessed a high degree of internal consistency for the non-clinical sample (a = .93) and compared favourably with that reported for the OQ-45. As would be expected from an ultra-brief measure, the test-retest reliability of the ORS (66 at second administration) was lower than the OQ-45 (.83 at second administration) (Miller et al., 2003). Concurrent validity was also assessed, and results showed all benefit indices were indicated moderately strong correlations between ORS items and OQ-45 subscales and total scores. In addition, an overall correlation of .59 was found between the ORS and OQ-45 total scores, demonstrating that the ORS was moderately related to the gold standard of self-report scales that the OQ-45 reflects.

One of the main reasons for the development of the ORS was to provide clinicians with patients with an outcome measurement tool that could be easily implemented on a routine basis within everyday clinical practice. Thus, to demonstrate the feasibility of the ORS, Miller et al. (2003) examined and compared compliance rates with the ORS and OQ-45 over a period of 12 months in a group of therapists (n = 86) practising at a community family service agency. A compliance rate of 89% was achieved for the ORS, whereas only a 25% compliance rate was achieved for the ORS. It was evident that the brevity, simple content structure, and scoring procedures of the ORS appealed to clinicians, who struggled to adopt the position of scientist-practitioner using more complex measures such as the OQ-45.

The ORS is another four-item visual analogue instrument that is based on encouraging patients to identify any alliance problems with their therapist so that the clinician may change to better fit patient expectations. The instrument was originally developed by Johnson (1995) as a 10-item Likert-scaled instrument, but concerns regarding the time needed to complete the questionnaire were quick to emerge among clinicians and patients. The SRS was developed as a brief alternative to the longer measure (Miller & Duncan, 2000). In order to determine whether or not the ORS was psychometrically able to act as an alternative measure of outcome, the reliability and validity of both the OQ-45 and ORS were assessed. Miller et al. (2003) assessed patients following an initial clinical encounter with the ORS using both a non-clinical (n = 86) and clinical sample (n = 435). Participants in the non-clinical sample received four concurrent administrations of the ORS and 32% of patients reported a reliable improvement from pre to post measure. Participants in the clinical sample realised only the ORS as part of standard treatment.

Recent evidence specifically indicated that the ORS possessed a high degree of internal consistency for the non-clinical sample (a = .93) and compared favourably with that reported for the OQ-45. As would be expected from an ultra-brief measure, the test-retest reliability of the ORS (66 at second administration) was lower than the OQ-45 (.83 at second administration) (Miller et al., 2003). Concurrent validity was also assessed, and results showed all benefit indices were indicated moderately strong correlations between ORS items and OQ-45 subscales and total scores. In addition, an overall correlation of .59 was found between the ORS and OQ-45 total scores, demonstrating that the ORS was moderately related to the gold standard of self-report scales that the OQ-45 reflects.

One of the main reasons for the development of the ORS was to provide clinicians with patients with an outcome measurement tool that could be easily implemented on a routine basis within everyday clinical practice. Thus, to demonstrate the feasibility of the ORS, Miller et al. (2003) examined and compared compliance rates with the ORS and OQ-45 over a period of 12 months in a group of therapists (n = 86) practising at a community family service agency. A compliance rate of 89% was achieved for the ORS, whereas only a 25% compliance rate was achieved for the ORS. It was evident that the brevity, simple content structure, and scoring procedures of the ORS appealed to clinicians, who struggled to adopt the position of scientist-practitioner using more complex measures such as the OQ-45.

The ORS is another four-item visual analogue instrument that is based on encouraging patients to identify any alliance problems with their therapist so that the clinician may change to better fit patient expectations. The instrument was originally developed by Johnson (1995) as a 10-item Likert-scaled instrument, but concerns regarding the time needed to complete the questionnaire were quick to emerge among clinicians and patients. The SRS was developed as a brief alternative to the longer measure (Miller & Duncan, 2000). In order to determine whether or not the ORS was psychometrically able to act as an alternative measure of outcome, the reliability and validity of both the OQ-45 and ORS were assessed. Miller et al. (2003) assessed patients following an initial clinical encounter with the ORS using both a non-clinical (n = 86) and clinical sample (n = 435). Participants in the non-clinical sample received four concurrent administrations of the ORS and 32% of patients reported a reliable improvement from pre to post measure. Participants in the clinical sample realised only the ORS as part of standard treatment.

Recent evidence specifically indicated that the ORS possessed a high degree of internal consistency for the non-clinical sample (a = .93) and compared favourably with that reported for the OQ-45. As would be expected from an ultra-brief measure, the test-retest reliability of the ORS (66 at second administration) was lower than the OQ-45 (.83 at second administration) (Miller et al., 2003). Concurrent validity was also assessed, and results showed all benefit indices were indicated moderately strong correlations between ORS items and OQ-45 subscales and total scores. In addition, an overall correlation of .59 was found between the ORS and OQ-45 total scores, demonstrating that the ORS was moderately related to the gold standard of self-report scales that the OQ-45 reflects.

One of the main reasons for the development of the ORS was to provide clinicians with patients with an outcome measurement tool that could be easily implemented on a routine basis within everyday clinical practice. Thus, to demonstrate the feasibility of the ORS, Miller et al. (2003) examined and compared compliance rates with the ORS and OQ-45 over a period of 12 months in a group of therapists (n = 86) practising at a community family service agency. A compliance rate of 89% was achieved for the ORS, whereas only a 25% compliance rate was achieved for the ORS. It was evident that the brevity, simple content structure, and scoring procedures of the ORS appealed to clinicians, who struggled to adopt the position of scientist-practitioner using more complex measures such as the OQ-45.
Division of General Practice. All current and any new patients thereafter for the period of the study were asked to take part in the research. A total of 65 participants were recruited for the study over a period of 7 months (54 females, 10 males, one unspecified). All participants were required to be aged ≥18 years. The mean age of the sample was 43 years (SD = 12.95) with an age range of 18-62 years. The main presenting problem of each patient was identified from a list of 25 commonly occurring problems. Main presenting problem was identified based on clinical judgment rather than on formal diagnosis. The most common presenting problem was depression (30.8%), followed by anxiety (15.4%) and family and relationship issues (15.4%).

Procedure
A number of measures were used to evaluate the validity of the ORS and SRS in psychological practice. These include the QO-45, QOLS, DASS, 21, GSE, and WAIS. These measures assess a number of domains including outcome, clinical presentation, symptom severity, therapeutic relationship, and quality of life.

Outcome Questionnaire-45. The QO-45 consists of 45 self-report items covering a broad range of symptom and functioning domains, including subjective global health status, global functioning, stress, and social role performance. The underlying factor structure of the QO-45 has been confirmed (Merrill, Lambert, & Butchins, 1998) although the subscales are acknowledged to be highly interrelated (Orumth, 1997). Scores are generated for each subscale and a total score is obtained by summing subscale scores. Each item response is measured on a 5-point scale yielding a range of possible scores from 0 to 180 (Lambert et al., 2002). The QO-45 provides criterion measures for the classification of patients into outcome groups including recovered, improved, deteriorated, and no change (Lambert, Oishi, Finch, & Johnson, 1998). The QO-45 is highly reliable (0.93) and evidence to suggest good construct and concurrent validity across a wide range of patient populations (Lambert & Hawkins, 2004). It is also sensitive to change over short periods in clinical samples while remaining stable in untreated individuals (Lambert et al., 2005).

Quality of Life Scale. The QOLS contains 16 items and is measured on a 7-point scale (3 = alleviated, 7 = terrible) (Burckhardt & Anderson, 2003). The 16-item instrument measures quality of life, and measures constructs distinct from health status and disease activity. The QOLS demonstrates strong analogue scale developed as a brief alternative to the QO-45. It demonstrates strong reliability estimates (α = 0.87 - 0.88) and moderately strong convergent and divergent correlations with the ORS items and QO-45 subscales (ORS total score = 0.59). This construct has been found Cronbach's alpha coefficients of 0.94 for depression, 0.87 for anxiety, and 0.91 for stress. Concurrent validity was also assessed and results indicated moderate to strong correlations (Antony, Bauchter, Conner, & Swanson, 1998). Scores are generated for each subscale and then double to that interpretations can be made based on the 42-item DASS scoring method (Lovibond & Lovibond, 1995). The factor structure of the DASS is well established (Antony et al., 1998; Norton, 2007).

Rosenberg Self-Esteem Scale and General Perceived Self-Efficacy. For use in test administration both the Rosenberg Self-Esteem Scale (RSES) and General Perceived Self-Efficacy (GSE) scales were used. The Rosenberg self-esteem scale is a 6-item Likert scale yielding total scores for each ranging from 10 to 40. The RSES is the most widely used self-esteem measure and has good reliability (α = 0.88) and validity estimates. A high score on the RSES indicates a high sense of self-esteem (Torrance, Mueser, Melguo, & Drake, 2000). As yet, no normative data exist for the GSE English-language version, although high internal consistency ratings (α = 0.92 - 0.93) and factorial validity estimates have been reported for the German version (Schwarzer, 1994). A high score on the GSE indicates a greater sense of self-efficacy.

Working Alliance Inventory-12. The 12-item WAI is a short form of the original 36-item patient version and is scored on a 7-point Likert scale (correspond, 7 = corresponds exactly) (Horvath & Greenberg, 1999). The four highest-loading items on the Task, Bond, and Goal subscales were used to form the WAI-Short, and each subscale demonstrates strong internal consistency estimates (α = 0.90, 0.92, and 0.90, respectively) (Tracey & Kolekovic, 1989). Concurrent validity estimates suggest a strong association between WAI and QOLS-12 subscale and total scores (Buskett & Tyler, 2003).

Outcome Rating Scale. The ORS is a four-item (overall, individually, interpersonally, socially) visual analogue scale developed as a brief alternative to the QO-45. It demonstrates strong reliability estimates (α = 0.87 - 0.96) and moderate correlations between the ORS items and QO-45 subscale and total scores (ORS total score = 0.59). This construct has been found Cronbach's alpha coefficients of 0.94 for depression, 0.87 for anxiety, and 0.91 for stress. Concurrent validity was also assessed and results indicated moderate to strong correlations (Antony, Bauchter, Conner, & Swanson, 1998). Scores are generated for each subscale and the total score can be made based on the 42-item DASS scoring method (Lovibond & Lovibond, 1995). The factor structure of the DASS is well established (Antony et al., 1998; Norton, 2007).

Rosenberg Self-Esteem Scale and General Perceived Self-Efficacy. For use in test administration both the Rosenberg Self-Esteem Scale (RSES) and General Perceived Self-Efficacy (GSE) scales were used. The Rosenberg self-esteem scale is a 6-item Likert scale yielding total scores for each ranging from 10 to 40. The RSES is the most widely used self-esteem measure and has good reliability (α = 0.88) and validity estimates. A high score on the RSES indicates a high sense of self-esteem (Torrance, Mueser, Melguo, & Drake, 2000). As yet, no normative data exist for the GSE English-language version, although high internal consistency ratings (α = 0.92 - 0.93) and factorial validity estimates have been reported for the German version (Schwarzer, 1994). A high score on the GSE indicates a greater sense of self-efficacy.

Working Alliance Inventory-12. The 12-item WAI is a short form of the original 36-item patient version and is scored on a 7-point Likert scale (correspond, 7 = corresponds exactly) (Horvath & Greenberg, 1999). The four highest-loading items on the Task, Bond, and Goal subscales were used to form the WAI-Short, and each subscale demonstrates strong internal consistency estimates (α = 0.90, 0.92, and 0.90, respectively) (Tracey & Kolekovic, 1989). Concurrent validity estimates suggest a strong association between WAI and QOLS-12 subscale and total scores (Buskett & Tyler, 2003).

Clinical utility of ultra-brief measures

**Statistical analysis**

Basic statistical analyses were conducted using SPSS Version 12.0 (SPSS, Chicago, IL, USA). The internal consistency of the measures was determined using Cronbach's coefficient alpha, and a series of bivariate correlations was performed to test the concurrent validity of the questionnaires.

**Results**

**Normative data**

In line with previous research, QO-45 scores were normally distributed (Shapiro-Wilks, p > 0.5). Shapiro-Wilk tests, however, showed that the distribution of ORS scores deviated significantly from a normal distribution. In particular, the "Other" and "Individually" items appeared to have bimodal distributions, peaking at both the low and high ends of the scale. The distributions of SRS and WAIS scores were negatively skewed (M = 5.64 and 7.43, respectively); this was expected, however, given the nature of the scales. The parametric analyses of the non-normal data were compared to non-parametric analyses and the violations of normality did not have a significant effect on the parametric analyses were reported throughout.

**Reliability**

Internal consistency was evaluated for the subscale and total score of each measure. Table 1 displays Cronbach's coefficient alphas for each measure, and shows that all measures were highly reliable (α = 0.89 - 0.95). The reliability coefficients for the ORS and SRS were particularly impressive given the

| Measure | ORS | SRS | QOLS | DASS | WAIS | GSE | Pool
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cronbach's alpha coefficient</td>
<td>0.90</td>
<td>0.93</td>
<td>0.93</td>
<td>0.95</td>
<td>0.95</td>
<td>0.93</td>
<td>0.93</td>
</tr>
</tbody>
</table>

Note: DASS-21 = Depression Anxiety Stress Scale-21, GSE = General Perceived Self-Efficacy, Pool = Outcome Rating Scale, QOLS = Quality of Life Scale, WAIS = Rosenberg Self-Esteem Scale, SRS = Outcome Rating Scale, WAIS = Working Alliance Inventory.
small number of items in each scale (α = .90 and .93, respectively).

Inter-item correlations were calculated to examine the extent to which each item represented the total scale. The inter-item correlations for the ORS and SRS are displayed in Table 3. Inspection of the inter-item correlations indicated moderate to strong correlations between the four ORS items (r = .58-.97). In particular, a strong correlation was found between "Overall" and "Individually" (r = .97, p < .01). The SRS displayed a consistent pattern of strong inter-item correlations (r = .74-.86, p < .01). The ORS and SRS items were not strongly correlated, and, apart from a weak correlation between "Goals and Topics" on the SRS and individual wellbeing on the ORS, none of the correlations was significant.

Correlations were also calculated for each of the other measures. Three items on the OQ-45 did not appear to accurately represent the corresponding subscale. Item 11 ("After heavy drinking, I need a drink the next morning to get going? Symptoms of Distress") had a corrected item-total correlation of -.02; Item 26 ("I feel annoyed by people who criticize my drinking/drug use"). Inter-item correlations ranged from zero to a corrected item-total correlation of -.08; and item 32 ("I have trouble at work/school because of my drinking/drug use."). Social Role) had a corrected item-total correlation of -.001. These items suggested that the drinking/drug use items were not stable in this sample.

Validity

Concurrent validity was computed using Pearson product-moment correlations (Table III). In support of previous research, moderate to strong correlations were found between the ORS items and OQ-45 subscale and total scores. In particular, strong correlations were found between the OQ-45 Symptom of Distress and ORS Overall (r = .75, p < .01) and Individually (r = .74, p < .01) but only moderate correlations were found between all other subscales. The ORS items were significantly correlated with the DASS scales. The strongest relationships were between the DASS Depression and Stress scales and the Overall and Individually wellbeing items on the ORS. The DASS Anxiety scores were moderately correlated with all but the Interpersonal wellbeing item on the ORS, which was not significant. The ORS items also demonstrated strong correlations with self-esteem (RSSES) (r = .46-.67) and moderate correlations with self-efficacy (GPSSE) (r = .36-.53). Strong correlations were found between the ORS items and quality of life (QOLS) (r = .49-.74).

The SRS had significant and consistently moderate correlations with the WAI. All correlations between SRS items and WAI subscales were within the range of .37-.63. In addition, the correlations did not identify any specific relationships between the SRS and the WAI subscales, such as SRS Relationship and WAI Bond. Instead, relative equal correlations were found between all subscales. There were some weak but significant correlations between the SRS and the OQ-45 Interpersonal Relationships subscale (r = .28 to .30) and the Total score (r = .27 to .30) but there were no significant correlations with the DASS scales or with quality of life, and self-efficacy. One weak but significant correlation was found between the SRS Overall item and self-esteem (r = .26, p < .05).

Discussion

The strong inter-item correlations for both the ORS and SRS suggest that a single dimension underlying each scale could be an interpretable summary. Although it is not common practice, it would be reasonable to summarise the item scores into a single score to globally represent outcome and session relationship, respectively. These findings support previous research, suggesting that the ORS is best thought of as a global measure of distress (Miller et al., 2003), and the SRS a global measure of alliance (Miller et al., 2003). The very strong correlations between the ORS items of Overall wellbeing and individually wellbeing raises the possibility that these two items are measuring the same underlying construct. It is possible that the four-item ORS could be reduced to three items with no real loss of information. This may further enhance the clinical utility of the measure because it would be a very brief scale.

The clinical utility of the ORS is further supported by the strong positive correlations between it and the OQ-45 and the DASS. This indicates that the ORS is able to provide rapid and valid information about patient functioning and wellbeing compared to these longer alternatives. The relatively stronger correlations with the DASS depression and DASS stress scales suggests that it may be more sensitive to these than to anxiety but this would need further clinical elaboration. The correlations between the ORS and scales of quality of life, self-esteem, and self-efficacy indicate that it is evaluating more than just symptoms distress. This also supports the clinical utility of the ORS because the scores on the ORS appear to be tapping similar dimensions to the OQ-45, but it is also generally well correlated with measures such as these. It should be noted, however, that there is a necessary cost to utilizing ultra-brief outcome measures in terms of the loss of clinical information, which is traded for utility and brevity.

The relationship between the SRS and the WAI was generally encouraging when compared to what was achieved with the ORS. This was due to the nature of the scale but is also likely to do with difficulties with conceptualising the concept of therapeutic alliance and relationship. The correlations between the SRS and the WAI support the idea that the SRS is measuring a construct of therapeutic alliance, but the lack of specificity between the subscales suggests that the SRS may be simply tapping a general alliance construct. Nonetheless, the SRS must still be considered a good candidate for the pragmatic measurement of alliance because it is so much easier and quicker to use than the WAI and other existing measures of the therapeutic relationship.

The present small sample size constrains the conclusions that we can make in relation to the ORS and the SRS. Nonetheless, our results are similar to those that have already been published and allow a comparison of the clinical utility of these ultra-brief measures for evaluating outcome on the basis of more than only symptom presentation. Another limitation to the study was that the subjects were drawn from a psychiatric clinic for which the SRS is arguably different from a psychiatric clinical population in terms of both severity and the likelihood of formal DSM diagnoses. It would be helpful to conduct an evaluation of ultra-brief outcome measures in other clinical populations covering the range of diagnostic conditions and severity. An additional direction for further research should incorporate factor analyses on the various measures to further
explore the psychometric properties of existing measures as well as the ultra-brief measures. Brief-outcome assessment measures, such as the ORS and SRS, should be carefully considered when developing measures of outcome in real-world settings (Campbell, 2002). One of the major blocks to good research in real-world settings is the compliance of clinicians with long and detailed measurement protocols. The rate of compliance with the ultra-brief measures ensures that much more information about the outcome of therapy and the therapeutic relationship can be collected than when more research-oriented measures are utilised. Compliance is a significant consideration in real-world research, which is required to establish an evidence base for the effectiveness, as opposed to simple efficacy (Campbell, 2005), of therapeutic activity.

References


**Appendix A**

**Outcome Rating Scale**

Looking back over the last week (or since your last visit), including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right represent high levels.

<table>
<thead>
<tr>
<th>Overall</th>
<th>Individuality</th>
<th>Interpersonally</th>
<th>Socially</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Appendix B**

**Session Rating Scale**

Please rate today’s session by placing a hash mark on the line nearest to the description that best fits your experience.

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Goals and Topics</th>
<th>Approach or Method</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>I had heard, understood and respected</td>
<td>We worked on and talked about what I wanted to work on or talk about</td>
<td>The therapist’s approach is not a good fit for me</td>
<td>Overall:</td>
</tr>
</tbody>
</table>