A Dissertation

Entitled

Changes of University of Rhode Island Change Assessment Over Time Associated with Stages of Change

By

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Submitted to the Graduate Faculty as a partial fulfillment of the requirements for the Doctor of Philosophy Degree in Counselor Education

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An Abstract of
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Approximately one-quarter of the American population are affected by their own mental illness each year (National Alliance on Mental Illness [NAMI], 2013). Of those who take part in counseling, one-third to one-half do not see treatment gains and approximately 50% leave counseling prematurely (Duncan, Miller & Hubble, 2007). Research examining immediate feedback on the therapeutic alliance and therapeutic progress has shown statistically significant therapeutic improvements (Reese, Norworthy, & Rowlands, 2009). In addition, the client’s stage of change has been shown through research to correlate with progress in counseling (Ogrodniczuk, Joyce, & Piper, 2005). Clients who have not met their goals and leave counseling prematurely have described a reduction in therapeutic improvement and more emotional distress and are two times as likely seek out mental health services again, often becoming “chronic” clients (Ogrodniczuk, Joyce, and Piper (2005). Premature termination, along with other factors, leads to 10% of clients being the source of 60-70% of expenses (Miller, n.d.). The purpose of this research was to determine whether completing Feedback Informed Treatment (FIT) moved clients through the Stages of Change more quickly, discouraging
premature termination and lowering mental health expenses. Participants were mental health clients 18 and over assigned to four counselors for counseling at a community counseling center. Half of the participants were given FIT and half were not. The intent was for the URICA scores of the two groups to be compared to determine if FIT moves people through the Stages of Change more quickly. URICA scores were measured at the beginning of counseling and at 30 days and 60 days when possible. Six participants consented to the research so descriptive statistics are presented. This study showed it would be worthwhile to rerun the study with a larger sample.
This dissertation is dedicated to Bob, mom, Molly, and Abby. Although I lost all of you during this process, your love, encouragement, support, and companionship made this project possible.
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Chapter One

Introduction

General Introduction

Chapter One will explain the problem addressed in this study. Chapter One will introduce the topic of Feedback Informed Treatment (FIT) and provide an argument that feedback is a necessary component of counseling. Chapter One will then address the purpose of the study, hypotheses, significance of the study, research design, and important terms. Chapter One will end with the organization of the dissertation and a summary.

FIT is a therapeutic approach that involves the use of two forms during the counseling session (Tartakovsky, n.d.). The Session Rating Scale (SRS) is used at the beginning of the session to assess the client’s functioning during the time between the current session and the last counseling session. It assesses overall functioning, social and interpersonal functioning, and general personal wellbeing. This information allows the counselor to discuss any progress or setbacks the client has experienced. The SRS is given at the end of the session and it assesses the therapeutic relationship, whether goals and topics were relevant to the client, whether the counselor’s approach was appropriate, and whether the overall session was a fit for the client.

Background of the Problem

Approximately one-fifth of the American population, or 43.8 million people, are affected by their own mental illness each year (National Alliance on Mental Illness [NAMI], 2013). According to Mojtabai and Jorm (2015) the United States experienced a large upsurge in the consumption of mental health services in the 1990s, however, they
report the pervasiveness of mental disorders did not wane in spite of the increased use of mental health services. Mojtabai and Jorm (2015) further state these perplexing trends raise questions about the efficacy of mental health treatments. In addition, the use of psychiatric medications grew significantly in the 1990s and continues to grow. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2013) found that an average of approximately 24.6 million people who have a mental illness in the United States receive treatment every year, Mental health treatment costs Americans $113 billion per year ($4593 per person per year), with $3.7 billion allocated to outpatient counseling (Kliff, 2012). A typical level of reimbursement is 50% resulting in a large financial burden being placed on the client themselves (Harvard University, 2004).

According to Szabo (2013) the recession, starting in 2009 and lasting until 2012, saw states reducing money for mental health services by $5 billion. According to the U.S. Department of Health and Human Services (n.d.) as of 2014 most individual and group health insurance plans are required to at least cover mental health. Even after mental health parity was passed into law through The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) behavioral health care providers still regulate how many sessions a person may have for a particular problem or limit overall expenses (U.S. Department of Labor, 2010).

Of those that take part in outpatient counseling, one-third to one-half do not see treatment gains and approximately 50% leave counseling prematurely (Duncan, Miller & Hubble, 2007; Duncan, 2012; Hatchett, 2011). Leaving counseling early, or premature termination, has been defined in several ways over the years (Renk & Dinger, 2002). For the purposes of this study, premature termination will be defined as leaving counseling
before the counselor and client agree goals have been met. Clients who have not met their goals and leave counseling prematurely have a tendency to seek out mental health services again. According to Ogrodniczuk, Joyce, and Piper (2005), clients who terminate counseling prematurely describe a reduction in therapeutic improvement and more emotional distress than they presented with, they also access mental health services two times as much as those who do not terminate prematurely. Ogrodniczuk et al. (2005) report those who terminate counseling early often become repeat or “chronic” clients, thus placing an additional burden on the mental health system. Premature termination, along with other factors, leads to 10% of clients being the source of 60-70% of expenses (Miller, n.d.). In addition, when clients terminate counseling prematurely it is demoralizing and often causes further deterioration in their mental health (Duncan et al., 2007; Ogrodniczuk et al., 2005).

Westmacott, Hunsley, Best, Rumstein-McCean, and Schindler (2010) found that counselors were not aware of any difficulty in the therapeutic relationship and the fact that the clients were not progressing as clinicians hoped the clients were. As a result, counselors were likely to underestimate the likelihood of premature termination and the reasons for early termination (Westmacott et al., 2010). In addition, Miller, Duncan, Sorrell, and Brown (2005) claim clients prematurely terminate counseling before discussing any issues with the counselor. Barrett et al. (2008) assert leaving counseling prematurely has been connected through studies to several client factors including lower levels of education, financial issues, being put on a waiting list, lack of concurrence with counselor on counseling objectives, a negative opinion about the counselor’s proficiency, and anticipation of the duration of the treatment process. Shaw and Murray (2014) state
that a poor therapeutic relationship is especially apt to lead to unsuccessful outcomes in counseling. Thus, clinicians have significant understanding of the vital impediments to effective counseling and the causes of premature termination, but missing are models and methods proven to successfully retain clients in counseling until treatment goals are met.

There is also a cost to counselors when clients do not improve or terminate prematurely (Ogrodniczuk et al., 2005). Counselors may feel as though they are not “good” counselors. This damage to their self-esteem can be accompanied by a feeling they have wasted time and energy. Thus, clients, counselors, and those who fund mental health services suffer when a client terminates prematurely or is not successful in counseling (Ogrodniczuk et al., 2005).

Statement of the Problem

Studies show feedback given by the client on therapeutic alliance and progress, which is immediately solicited and received by the counselor in session, has been shown to lead to statistically significant therapeutic improvements and therefore increased commitment to the counseling process (Reese et al., 2009). If a client is committed to the process of counseling, and stays in counseling until goals are met, the client will be less likely to use mental health dollars in the future and will be more likely to have a successful outcome. In order to meet goals clients must go through some iteration of the Stages of Change (Mander, et al., 2014). However, there is a significant dearth of information in the literature body on how formal feedback from the client on the therapeutic alliance and therapeutic progress affect Stage of Change in outpatient counseling.
Purpose of the Study

The purpose of this study was to determine if clients who received FIT, a method of feedback from clients to clinicians on treatment progress and therapeutic alliance, moved more quickly through the Stages of Change from initial administration of the University of Rhode Island Change Assessment (URICA) to 30 days and at 60 days than those who did not receive FIT. The research undertaken asked clients in the treatment group for immediate feedback about the therapeutic process and therapeutic alliance using FIT, and assessed their progress through the Stages of Change as measured by the University of Rhode Island Change Assessment (URICA) (Mander, et al., 2014). Duncan et al. (2007) assert commitment to the counseling process and a positive result from counseling is foretold by early progress through the Stages of Change in the client. They go on to say that standardized assessments that provide feedback to the counselor about the counseling relationship and the psychotherapeutic approach deliver information that strengthens the odds for treatment success. The purpose of asking for feedback is to be able to more accurately assess the impact of counseling, with the objective of counselors refining their actions with clients (how the counselor changes the techniques will not be assessed in this study) to tailor services directly to the client and move the client more quickly through the Stages of Change (Duncan et al., 2007).

Moving quickly through the Stages of Change is an advantage because patient suffering is decreased and the use of financial resources is minimized, both for the client and the payer. Although Josefsson (2013) argues more sessions do not necessarily lead to better outcomes, when managed care organizations universally allow a certain number of sessions for a specific problem, it is difficult when the client progresses more slowly than
expected. Clement (2013) did a study of his 45 years in practice as a counselor; he looked at outcomes and interestingly found that the years he had the most clients with managed care insurance were some of the years with the worst outcomes. This may be because the client was not able to stay in counseling long enough for maximum benefit and could not afford to continue. On the other hand, this study lacks information about Clement’s effectiveness as a counselor.

According to Norcross et al. (2011) a 35 to 58% increase in treatment effects (a medium effect size) was measured when interventions were tailored to the Stages of Change, implying information about the Stages of Change of a client and subsequent tailoring of the counseling were effective. However, the speed of change may fluctuate substantially across clients (Josefsson, 2013). Measuring progress through the Stages of Change can help to forecast improvement of symptoms, quitting counseling prematurely, and the strength of the therapeutic alliance (Norcross et al., 2011). Norcross et al. (2011) state the result of counseling can be forecast by the client’s movement through the Stages of Change. Knowing the Stage of Change of the client allows the counselor to tailoring their treatment method to best assist the client. Josefsson (2013) points out that assessment of the client’s Stage of Change early in the process of counseling can allow the clinician to begin tailoring their treatment to clients when counseling is most effective. In this study the Stage of Change was measured at the initial counseling session, allowing for tailoring of the counseling, although whether or not the counseling was tailored based upon the Stage of Change of the client was not measured in the study.
Research Question

The following research question was addressed in this study:

The general research question was, “Is there a statistically significant difference in the URICA scores at 30 days and 60 days versus the scores at the start of the study in clients who do complete FIT assessments and clients who do not complete FIT assessments?

Specific RH₁: Clients who have completed FIT assessments will rate themselves statistically significantly (p < .05) higher on the URICA at 30 days and 60 days than clients who have not completed FIT assessments.

Specific RH₀: There will be no statistically significant difference on overall URICA rating at 30 days and 60 days between clients who have completed FIT assessments and clients who have not completed FIT assessments.

Significance of the Study

Counselors are increasingly being held to standards of “proving” that counseling is working, especially in the era of managed care. Increasingly, payer sources are requiring evidence of successful treatment in order to reimburse providers (Office of Inspector General, 2000). The Office of the Inspector General (2000) also points out that “return on investment” and “accountability” are significant components in the future in mental health reimbursement. Outcome assessment is the key to maintaining current funding sources and obtaining other ones. Payers expect accountability and documentation demonstrating a positive return on their investment and the competent use of resources (Office of the Inspector General, 2000). Counselors are in need of immediate feedback from clients so that they can change the method of counseling they are using,
change how the counseling is given (how many times per month or week), or possibly terminate counseling altogether. Miller et al. (2005) assert that consumers, in the case of counseling clients, increasingly want proof that the product they are purchasing is working. The FIT protocol offers immediate feedback about the client’s progress since the last session and the client’s satisfaction with the current session. According to Stoltz and Kern (2007), the crux of counseling is the skill to prompt change. The URICA offers information about Stage of Change. This study looked at whether completing the FIT protocol affected the Stage of Change of the client.

Looking at progress through the Stages of Change is important in part because it has been shown in a meta-analysis of 47 studies that looked at the associations of the stages and the courses (processes) of change, with counseling being one of the areas studied, mean effect sizes (d) were roughly .70 for difference in cognitive-affective courses by stage and .80 for differences in behavioral courses by stage. These effects are moderate and large and it is important to note that the issue being treated did not affect the results (Norcross, 2011). Thus, Stages of Change reliably predict outcomes in counseling. By using an outcomes measurement that increases the speed of the client through the Stages of Change a clinician can prevent a disorder from becoming worse and the client becoming discouraged and leaving counseling prematurely. This study aimed to determine whether FIT increases a client’s progress through the Stages of Change.

When clients leave counseling prematurely they then may have a greater tendency to become disabled or to use mental health services at a greater rate (Ogrodniczuk et al., 2005). This then has an effect on the economic status of the client and the mental health
system. By the counselor being aware of the Stage of Change of the client, the client’s perception of progress, and the client’s perception of the therapeutic alliance they can tailor counseling to increase the chances that the client completes counseling successfully.

**Research Design**

In this study the independent variable (FIT) was manipulated by the researcher, however, there was not random assignment to groups making this a quasi-experimental non-equivalent control group design. The URICA was given at the initial counseling appointment and at 30 days and 60 days when possible. A convenience sample was used for this study; new clients of four mental health counselors participated. The independent variable had two levels: completed FIT and did not complete FIT and was a nominal variable. The dependent variable had three levels: initial level of change, level of stage of change at one month, and level of change at three months and was a ratio variable. In order to compare URICA scores t-tests were to be utilized.

**Definition of Terms**

For the purpose of this study, the following terms were utilized as defined:

Feedback Informed Treatment (FIT): standardized forms that measure client’s satisfaction with treatment (Duncan et al., 2007).

Outcome Rating Scale (ORS): A measure of the client’s progress in counseling and perceived value of treatment (Duncan et al., 2007).

Patient-Focused Research: Studies about feedback that comes directly from the client about the client’s wellbeing and improvement in counseling (Sapyta, Riemer, and Bickman, 2005).
Premature Termination: A situation where a client makes a decision to terminate counseling after the first session without meeting their goals and without concurrence of the counselor (Westmacott et al., 2010).

Session Rating Scale (SRS): A measure of the client’s perception of the alliance between the client and counselor (Duncan et al., 2007).

Transtheoretical Model (TTM): A model in which “Behavior change is conceptualized as a process that unfolds over time and involves progression through a series of five stages: Precontemplation, Contemplation, Preparation, Action, and Maintenance” (Norcross et al., 2011, p. 143).

University of Rhode Island Change Assessment (URICA): A 32-item survey that measures the Stage of Change (Precontemplation, Contemplation, Preparation, Action, and Maintenance) (Norcross et al., 2011).

**Organization of Chapters**

Chapter One offers information on the background of the problem and the significance of the study designed to address the problem. It also offers some specific information about the study being proposed and the organization of the dissertation. Chapter Two offers a review of the literature pertinent to the study. Chapter Three will cover the research design, method, instruments, and procedures. Chapter Four will present the statistical outcome of the study. Chapter Five will offer a discussion of the outcome of the study and will detail the strengths and weaknesses of the study. Finally, suggestions for practice and additional research will be presented.
Summary

Clients who terminate counseling early or are not successful in counseling place a burden on the mental health care system as they often become “chronic” clients leading to 10% of clients being the source of 60-70% of expenses (Miller, n.d.). They also often see a deterioration in their mental health and counselors are affected negatively (Duncan et al., 2007; Ogrodniczuk et al., 2005). Given that 50% of clients prematurely terminate counseling and one third to one half do not see treatment gains, it is essential that we find a way to increase successful treatment (Duncan et al., 2007, Duncan, 2012).

Duncan et al. (2007) claim that evaluating our efficacy in counseling through asking clients for their opinions, especially with clients who are not advancing early in the counseling process, can predict and increase the chance of positive attainment of treatment goals. This information allows us to evaluate whether we, the client, and the therapeutic methods we are using are complimenting each other and to determine if changes need to be made to increase the chances of a successful outcome and lower the chances of premature termination.

The purpose of this study was to determine if clients who receive FIT moved further through the Stages of Change after three months than those who did not receive FIT. The purpose of asking for feedback was to be able to more accurately assess the impact of counseling, reduce premature termination, tailor services directly to the client, and assist the client to effectively and efficiently complete treatment (Duncan et al., 2007).
Chapter Two

Literature Review

Introduction

This chapter presents a review of the literature concerning the prevalence of mental health issues in the United States; the effect of caring for the mentally ill on the American economy; the “age of accountability;” treatment progress, premature termination, and client deterioration. In addition, ethical responsibilities of mental health professionals; feedback; the history and importance of outcomes (defined as formal feedback from the client about client functioning and therapeutic alliance), including potential reluctance to use outcomes by counselors; and the use of (TTM) outcomes will be detailed. Prochaska’s Stages of Change and the Transtheoretical Model; measures of Stages of Change; an overview and history of Feedback Informed Treatment (FIT); and measures of feedback on client functioning and the therapeutic alliance will also be covered.

Prevalence of Mental Health Issues in the United States

Approximately one-quarter of the American population are affected by their own mental illness each year (NAMI, 2013). Statistics by the Social Security Administration (SSA) show the number of people disabled by mental illness has increased dramatically to the point where in the United States behavioral health disorders are the number one cause of disability (Bohanske & Franczak, 2010). In 2003 there were nearly six times the number of people disabled by a mental illness as in 1955 (Bohanske & Franczak, 2010). Clay (2011) maintains the work force is increasingly over-worked and in need of behavioral health care, with depression and anxiety on the rise. In addition, more people
serving in the military need mental health care. More people will qualify for government-funded health care in the future, and people are living longer (Lambert et al., 2013). For these reasons, the mental health system must become more outcome-driven in order to maximize resources, both human and financial.

**Effect of Caring for the Mentally Ill on the American Economy and How We Can Manage It**

Wells, Burlingame, Lambert, Hoag, and Hope (1996) state that mental health costs rose significantly in the early 1980s and have been on the rise ever since. Mental health treatment costs Americans $113 billion per year ($4593 per person per year), with $3.7 billion going into outpatient counseling (Kliff, 2012), with 10% of clients being the source of 60-70% of expenses (Miller, n.d.). The Substance Abuse and Mental Health Services Administration (SAMHSA, 2013) has found that approximately 40% of the people who have a mental illness in the United States receive treatment every year, an average of approximately 24.6 million people. Mental health costs have surpassed physical health costs within the American medical care system (Bohanske & Franczak, 2010).

In the managed care system clients often have copays and deductibles (Harvard University, 2004). Harvard University (2004) asserts copays are often higher for mental health services than for physical health services. This means that the 10% of clients who are accessing mental health care repeatedly and are responsible for 60-70% of the expenses are taxing not only the mental health care system, but themselves.

Brown and Minami (2010) maintain that there should be a focus on counseling as a business. Managed care reimbursement for mental health care has not kept up with the
growing cost of living in the past decade, and managed care continues focusing on lowering expenses. Counseling is not reimbursed as well as other types of treatment for mental illnesses, such as medication, and Brown and Minami (2010) go as far as to say counseling is losing its market to medications. In addition, they avow consumers do not view counseling as highly as medications. While most people believe that counseling works, the majority think it takes too much time and is too expensive; Brown and Minami (2010) believe keeping track of outcomes is the way to reverse the trend of lower reimbursement for mental health services. This is not a quick fix. According to The National Institutes of Mental Health (NIMH, 2015) the effectiveness, or outcomes, of mental health counseling are crucial for the future of mental health reimbursement. The Patient Centered Outcomes Research Institute (PCORI) provides financial backing for numerous studies of outcomes.

Lambert (2010) asserts measuring outcomes represents a substantial alteration in the manner in which counseling is managed. They claim several outcomes methods have been validated and when used they increase the chances of positive client outcome and increase quality of care. Brown and Jones (2005) found making sure each client is getting effectual counseling is the manner in which to control expenditures. In most cases making certain that clients receive the most efficacious treatment results in clients needing fewer sessions and therefore keeping costs down (Brown & Jones, 2005). Lambert et al. (2003) explain that clients who gave feedback to their counselor and were on track had fewer counseling sessions than if feedback had not been given and progress not monitored. They discussed further how clients who were not seen as “on track” were given on average an additional one and one-half sessions. Employing feedback lowers the
typical cost of treatment per client; adding sessions when treatment failure has been predicted may be completed in a cost-effective way (Lambert et al., 2003). He states a one and one-half session increase is inconsequential to payers. Brown, Burlingame, Lambert, Jones, and Vaccaro (2001) assert their research indicates using outcomes ends in considerably enhanced therapeutic outcomes and a more sensible distribution of mental health care dollars.

Client satisfaction is going to increase if clients are achieving their goals in a time-effective manner. In addition, if costs are kept to a minimum it will take the pressure off the clients to meet copays and deductibles. Clients also have nonmonetary costs with counseling such as potential unpleasantness, travel expenditures, time, effort, and loss of work time (Lambert et al., 2003).

Lambert et al. (2003) maintain outcomes will be used by payers in order to determine whether to cover an intervention. They go further to say payers will want to keep track of how much the use of the intervention lowers use of additional health care services and the level of satisfaction of the client with the intervention.

“The age of accountability.”

Wells et al. (1996) assert the “age of accountability” (p. 275) was pushed on counselors due to increasing costs of healthcare and increasing managed care. Miller, Hubble, Chow, and Seidel (2015) discuss the rise of managed care in the late 1980s and early 1990s, stating that the “call for more accountability” (p. 450) was on the rise. Merrick, Garnick, Horgan, and Hodgkin (2002) state 92% of Americans were covered by managed care plans by 2002. Increasingly, people have been covered by managed behavioral health care organizations (MBHOs), a “carve out” of the medical managed
health care organizations (Zuvelas, Rupp, & Norquist, 2005). Wells et al. (1996) assert in the early 1990s managed behavioral health care began to require accountability and demonstration of usefulness of treatment. They maintain as early as in 1996 keeping track of outcomes seemed to be becoming a necessity. By 1999, however, Merrick et al., (2002) found that managed care organizations were only measuring clinical outcomes approximately 50% of the time. Counselors since have been increasingly required to document improvement in counseling and Miller et al. (2015) insist routine outcome monitoring (ROM) has become a permanent part of mental health services.


**Ethical Responsibilities of Mental Health Professionals**

Lambert, Jasper, and White (2005) believe counselors must demonstrate scientifically they are assisting clients. They state further it is an ethical obligation to determine if what they are doing is working. The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) implemented the Continuous Quality Improvement (CQI) standard in 1992 (Wells et al., 1996). This standard necessitates continual assessment of client care through outcomes measurement.
Tarescavage and Ben-Porath (2014) discuss the American Psychological Association (APA) and the American Medical Association (AMA), professional associations that recommend outcome assessments to examine treatment improvement. Duncan (2012) reports the APA advises members that demonstrating expertise requires assessment of client improvement.

The American Counseling Association (ACA) Code of Ethics (2014) professional values in the Preamble include protecting the integrity of the counselor client bond, a key element of outcomes that look at the therapeutic alliance. Several ethical principles apply to outcomes: Autonomy, which is defined by clients maintaining control over their own life and Veracity or being truthful with clients. A client maintains autonomy when they are asked for their feedback and it is acknowledged and acted upon. Discussing the results of the assessment tools honestly is one-way Veracity is maintained.

Section A. of the ACA Code of Ethics (2014) addresses the counseling relationship and discusses the importance of the therapeutic alliance. The SRS specifically analyzes the therapeutic relationship through client feedback and allows the counselor to work on creating and maintaining a strong relationship.

Section A.11.a. speaks to terminating the counseling relationship and referral. The counselor is expected to be aware when counseling is not helping or is making a client worse. In either case the counselor is to be open with the client and refer them to someone else. The Outcome Rating Scale (ORS) and Session Rating Scale (SRS) allow a counselor to become aware quickly the counseling is not working and fix what is wrong or transfer the client.
In Section C.2.d. of the ACA Code of Ethics (2014) counselors are mandated to constantly assess their effectiveness and take steps for remediation if necessary. The SRS and ORS allow this to occur.

In Section E.1.a. counselors are told that they are to use assessments if it will help the client make decisions or be of use in treatment planning. Section E.1.b. states counselors must respect the right of the client to know the outcome of the assessments they are given. Both of these mandates are met with Feedback Informed Treatment (FIT).

Tarescavage and Ben-Porath (2014) state that in spite of recommendations by major professional organizations, global outcome measures are not consistently used in clinical practice. They conducted a review of outcome measures to discover the reason outcomes aren’t used universally. Some reasons mentioned are a concern with excess paperwork, concerns about time, concerns about putting an extra encumbrance on clients, believing they are not of assistance, lack of money, and a concern that an assessment will alter the effect of treatment.

**History of Outcomes**

Gold (2015) reports that investigation into outcomes started in the 1950s as a response to questions about whether counseling worked. Clement (1999) asserts that counselors began competing for clients in the 1960s; Managed Care Organizations (MCOs) began heavily competing in the 1990s. All of the above have led to increased focus on measuring outcomes in counseling. According to Gold (2015) there have been several outcome studies to date. They have determined counseling is effectual, however, no particular type of counseling is better than another in every situation. Minieri, Reese, Miserocci, and Pascale-Hague (2015) affirm any type of counseling is more effective.
than no counseling at all. Counselors will have an easier time focusing their counseling on the needs of a particular client if they have outcomes to base their decision upon.

**Importance of Outcomes**

Reese et al. (2009) found that clients who were asked to provide continuous feedback to their counselor on the therapeutic alliance and therapeutic progress showed statistically significant therapeutic improvements over clients not asked to provide feedback. Their study used the ORS and SRS with a study group and no outcomes information with the control group to demonstrate this. Shaw and Murray (2014) report that studies where clients were asked directly for feedback have increased significantly in the last several years and resulted in significant increases in client’s positive results. Ogrodniczuk, Joyce, and Piper (2005) state receiving feedback from the client on the method in which a client’s problem is being addressed, and the strength of the alliance, reduces premature termination. Counselors can get counseling back on track if they can pinpoint clients who are not benefiting from counseling with a continuous feedback method (Reese, Norworthy, & Rowlands, 2009). Shaw and Murray (2014) assert that when clients are asked for their opinions therapeutic improvements are much greater.

According to Wells, Burlingame, Lambert, Hoag, and Hope (1996) studies have been done that found as many as 1,430 various outcome assessments, a great number of which are not empirically sound. Wells et al. (1996) call for uniform outcome measurement and assert professional judgment should not be used as it is not as accurate as statistically validated assessments. Green and Latchford (2012) assert counselors are less likely to be accurate in judging the effectiveness of their services than they think they are.
Brown and Minami (2010) state some counselors are better than others and it is just a matter of time before managed care organizations will try to find the most effective counselors. Brown and Minami (2010) report a couple of managed care organizations have already attempted to assess counseling outcomes and identify the most effective counselors. They describe the initiatives which included a self-report questionnaire that was administered frequently to clients, with the information being put into a database of client outcomes. Counselors were given feedback on individual clients in addition to feedback on their entire caseload. Perhaps most interesting was the desire to identify the most effective counselors and give them referrals. Brown and Minami (2010) state that assessing outcomes and utilizing the most effective counselors is especially important to businesses to increase productivity and lower mental health costs.

Green and Latchford (2012) avow that since the early 1900s there has been a movement to allow the clients of mental health services to have a greater say in their counseling. They point out that there have been abuses in the mental health system because clients did not have power to speak up for themselves. They assert the rights of people who are using mental health services are taken into consideration through the process of obtaining outcomes information. Green and Latchford (2012) aver that when clients are an active part of their treatment their satisfaction and outcomes improve.

**Reluctance of Counselors to Use Outcomes**

The greatest issue with outcomes is reluctance to use them by counselors (Lambert, 2010; Lambert, 2013; Wells et al., 1996). Counselors have proven to be inaccurate when they attempt use their judgment to predict the benefits clients are getting from counseling, especially when clients are not improving (Green & Latchford, 2012;
Lambert & Shimokawa, 2011). This is true even when they have been given feedback for many years (Miller, Duncan, Brown, Sparks, & Claud, 2015). Lambert and Shimokawa (2011) assert counselors’ self-reliance and belief in their ability to accurately identify clients who are not improving, even though there is evidence to show that their clinical judgment is most often not accurate, is one reason counselors often do not use outcome systems.

Cost of outcome assessments is a practical concern of many counselors, although there are empirically proven instruments that are free of charge on the internet (Miller et al., 2015). At this point, Miller et al. (2015) assert, the cost of the instruments or the cost of interpretation are not covered by an increase in payment. The time it takes to use, interpret, and discuss a measurement tool is not always seen as time well spent by counselors. When choosing an instrument, the client, counselors, payers, and governing organizations of the profession may not agree on the best assessment. Thus, more research and education regarding outcomes tools is needed.

Some may argue goal setting and meeting goals is evidence enough counseling is working. However, goals can be met and not maintained. In addition, goals could be met more quickly if the counselor had feedback offered by outcomes measurements (Miller et al., 2015).

Lambert (2010) maintains most counselors use their personal judgment to determine if they are more successful than most other counselors, Counselors have been found through qualitative studies to be confident they help a majority of, “if not all,” clients and don’t find feedback necessary. Outside assessments of progress in clients are frequently viewed as threatening to the counselor’s own idea of how successful they
really are. Some counselors are offended when they are informed that they should watch how their clients are reacting to treatment (Green & Latchford, 2012; Lambert et al., 2003). Clinicians may be concerned about their performance being evaluated through outcomes measurement due to a fear of negative results (Wells et al., 1996). Miller et al. (2015) discuss the fears of counselors that outcome results will be used to employ, fire, determine pay, or discipline. Other issues of concern may be the length of time it takes to complete the measures and the threat of additional paperwork. The bottom line is often outcome assessments are not seen as either practical or useful (Tarescavage & Ben-Porath, 2014).

In spite of their reluctance to use feedback in the form of Routine Outcome Measurement (ROM), counselors do report they want to improve their efficacy (Miller et al., 2015). Miller et al. (2015) suggest three actions counselors need to take to improve: first, they determine a starting point of their current effectiveness; second, they obtain constant feedback, and third employ a thoughtful practice of using ROM. The first two steps are provided by most outcome systems, the third is in the realm of the counselor’s actions.

Another issue, according to Miller et al. (2015) is the difficulty with assessing how the feedback is being used by the counselor, if it is at all. Miller et al. (2015) reported half of the counselors given feedback from clients did not use it at all. Of counselors who did use it only 50% reported profiting from using feedback. In spite of the information above, Miller et al. (2015) assert when counselors were committed to using feedback, and did so, clients improved more quickly. Minieri, Reese, Miserocchi,
& Pascale-Hague (2015) assert using feedback doubles the chance that counseling will be effective.

If counselors have been allowed to choose to assess client progress they are much more open to employing the system chosen for them to use. The problem is the system is usually forced upon them by administration of their companies or insurance providers. When this happens, the counselors do not believe the measurement of progress in treatment benefits them. When all involved realize that the client is the benefactor of the outcomes counselors will have more buy-in to the system.

**Feedback**

Claiborn and Goodyear (2005) define feedback as a reaction to behavior that affects that behavior. They go on to state that feedback is crucial to the results of, and an inescapable part of, the process of counseling. Outcomes are a form of feedback from the client to the clinician. ROM is defined as consistent feedback from the client to the clinician and there is solid empirical backing for using ROM in routine counseling (Miller et al., 2015).

While the concept of feedback is often associated with counseling and communication, the first example of progress assessment and feedback is in behaviorism (Lambert, 2015). In behaviorism, behavior change is facilitated through monitoring and reinforcement. While behaviorism focuses on a specific action, or behavior, monitoring and feedback are currently used to measure overall mental health.

Further origins of feedback are in cybernetics and engineering (Claiborn and Goodyear, 2005). Kurt Lewin, a psychologist associated with social psychology, and Gregory Bateson, a social scientist and cyberneticist, along with additional social
scientists developed the concept of feedback to catch “behavior in interaction” (Claiborn & Goodyear, 2005, p. 209). Feedback can be evaluative and interpretive and can include information about emotions.

Michael Lambert is a forerunner in the use of client feedback in counseling (Duncan & Miller, 2008; Duncan, 2012; Green & Latchford, 2012). He works at Brigham Young University and has studied client’s progress as relates to feedback from clients in counseling. Michael Lambert did a meta-analysis of three studies in 2003 and concluded when he looked at counseling that was headed for a negative outcome, counselors who got feedback about progress had better outcomes than 65% of those who did not get feedback. Feedback was especially important for clients who were not progressing as expected or considered “at risk” (approximately 20 to 40% of the clients) (Lambert, 2015). Double the clients attained significant change if their counselors received feedback than if their counselors did not, and premature termination and deterioration of the client were cut in half (Hubble, Duncan, Miller, & Wampold, 2010; Lambert & Shimokawa, 2011; Miller et al., 2015). Green and Latchford (2012) assert this research increased the growing evidence that feedback improves effectiveness for all clients, and especially for clients who are not progressing as expected.

Reese et al. (2009) found that clients who were asked to provide continuous feedback to their counselor on the therapeutic alliance and therapeutic progress showed statistically significant therapeutic improvements over clients not asked to provide feedback. In their study they found that clients who were given the opportunity to offer feedback using the Partners for Change Outcome Management System (PCOMS), which uses the SRS and ORS, demonstrated reliable change in fewer sessions. Shaw and
Murray (2014) report that studies into obtaining opinions directly from the client have increased significantly in the last several years and studies have shown that formal feedback dependably increases client’s positive results. Ogrodniczuk et al. (2005) assert that receiving feedback from the client on the manner in which a client’s problem is being addressed and the strength of the alliance reduces premature termination.

Counselors can get counseling back on track if they can pinpoint clients who are not benefiting from counseling with ROM (Reese et al., 2009). Shaw and Murray (2014) assert that when clients are asked for their opinions therapeutic improvements are much greater. They also aver when counselors use clinical judgment to determine whether counseling is successful and the relationship positive, the results are not the same as the results when the opinion of the client is asked. Counselors tend to overestimate progress of the client in counseling and the strength of the counseling relationship. Lambert and Shimokawa (2011) assert clinicians are incapable of recognizing the 5-14% of clients who deteriorate during the treatment process, therefore obtaining feedback is crucial. They assert results of a counselor’s functioning are difficult to determine because the evidence of results is often quite subtle. They also have found counselors often are excessively positive when evaluating client’s advancement toward goals.

Duncan (2012) discusses a meta-analysis of six investigations into an outcomes system of feedback that showed that clients in a group where their clinicians received feedback were 2.6 times more likely to realize consistent progress and had less than half the chance of getting worse than the group whose counselors did not receive feedback. Simon, Lambert, Harris, Busath, and Vazquez (2012) found in their study that clients of counselors who received feedback were significantly more likely to improve than clients
of counselors who did not. At risk clients showed substantial improvement if they were in the feedback groups. Overall, clients who were forecast to deteriorate in treatment profited the most from feedback. Miller et al. (2015) discuss evidence from over a dozen randomized controlled trials (RCTs) and numerous meta-analyses that provide evidence of the positive effects of feedback in the form of ROM in counseling. They report that the use of ROM may: lower premature termination by 50%; lessen the chance of deterioration by 33%; cut periods of treatment by 66%; increase clients who improve in counseling; and decrease costs.

Sapyta et al. (2005) says feedback must allow the professional to understand the discrepancy between where they are and what the goal is. Feedback must be collected routinely and with standardized assessments to increase the perceived reliability of the feedback. Next, the substance of the feedback must be considered. Patient-focused research allows the clinician to determine whether the client is moving through treatment as expected. Feedback should be given as soon as possible, on a regular basis, and as simply as possible for it to make the most difference. No matter the theory being used feedback has been found effective (Lambert, 2010; Lambert, 2015; Miller et al., 2015). In addition, when studies of treatment locations, types of patients, and countries have been completed, feedback was shown to be helpful across the board.

There are several rationales for using feedback. RCTs have shown feedback on the alliance and progress considerably increases positive outcomes. It is valuable for increasing the quality of services and this has been demonstrated in real-world settings. Feedback lowers the number of premature dropouts, cancellations, no shows, and the number of sessions required. Objective data about counselor’s effectiveness is gained and
inconsistency between counselors is lowered. The alliance and early change are evaluated with the most-used feedback systems and these are proven forecasters of the result of treatment. Feedback, perhaps most importantly, allows the client to have a voice in the therapeutic process (Duncan & Reese, 2015).

A number of feedback systems have been developed, however there are two in the Substance Abuse and Mental Health Administration’s (SAMHSA) National Registry of Evidence-Based Programs and Practices. The Outcome Questionnaire (OQ) was developed by Michael Lambert and was the initial assessment that was designed to assess client progress at every counseling session. The Partners for Change Outcome Management System (PCOMS), which uses FIT, is also approved by SAMHSA. Both have been developed through patient-focused research and continue to be studied by patient-focused research (Duncan & Reese, 2015).

**Patient-focused research.**

Sapyta et al. (2005) claim *patient-focused research* is studies about feedback that comes directly from the client about the client’s wellbeing and improvement in counseling. Lambert et al. (2003) state, “Such systems monitor and feedback information about a patient’s progress during counseling for the purpose of enhancing outcomes” (p. 288). Warren, Nelson, Burlingame, and Mondragon (2012) describe how in 1996 Howard and colleagues suggested this method to find adult clients who were headed for less than ideal counseling results. They go further to explain that in the United States and Europe there have been numerous types of patient-focused research created. Hawkins, Lambert, Vermeersch, Slade, and Tuttle (2004) declare patient-focused research grew out of an emphasis on the value of counseling along with counselor’s and researcher’s
disappointment in research into the efficacy and effectiveness of counseling. Lambert and Shimokawa (2011) assert previous to this time supervision and experience in practice were the principal means of feedback. The true effect was never measured; we are unsure of the effect of supervision and experience, however, Sapyta et al. (2005) avow that experience alone does not provide the feedback required to improve a clinician’s skills.

Patient-focused research, however, offers the clinician information about whether treatment is working. It is individual and looks at whether a treatment method is working for a particular client. This allows the clinician to look at the information and make changes in treatment factors to improve outcomes. Lambert (2003) discusses the use of patient-focused research as a form of quality control designed to improve client outcome. It necessitates effective outcome measurement.

**Use of Feedback/Outcomes**

Harmon, et al. (2007) assert offering counselors information about their client’s progress during counseling allows the counselor to make real-time changes to treatment. They further aver that while the advantages of counseling have been recognized, a small number of clients (approximately 8%) get worse in counseling. For clients who were expected to get worse in treatment, giving feedback to counselors enhances outcomes (Lambert et al., 2001; Lambert et al., 2002).

Lambert and Shimokawa (2011) assert feedback will be of most assistance to the counselor when there is cognitive dissonance, in other words there is a difference between how the counselor believes the counseling is progressing and the results of the outcome measurement completed by the client. Lambert and Shimokawa (2011) conclude that, “feedback in clinical practice improves patient outcome” (p. 74). Lambert and
Shimokawa (2011) aver “formal feedback” encourages the counselor to have a conversation with the client about negative changes. Lambert and Shimokawa (2011) assert that information on how life is progressing from the client’s viewpoint can be provided by systematic assessment. They avow this may not be available any other way to the counselor.

Lambert (2005) reports that counselors are not good at predicting who will succeed and who will not succeed in treatment. He further states that typically a counselor predicts a better outcome than what is actually occurring. Lambert (2005) asserts that when counselors can be notified of a potential negative outcome they can take steps to prevent it. Therefore, Josefsson (2013) asserts outcome measures may become as widely used in counseling as taking vital signs such as blood pressure and temperature when visiting a physician.

**Evidence-based practice.**

Gold (2015) discusses evidence-based practice (EBP). This refers to the use of existing best evidence in a diligent, overt, and thoughtful manner to decide about precise treatments for precise circumstances in the treatment of clients. EBP determines the effectiveness of an intervention. However, Gold (2015) makes the point that treatment choices should be individualized, take into account personal conditions of the client, and not be manualized. Gold (2015) points out that EBP has become known for using RCTs. Josefsson (2013) points out RCTs typically use homogeneous groups of clients, a condition he asserts is not often seen in practice. Internal validity is the focus of EBP (Josefsson, 2013). Therefore, there has been a turn toward the use of practice-based designs to study best practices in counseling.
**Practice-based evidence.**

Green and Latchford (2012) discuss practice-based evidence versus evidence-based practice. Practice-based evidence encourages clinicians to methodically gather data on the procedure of change and outcome of counseling in natural settings and to participate in the discussion of why counseling does work. Practice-based evidence establishes the effectiveness of an intervention and is often called ROM. In practice-based evidence counselors collect information in a scientific manner during their routine counseling practice. Josefsson (2013) explains that practice-based evidence has a double purpose: to study queries of quality and delivery to improve practice and to augment the evidence base for all psychotherapies. Thus, external validity is the focus of practice-based evidence.

Assessment systems which measure various parts of client functioning began when medical insurance companies wanted some indication of outcomes in counseling. According to Josefsson (2013), ROM should be used to determine how many sessions a client needs rather than predetermined does of counseling as some managed care companies would like to use. Later, practice-based research, which leads to practice-based evidence, adopted the use of outcome systems. This has enabled counselors to do practice-based research and has closed the gap between research and practice. It also enabled counselors to use the information to change their methods, frequency, or timing of counseling, along with providing research to the profession. Lambert et al. (2003) maintains effectiveness research, or practice-based research gives us evidence of the utility of intervention in a real-world setting. The first of the practice-based assessments to be used in this study assess the stages of change of a client in counseling.
Overview and History of FIT

Taratovsky (n.d.) describes the roots of Feedback Informed Treatment (FIT) in the 80s and 90s at the time a few investigators started to trace the efficacy of counselors. At the time, most investigators worked alone at universities and were using long assessments of feedback from clients, many of them had over 90 questions, making them unable to be used routinely. Scott Miller and Barry Duncan, in the late ‘90s, set out to make assessments that were brief enough to use during counseling sessions. Their goal was to come up with assessments that were inclusive enough to provide data on progress of the client and how effective the counselor was.

Taratovsky (n.d.) explains that FIT is regularly and formally asking for feedback from clients about the procedure (process) of counseling, therapeutic relationship, and general functioning. Duncan (2012) avers FIT is atheoretical; no matter the theory being used it is a way for clients to be heard. It is brief allowing it to be used in every counseling session. FIT is a Substance Abuse and Mental Health Services Administration (SAMSHA) evidence-based practice.

FIT incorporates two scales, the ORS, which looks at functioning and the SRS, which looks at the therapeutic alliance. They both are brief (four questions) and are visual analog scales. They were developed from the concept of scaling in Solution-Focused Counseling. The measures are completed by the client at every session and are scored immediately, offering feedback in real time. Immediate feedback from the client on the therapeutic alliance and therapeutic progress has been shown to lead to statistically significant therapeutic improvements (Reese, et al., 2009).
A computer-based method (https://MyOutcomes.com) has been developed which has advantages over using a paper-and-pencil form. It offers administration, gathering of information, a method for comparing results to norms, empirically founded feedback, and cumulative data.

Duncan and Miller (2008) call using FIT practice-based evidence instead of evidence-based practice. They assert FIT can be used to improve therapeutic effectiveness through five steps: (1) give the client the ORS in the initial session (2) explain to the client how their score relates to the cutoff (we are reminded at this point that we keep no secrets from the client; everything is shared, (3) give the client the SRS, (4) discuss the results of the SRS realizing that clients are apt to score alliance assessments positively so the counselor should address any idea of an issue, and (5) watch for change in future sessions.

Lambert and Shimokawa (2011) report on two studies centered on FIT (the ORS in particular): Anker, Duncan, and Sparks (2009) and Reese et al. (2009). They report both studies compared outcome of treatment for those getting no feedback versus those getting feedback through FIT. Reese, et al. (2009) used a university counseling center in their study; their goal was to assess the results of feedback on client outcome. Participants were assigned randomly to the control and treatment groups. They found 54% of participants in the no-feedback group underwent reliable change whereas 80% of participants in the feedback group underwent reliable change.

Reese et al. (2009) led a second study at a graduate training clinic. In this study the participants were counselors who were training in a graduate practicum. Again, they were assigned randomly to a control or treatment group. In this study they were able to
identify trainees who were not progressing in treatment—clients who would be at risk of a negative outcome. The study resulted in 41% of trainees in the control group attaining dependable change and 67% of those in the treatment group attaining dependable change (Lambert & Shimowaka, 2011).

Anker et al. (2009) looked at individuals in couples counseling at a community family counseling clinic. Individual outcomes were not tabulated. In the study 51% of couples in the treatment group attained significant or consistent change; whereas 23% of couples in the control group attained significant or consistent change. When the results of the Anker et al. (2009) and Reese et al. (2009) studies were combined the typical participants in the feedback groups attained greater change than 68% of those in the control groups. In other words, the feedback groups had a 3.5 times greater chance of undergoing reliable change and lower than half the chance of deterioration compared to those in the control groups (Lambert & Shimowaka, 2011). Duncan (2012) reports a meta-analysis was completed of FIT studies by Lambert and Shimokawa (2011). In this meta-analysis the feedback groups had less than half the odds of getting worse and 3.5 higher odds of having meaningful change. Over all the studies a medium treatment effect was found with an average effect size of .52 for FIT versus no feedback.

Duncan (2012) discuss the benefits of FIT and allowing clients to offer feedback about their services on a routine basis. They assert that the power differential between counselors and clients is lessened with giving clients a voice. This is especially important for clients who are not a part of the dominant culture making this a multicultural intervention. Also, this is a model that supports positive change and not an illness-based
model. Giving a client power in decision making allows them to take control of their lives and begin to achieve the autonomy they will need to function in society.

FIT was incorporated into the Partners for Change Outcome Management System (PCOMS), a consulting service designed for healthcare providers desiring the use of FIT to assess outcomes (Miller et al., 2005). Duncan (2012) asserts PCOMS is being adopted by community mental health agencies around the United States, Canada, the United Kingdom, and New Zealand among many others. PCOMS is delivered to over 100,000 clients per year. Duncan and Reese (2015) report PCOMS has been administered more than 1.5 million times. PCOMS and FIT are often used interchangeably.

Measures of Client Functioning and Effect on Outcomes.

Tarescavage and Ben-Porath (2014) describe global assessments of client functioning and explain that instead of measuring symptoms unique to psychological illnesses, they usually assess larger concepts such as general distress, depression, anxiety and interpersonal issues often existent over many psychopathological issues. When counselors are given information on functioning they are able to change their therapeutic methods, if needed, to work more effectively for a specific client.

Therapeutic Alliance as it Relates to the Outcome of Counseling

Falkenstrom, Granstrom, and Holmqvrist (2013) assert the original concept of the therapeutic relationship comes from psychoanalytic theory. They further assert that Bordin proposed a more transtheoretical definition. According to Falkenstrom et al. (2013) Bordin describes the alliance as, “Agreement on the goals and tasks of counseling in the context of a positive affective bond between patient and counselor” (p. 317). Goldfried and Davila (2005) assert Carl Rogers may be the greatest proponent of the
significance of the therapeutic relationship and change. Goldfried and Davila (2005) claim even behavioral counselors, whom one would assume would not acknowledge the importance of the relationship, do acknowledge that the counselor themselves affect outcomes.

Duncan (2012) reports clients who are pleased with their alliance with their counselor are apt to stay in counseling and change positively. The therapeutic relationship was found to be a crucial forecaster of outcome in more than 100 published articles (Duncan et al., 2007; Falkenstrom et al., 2013; Harmon et al., 2007; Miller et al., 2015; Norcross, 2010; Whipple et al., 2003). Fluckiger, Del Re, Wampold, Symonds, and Horvath (2012) assert there is a strong connection between therapeutic alliance and outcomes no matter the method of counseling, type of disorder or issue, environment “context”, or assessment.

Ogrodniczuk et al. (2005) declare clients will endure the tough experiences in counseling more easily if a solid therapeutic relationship is present. A positive relationship encourages clients to not terminate prematurely (Goldfried & Davila, 2005; Ogrodniczuk et al., 2005; Xu & Tracy, 2015). Slone and Owen (2015) found that results of counseling increase when the counselor discusses the therapeutic alliance with the client.

Fluckiger et al. (2012) discuss other factors that may affect the therapeutic alliance. Level of symptomology has been studied and some studies demonstrate a positive relationship and others a negative relationship. Interpersonal functioning might also affect the creation of a therapeutic alliance. Interpersonal functioning is described as the capability of creating solid and established relationships out of counseling. There
have been mixed results in studies in this area. Some studies have shown interpersonal functioning to not be associated with alliance and others have shown it to be positively associated. Clients with a personality disorder also might have difficulty forming an alliance but according to Smits, Luyckx, Smits, Stinckens, & Claes (2015) more studies are needed.

Hubble et al. (2010) assert that counselors are not as good as clients in assessing the therapeutic alliance. Norcross (2010) reports when clients rate the strength of the therapeutic relationship the correlation with counseling outcomes is stronger than when counselors rate the strength of the therapeutic relationship. Bachelor (2013) states that there is a low correspondence between client’s and counselor’s assessment of the alliance.

Horvath, Del Ray, Flückiger, and Symonds (2011) found 30 various alliance assessments and this did not include various versions of the same assessments. This author chose several of the most well-known for inclusion in this paper.

**Measures of Feedback on Client Functioning**

Outcome measures have been developed with increasing frequency due to evidence of the benefits of making feedback available to counselors and the growing requirement for counselors to show the outcome of their work (Kopta, Owen, & Budge, 2015). There are numerous outcome measures for the counseling field, in fact Lambert (2015) asserts there are “thousands” of self-report assessments. The most frequently used and cited assessments were chosen for review for the purposes of this discussion.
Behavior and Symptom Identification Scale (BASIS-24).

The BASIS-24 by Eisen, Normand, Belinger, Spiro, and Esch (2004) contains 24 items scored on 5-point scales (Tarescavage & Ben-Porath, 2014). It takes roughly 5 to 15 minutes to finish. A fifth-grade reading level is needed. Software is available as is a pencil-paper version. Hand-scoring is too complicated; therefore, it is sent in to be scored. There is a license fee of $395 for one location and $95 for each other location. Every time it is scored there is a $3 fee. Answers are shown on a 5-point scale with 0 being a lower frequency of symptoms.

For psychiatric outpatients the test-retest reliability approximations over 3 days ranged from .77 to .91 (Eisen et al., 2004). Tarescavage and Ben-Porath (2014) stated a sample of outpatients were studied to determine internal consistency and Cronbach’s Alpha estimates ranged from .77 to .91. Cameron, et al. (2007) found the Overall Score was effective in discerning between inpatient, outpatient, and nonpatient samples. Eisen et al. (2004) found that the factorial validity of the assessment is supported. The sensitivity to change has been shown (Cameron et al, 2007; Eisen et al., 2004; Eisen, Ranganathan, Seal, and Spiro, 2007). Eisen, Gerena, Ranganathan, Esch, and Idiculla (2006) looked at psychometrics across several ethnic groups (Caucasians, African Americans, and Latinos). Caucasians, African Americans, and Latinos had similar psychometrics. In distinguishing inpatients from outpatients, the assessment had greater discriminant validity for Caucasians than for African Americans and Latinos. Tarescavage and Ben-Porath (2014) sum up the BASIS-24 by stating that it is a brief assessment that has been well-studied, is sensitive to change, and has satisfactory factorial validity. They assert the scale assesses wide, clinically applicable areas. Whether
the areas, or domains, assess the developer’s anticipated constructs is not known due to the lack of convergent validity confirmation. Due to the fact that it cannot be hand-scored this assessment will not be used in this study.

**Clinical Outcomes in Routine Evaluation (CORE-OM).**

Evans et al. (2000) developed the CORE-OM through funding by the United Kingdom’s National Health Service as an assessment of psychological issues (Barkham et al., 2001). The initial form had 34 items, they also developed shorter forms containing 18, 10, and 5 items. Clients use 5-point ratings, need a fifth-grade reading level, and are able to finish the assessment in 5 to 10 minutes. The items range from “not at all” to “most or all the time.” A written form is available for free and the elective software that administers and scores the assessment is $3 each administration.

Mellor-Clark, Barkham, Connell, and Evans (1999) describe how insurance providers and mental health clinicians were asked about assessment areas. There are four domains: Subjective Well-Being; Problems, which is described as an assessment of features shared by people with depression, anxiety, problems with physical health, and consequences of trauma; Functioning in interpersonal relationships and Overall Functioning; and Risk to one’s self and other people. Connell et al., (2007) estimate the reliable change index (RCI) at five. The instrument is able to distinguish the general population from a clinical population (Connell et al., 2007; Tarescavage & Ben-Porath, 2014). Barkham, Mullin, Leach, Stiles, and Lucock (2007) report a 1-month test-retest reliability estimate of .88 for the Total Score. Connell, et al. (2007) report an internal consistency for the Total Score of .91 in the general population. Evans, et al. (2002) reported correlations from .68 to .88 with the SCL-90-R using Total score and domain
scores (not using the Risk domain) in order to demonstrate convergent validity. Evans, et al. (2002) report a lack of factorial validity. Overall Tarescavage and Ben-Porath (2014) state looking at the Total score as an assessment of overall distress is most suitable. Tarescavage and Ben-Porath (2014) report the Total score has shown sensitivity to change. Test bias in ethnic groups has not been studied other than one study by Wan in 2001 that showed that British Chinese and white Europeans did not have different scores. Being developed in the United Kingdom it has not been studied extensively enough to be used in the United States. Thus, it will not be used in this study.

**Outcome Questionnaire (OQ-45).**

The OQ-45 is a 45-item measure developed in 1996 by Lambert, Huefner, and Reisinger along with clinicians, academic researchers, and administrators of two big managed health companies (Tarescavage & Ben-Porath; Wells et al., 1996). It takes 3 to 5 minutes to fill out and a Likert scale where 0 is *never* and 4 is *almost always* is used, 36 items are negatively worded and 9 positively worded. It is self-report and there are three scales. There are paper-and-pencil and computer versions and it may be hand or computer scored. For full output a computer is needed to analyze the data. Therefore, counselors may not receive the feedback every session but at the next session. The OQ-45 requires a fifth-grade reading level. Designed to be used weekly, it reacts strongly to treatment effects (Lambert, 2010; Okiishi. Lambert, Eggett, Nielsen, & Dayton, 2006). A form that is good for the lifetime of the user runs from $75 for an individual to $3,500 for an organization. The software used to score and conduct the assessment is $250 each year for each clinician.
Tarescavage and Ben-Porath (2014) discuss the rational item selection method used for scale creation. These scales were changed at a later date because of internal consistency evaluations. Four scale scores remained: Symptom Distress, Interpersonal Relationships, Social Role, and an overall score (Total score). It can also assess for risk for suicide or violence, and substance abuse. Normative information and raw scores are interpreted in the assessment manual. There is an RCI of 14 points. Anticipated recovery curves are included which makes this instrument stand out. This allows for warnings about clients who are not improving.

Kadera, Lambert, and Andrews, 1996, as cited in Rochlen, et al. (2005) found an internal consistency of .93 and a test-retest reliability of .84. Rochlen et al. (2005) found a coefficient alpha of .95 for the total score and assert the OQ-45 is constructed well and has respectable (good) psychometric features. Hawkins, et al. (2004) assert that OQ-45 has concurrent validity as shown through its correlation with the Symptom Checklist-90-Revised, Beck Depression Inventory, Zung Depression Scale, Taylor Manifest Anxiety Scale, State-Trait Anxiety Inventory, Inventory of Interpersonal Problems, and the Social Adjustment Scale. Blais, Blagys, Rivas-Vazquez, Bello, & Sinclair, (2015) aver there are questions about the construct validity of the subscales, leading to a recommendation that total scores be used to assess treatment. They state the factor structure is uncertain. It is desirable to have feedback immediately, which is not possible with this assessment, thus this assessment was not chosen for this study.

**Patient Reported Outcomes Management Information System (PROMIS).**

Tarescavage and Ben-Porath (2014) include the Patient-Reported Outcomes Measurement Information System (PROMIS®) in their study of outcome measures. The
PROMIS® was paid for by the National Institute of Health (NIH) and was incorporated into the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5). It contains items measuring medical and emotional issues. It was developed by Pilkonis et al. (2011). This assessment includes 28 items for Depression, 29 items for Anxiety, and 29 items for Anger. Rated on a 5-point scale, there are also brief forms for each domain. As long as the client has a first-grade reading level they will be able to answer the items in around 5 minutes per domain. Both computer and paper-and-pencil versions are obtainable at no charge.

Pilkonis et al. (2011) explain they first performed literature reviews which discovered 1,404 items assessing depression, anxiety, and anger. 457 items remained after unclear, confusing, and superfluous items were removed. Each domain was reduced to 56 items after lay people were tested for their comprehension of the items. Items for domains were reduced for a variety of reasons including measurement bias, differential item functioning, and intellectual property problems. Item Response Theory (IRT) calibrations assisted the authors in choosing the items that performed the best.

Tarescavage and Ben-Porath (2014) assert the PROMIS® has not been widely researched but due to the fact that it is part of an NIH paid for project will probably get extensive use. Numerous studies have been done with the PROMIS medical scales but few with the emotional scales. Tarescavage and Ben-Porath (2014) state t-scores report results of the PROMIS® which is normed on the general population. Pilkonis et al. (2011) researched the PROMIS® and found good factorial validity, however there were high intercorrelations across items for depression, anxiety and anger. Tarescavage and Ben-Porath (2014) assert more studies must be done on construct validity, sensitivity to
change and compatibility with Jacobson and Truax’s (1991) clinically significant change criteria. This instrument needs to also be studied to determine cultural bias. This assessment has not been researched extensively enough to use in this study.

**Symptom Checklist-Revised (SCL-90-R).**

Developed by Derogatis in 1983 from the Hopkins Symptom Checklist (HSCL), the SCL-90-R has 90 items and takes around 12 to 15 minutes to finish. A client with a sixth-grade reading level will be able to complete the assessment. Many options for administration such as paper-and-pencil, audio, and computer are offered. There are costs associated with the assessment ranging from $1.50 per self-scored administration to $8 per mailed in administration. The SCL-90-R has nine symptom scales: Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. Three overall scales are included and they are Global Severity, Positive Symptom Distress, and Positive Symptom Total. Three groups of t-scores are supplied. In addition, a progress report is supplied to watch progress across five administrations.

Tarescavage and Ben-Porath (2014) report test-retest reliability for the SCL-90-R ranged from .78 to .90 over one week. Internal consistency goes from .79 to .90. Discriminant validity of the SCL-90-R has been satisfactory. One study showed no cultural bias when the SCL-90-R was administered to African Americans. Mander et al. (2014) say the SCL-90-R has superb internal consistencies, respectable retest reliabilities and adequate construct validity. This assessment was too lengthy to choose for this study.
**Brief Symptom Inventory (BSI).**

The Brief Symptom Inventory (BSI) was developed by Derogatis in 1993 as a short form of the SCL-90-R. It is a self-report assessment consisting of 53 items assessing psychological symptoms and the severity of the symptoms. It has the same symptom scales as the SCL-90-R. The BSI takes 8 to 10 minutes to finish. Tarescavage and Ben-Porath (2014) assert the BSI has been extensively employed in outcomes studies.

The BSI has substantially lower reliability due to its brevity (Tarescavage & Ben-Porath, 2014). Test-retest scores were taken for a two-week interval and ranged from .68 to .91. Internal consistency for the BSI went from .71 to .85. Tarescavage and Ben-Porath (2014) aver that there are high correlations between the SCL-90-R and BSI scales and therefore any studies reinforcing validity of the SCL-90-R also apply to the BSI. This assessment was not chosen due to the number of items.

**Outcome Rating Scale (ORS).**

Duncan and Miller (2008) explain they developed the ORS because measures that were being used were too long and cumbersome and did not offer immediate feedback to the counselor so that issues could be addressed. Green and Latchford (2012) state the ORS is a model short assessment of psychological functioning. The ORS is a measure of functioning filled out at the beginning of the session; it lets the counselor know how the client has been doing since the last meeting. This allows the counselor and client to discuss any issues immediately (Green & Latchford, 2012).

Duncan (2012) describes the four facets the ORS measures: (1) problems or well-being in the personal domain or with symptoms, (2) the client’s functioning in personal
close relationships, (3) happiness with school or work and social relationships, and (4) a
global interpretation of personal well-being. The four facets are then put into a visual
analog layout consisting of four 10 cm lines. The client places a mark on the line and low
scores are to the left and high scores are to the right side. The counselor measures the
score with a ruler or template. There is an overall score of 40. A score of 25 is the cutoff
for individuals who are having enough symptoms to be in counseling versus those who
are not Duncan and Miller (2008). A graph is used to watch change over time. Duncan
(2012) asserts that watching the ORS closely for quantifiable change assists the counselor
in preventing premature termination or a bad outcome of counseling. It is written at a
seventh-grade level and in several languages.

Duncan (2012) discusses four studies designed to validate the ORS. Cronbach’s
alpha coefficients for ORS scores ranged from .85 in a clinical sample and .95 in a
nonclinical sample. ORS scores have been shown to be susceptible to change for clinical
and steady for nonclinical samples. Concurrent validity has been studied by correlating
the ORS with recognized outcome assessments. There was moderately strong concurrent
validity (.62) with the OQ-45 over three studies. Duncan and Miller (2008) assert the
ORS correlates decently with a number of other generic measures of psychological
functioning such as the Symptom Checklist-90-Revised (SCL-90-R) (.57) and the CORE-
OM (.67). Additionally, scores taken before treatment differentiated nonclinical and
clinical samples, promoting validity. Duncan (2012) asserts the ORS seems to assess
global distress. The ORS will be used for this study.
**Measures of the Therapeutic Alliance**

Measuring the therapeutic alliance is crucial according to numerous studies (Shaw & Murray, 2014). There are many measures of the therapeutic alliance but few appear in the literature repeatedly and have been extensively studied. For this paper the measures that most often appear in the literature and have been most extensively studied will be described.

**California Counseling Alliance Scale (CALPAS).**

The CALPAS is a measure of alliance with a counselor and patient version (Gaston, 1991; Harmon et al., 2007). This paper will focus on the patient version. The CALPAS has four separate scales: Patient Commitment (PC) (therapeutic alliance), Patient Working Capacity (PWC) (working alliance), Counselor Understanding and Involvement (TUI) (clinician’s input in alliance), and Working Strategy Consensus (WGSC) (concurrence on goals and tasks). The CALPAS uses a 7-point scale with 1 standing for *not at all* and 7 *very much so* and has 24 items. The client assesses the counseling session just finished. The four CALPAS scales coefficients ranged from .43 to .73. In the Gaston (1991) study internal consistency was high with a Cronbach’s alpha coefficient of .84 for the entire CALPAS scale. Gaston (1991) asserts no relationship was seen between CALPAS scores and client’s age, education level, or income. The CALPAS ratings were not significantly correlated with quantity of counseling sessions, experience as a counselor, gender of clinician, or theory used. CALPAS scores were discovered to be moderately intercorrelated showing they manifest separate factors of the therapeutic alliance. There were adequate estimates of internal consistency (Gaston, 1991). Perhaps most importantly the CALPAS was found to be able to be used with any theory and at
any time in counseling. Gaston (1991) asserts more studies need to be done on the criterion-related validity of the assessment. Potential for the halo effect is present. More study needs to be done on this assessment so it was not chosen for this study.

**Helping Alliance Questionnaire (HAQ).**

Bachelor (2013) describes the Helping Alliance Questionnaire (HAQ), one of the first assessments of the therapeutic alliance, developed by Alexander and Luborsky in 1986. They developed it using Bordin’s separation of the alliance into goals, tasks, and bond. Containing 11 items, eight measures observed helpfulness and support and three measure alliance with the clinician to meet goals. The HAQ has satisfactory reliability (Luborsky, McLellan, Woody, O’brien, and Auerbach, 1985, as cited in Bachelor, 2013).

The HAQ was revised around 1996 and Luborsky added 14 new items and eliminated 6 items. Items are rated on a 6-point Likert scale where 1 indicates *I strongly feel it is not true* to 6 which indicates *I strongly feel it is true* where negative items are reverse scored. This study assessed the client form but a counselor form is also available (Harmon et al., 2007). Luborsky et al. (1996) tested the revised HAQ-II, which includes 19 items, on a sample of clients diagnosed with cocaine dependence. The authors assert the HAQ-II has superior internal consistency and test-retest reliability. The CALPAS and the HAQ-II showed good convergent validity. Luborsky et al. (1996) found the internal consistency of the HAQ-II and CALPAS total score, measured over several sessions, revealed similar scales. Test-retest reliability coefficients were high for the HAQ-II for a three-session duration. Luborsky et al. (1996) reported a high internal consistency for the whole scale. The HAQ-II and CALPAS, when completed by the same person had large
significant correlations. This assessment was not chosen for the study due to the assessment being more accurate if the counselor completes it also.

**Working Alliance Inventory (WAI).**

Horvath and Greenberg developed the WAI in 1989; it is an assessment that gauges both clients and counselors view of the therapeutic relationship, goals, and tasks (Rochlen, et al., 2005). It incorporates Bordin’s concept of the therapeutic alliance (Gaston, 1991). Bordin’s concept views the alliance as including the link between client and counselor, agreement about goals in counseling, and agreement on the tasks of counseling. For the purposes of this study the client’s form will be used and evaluated. The 36-item assessment scores items on a 7-point scale from 1 (rarely) to 7 (always).

Total scores go from 36 to 252. Horvath and Greenberg demonstrated internal consistency estimates with alphas for the client’s total score of .93 (Rochlen et al., 2005). In order to establish validity WAI scores and counseling outcomes, client qualities, and counselor method were correlated. Rochlen et al., (2005) report “for the client-rated scales, all correlations between subscales were above .73” (p. 56). Total WAI scores were used in the above analyses. Rochlen, et al. (2005) report a Cronbach’s alpha of .95. However, according to Gaston (1991) on the WAI the goals and tasks of counseling are not discrete. Smits, et al., (2015) assert the WAI is the most studied of the alliance assessments.

In order to address the issue of the Task and Goal subscale not being differentiated enough Tracey and Kokotovic (1989) created the Working Alliance Inventory- Short Form (WAI-S) (Bachelor, 2013). Smits et al. (2015) describe the WAI-S as having 12 items. The subscales are rated on a 5-point Likert scale that ranges from 1
(never or rarely) to 5 (very often) and each consists of four items. Smits et al. (2015) point out in an initial study it showed reliability with alphas from .82 to .85 and outstanding internal consistency of the WAI-S subscale ratings. It has been translated into several languages. The full form and short form have been found to be interchangeable (Bachelor, 2013). The WAI will not be used for this study due to the need for counselor input.

**Session Rating Scale (SRS).**

The Session Rating Scale (SRS) is the second part of the FIT protocol. It is an assessment measuring the client’s opinion about the therapeutic alliance given to and discussed with the client at the end of each session. Miller, Duncan, and Johnson created the SRS to inspire discussions between clients and the counselor about the therapeutic alliance. Duncan and Miller (2008) used the client’s assessment of the therapeutic relationship because it is more prognostic of advancement in counseling than the therapeutic method used or the clinician’s scores on the relationship. They used Bordin’s (1979) facets of the alliance: the interpersonal connection and whether there is accord between the client and clinician regarding the objectives and tasks of counseling.

The SRS has four scales and is measured in the same way as the ORS; the client makes a mark on a 10 cm line and marks to the left of the line indicate a negative response and to the right a positive response. The clinician uses a template or ruler to measure the score from 1 to 10 and total the scores which can range from 0 to 40. Duncan and Miller (2008) report that a poor therapeutic alliance is represented by SRS scores between 0 and 34, a fair alliance between 35 and 38, and a good alliance between 39 and 40.
The first scale measures whether the client felt listened to, understood, and respected. The second scale measures whether the client and counselor addressed what the client intended to work on or converse about in the session. On the third scale the client measures whether the counselor’s approach was appropriate for the client. The final scale assesses the entire session determining whether the “session was right for me” (Duncan, 2012).

Duncan (2012) discuss the psychometrics of the SRS. He reports that four studies found an internal consistency estimate that averaged .92. This indicates the SRS measures one overall alliance construct. This is consistent with the WAI and other alliance assessments. Test-retest average reliability coefficient was .59, this is acceptable stability. In reporting concurrent validity of SRS scores there was a correlation of .48 with the HAQ-II and .58 with the WAI-S. This is reasonable concurrent validity considering the other assessments contain more items.

Duncan (2012) states continual measurement of the therapeutic alliance allows clinicians to find and fix issues before they end in premature termination or a negative result for the client. Duncan et al. (2003) avow SRS scores from early therapeutic sessions forecast ORS scores from the end of treatment; this supports earlier research that connected initial client observations of alliance with results of counseling. Duncan and Miller (2008) assert the greatest way to improve one’s effectiveness in counseling is to maintain engagement with the client. The SRS was chosen for this study.

**Stages of Change**

Prochaska, Norcross, and DiClemente (2005) discuss their research, beginning in approximately 1980, into the organization of self-directed and treatment-mediated change
processes. Their theory asserts there are five stages through which a person progresses as their cognitions change and in turn behavior changes. This model includes persons who have not yet begun thinking about change and those who are not convinced change is necessary. Parker and Parikh (2001) and Mander et al. (2014) explain the theory avows several tries will be necessary before true behavioral change occurs. The theory has primarily been used in research into acquiring healthier behaviors and to eliminate unwanted behaviors. Parker and Parikh (2001) assert the usefulness and validity of this theory have been proven in a range of situations. Rochlen et al. (2005) assert their research delivers early backing for the idea that the Stages of Change can be used for a variety of clients and issues. Mander, Wittdorf, Klingberg, Teufel, Zipfel, and Sammet (2014) report that the Stage of Change model has been studied and shown useful across a variety of issues and clients, including in numerous other countries than the United States.

Prochaska and DiClemente developed the stage of change model in 1983 (Prochaska, Norcross, & DiClemente, 2005). The first stage is precontemplation in which the person is not even thinking of changing, the second is contemplation where a person is conscious of an issue but has no intent to change, third is preparation where a person begins readying for change, fourth is action which is described as current substantial alteration of behavior and fifth maintenance where behavioral alteration is persistent (Cohen et al., 2005; Parker & Parikh, 2001). Movement through stages is not unilateral and people cycle in and out of them. Parker and Parikh (2001) describe how Prochaska and DiClemente’s theory can be used to assess outcomes in two ways: assessing actual behavioral change and assessing a person’s inclination to alter their behavior.
Prochaska and Prochaska (1999) as cited in Harmon, et al. (2007) found that a positive counseling result may be forecast by a client’s readiness to change as assessed by the Outcome Questionnaire-45 (OQ-45). Brogan, Prochaska, and Prochaska (1999) assert premature termination of counseling may be forecast by a client’s readiness to change. Stage of change at the beginning of treatment forecasts the speed with which the client will move through the stages and how successful they will be (Prochaska et al., 2005).

Rochlen et al. (2005), using the Stages of Change Scale (SCS), assessed the stage of change at the beginning of counseling in a group of college counseling students. As a result, they aver the relevance of using a measure of stage of change at the beginning of counseling. They assert if counselors are able to find which clients are in the precontemplation stage they can begin addressing important issues of doubt about counseling early in the process. They aver addressing these issues may increase the amount of time the client participates in counseling and enhance the client’s view of the therapeutic alliance.

**Transtheoretical Model.**

According to Cohen et al. (2005) and Sutton (2001) the Transtheoretical Model of Behavior Change (TTM) by Prochaska and DiClemente encompasses the Stages of Change model, even though the terms TTM and Stages of Change are at times used interchangeably. The TTM, along with including the central concept of Stages of Change, incorporates the methods of altering one’s behavior, the pros and cons of changing, temptations, and the belief one has that they can make changes (self-efficacy). According to Cohen et al. (2005) the stages of change were developed for and primarily are used in the area of addictions, where much of the research emanates for this model. Mander et al.
assert the main supposition of the TTM is that the motivational stage of the client should be matched to the interventions used.

McConnaughy et al. (1983) assert 1) knowing the stage of change of a client allows a specific method to be used that will be most useful 2) if the client and counselor are in a dissimilar stage of change there will be opposition to counseling 3) if the client’s social system is involved in some of the stages of change there will also be opposition to counseling 4) the stage of change of a client when counseling starts is associated with premature termination and number of counseling sessions, and 5) counseling will be at its best if the counselor coordinates the client’s stage of change information with suitable methods of change. McConnaughy et al. (1983) describe studies that show that methods of inducing change are altered depending on the stage of change of the client.

Mander et al. (2014) discuss the 10 methods of change that result from interventions. The “processes of change” are hidden or obvious actions of the client which somehow change emotion, cognitions, actions, or relationships linked to particular issues. These methods, or processes, of change are put into two groups. “Experimental processes of change” raise increased consciousness of the issue and are pertinent for the period of initial stages of change such as precontemplation, contemplation, and preparation. “Behavioral processes of change” promote effort on the issue and are pertinent in the action and maintenance stages.

**Measures of Stages of Change**

Cohen et al. (2005) report on the small number of measurement tools that assess change in counseling that follow the TTM. According to Cohen et al. (2005) “multidimensional scaling approaches” and “staging algorithms” are used. Not protected
from controversy, Sutton (2001) questions if any of the assessments used to measure stage of change are assessing distinct stages. In spite of that fact, four of the most frequently used assessments were chosen to evaluate for this project (Cohen et al., 2005).

**Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES).**

According to Cohen et al. (2005) and Sutton (2001) the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) developed by Miller and Tonigan in 1996 is a multidimensional assessment. The SOCRATES was designed to measure readiness to alter behavior in the area of alcohol abuse and was an alternative to the URICA and can be use before treatment starts and during the treatment process. It is a 20-item assessment and according to Cohen et al. (2005) actually defines a “motivational process” instead of a sequence of stages. The stages are Precontemplation, Contemplation, Determination, Action, and Maintenance and there are four items for each. He asserts studies show no obvious difference between the Precontemplation and Determination and between Action and Maintenance. Sutton (2001) states the SOCRATES doesn’t measure the stages popularized by Prochaska and DiClemente but instead measures motivational procedures that may bring about stages of change. This assessment was not chosen for the study due to its inability to delineate between Stages of Change as described above.

**Readiness to Change Questionnaire.**

The Readiness to Change Questionnaire (RCQ) by Rollnick, Heather, Gold, and Hall (1992) has 12 items and was made to use for alcohol use (Sutton, 2001). It is designed to assess stages of change (only precontemplation, contemplation, and action) in the area of lowering the use of alcohol in heavy drinkers who are not asking for help with
their alcohol issue. The fact that this assessment was designed for people abusing alcohol is the reason it will not be used in this study.

**Scale for the Multiperspective Assessment of General Change Mechanisms in Counseling (SACiP).**

Mander et al. (2015) discuss the Scale for the Multiperspective Assessment of General Change Mechanisms in Counseling (SACiP). He explains the SACiP has six subscales representing Grawe’s change processes and Bordin’s theory of the therapeutic alliance. The SACiP has 21 items on a scale from 0, *very untrue*, to 4 *very true*. It assesses six universal methods of change. It applies specifically to individual counseling. Both the counselor and the client fill it out. It has a superb factor structure, respectable to superb internal consistencies, and has construct validity, with substantial outcome forecasts. This assessment is based upon having the counselor fill it out; this does not fit with the study being proposed.

**University of Rhode Island Change Assessment (URICA).**

The URICA is one of the most frequently used assessments of readiness for change (Cohen, et al., 2005; Sutton, 2001; Norcross, 2011). Originally named the Stage of Change Scale (SCS), it was developed by McConnaughy et al. in 1983. It was created to measure the change methods for several addictive and wellbeing actions and the motivational inclination for change in counseling clients. The URICA focuses on a universal issue and not a target behavior such as smoking. Therefore, the 32-item URICA can be used for a variety of issues. Each dimension (there are four) has eight items making the lowest possible score 0 and the highest possible 40.
Sutton (2001) asserts the URICA was the initial multi-dimensional assessment of Stages of Change. They describe the five stages theorized to describe the change process in counseling: Precontemplation, Contemplation, Preparation, Action, and Maintenance. Preparation, one of the theorized stages, was taken out based on statistical analysis. Pre-Contemplation, Contemplation, Action and Maintenance were found to count for 58% of total variance. The four scales that were kept have Cronbach’s coefficient alphas that range from .88 to .89. Mander et al. (2014) assert many studies establish the URICA’s validity. Mander et al. (2014) report a mean effect size of d=.46 for the connection between URICA stages of change and outcome in counseling studies in a meta-analysis. Dozois, Westra, Collins, Fung, and Garry (2004) assert in their study the reliability and validity of the URICA were largely reinforced. They further state the URICA meaningfully forecasted retention and dropout and had limited usefulness for forecasting treatment outcome. Dozois et al. (2004) assert it has good internal consistency (coefficient alphas from 0.79 to 0.89) for all four subscales. They also state factor analysis has reinforced construct validity. Cronbach’s alphas ranged from .77 to .84 for the four subscales.

Cohen et al. (2005) describe the five Stages of Change and give some idea of items on the parallel scale of the URICA. In Precontemplation the client does not acknowledge a problem exists and does not want to take action to get rid of the behavior. Issues, known to those around the client, are not acknowledged by the client. At this stage many clients feel forced into treatment by others. In the Precontemplation subscale of the URICA there are items such as, “As far as I’m concerned I don’t have any problems that need changing” (p. 47). In the Contemplation stage the person has an awareness of the
issue and may realize it is not desirable. On the URICA a contemplation item might say, “I think that I might be ready for some self-improvement” (p. 47). In Preparation a person is ready to take action to make a behavior change. People in the Preparation stage often have an elevated score on the Contemplation and Action subscales even though no specific questions measure Preparation on the URICA. During Action changes are being made. The URICA measures Action by statements such as, “I’m really working hard to change” (p. 48). During Maintenance the URICA says such things as, “I may need a boost right now to help me maintain the changes that I have already made” (p. 48). At this stage change is maintained and reversion is avoided. Thus, this measure was the one chosen for this study.

Summary

With 25% of the population of the United States suffering from a mental illness at any one time, and mental illness being the number one cause of disability, the costs to the American medical system to care for the mentally ill are high. Unfortunately, a large number of clients drop out of counseling before it is clinically recommended and others do not benefit from counseling. Information in the form of feedback from clients assists in measuring the outcomes of counseling. Managed care has begun to require information on the efficacy of counseling in order to reimburse for care. According to Miller et al. (2015) ROM has become a permanent part of counseling due to statistical support for its efficacy and growing requirements for accountability.

Studies have shown that the Stage of Change of the client, and how the client moves through the Stages of Change, predicts therapeutic outcome. In addition, offering counselors information about the day-to-day functioning of the client and the client’s
opinion of the therapeutic alliance allows the client and counselor to work together to
achieve a better outcome. Numerous assessments of the stage of change of the client, the
functioning of the client, and the client’s opinion of the therapeutic alliance have been
developed and several were reviewed in this chapter.
Chapter Three

Overview of Study

Introduction

Chapter Three will begin with an overview of the method that will be used in the study. Next the research design will be laid out which will include a description of the participants and sampling procedures. The instruments used in the study will be described in detail. Variables, procedures, the statistical hypothesis, and data analysis will follow. Limitations will be detailed.

Overview of the method

The Feedback Informed Treatment (FIT) program was implemented by professional counselors who conduct behavioral health care services. The primary researcher was a female Professional Counselor with nine years of experience in the field and eight years with the agency. The other three researchers were: a male Professional Clinical Counselor with 20 years of experience total, all at the participating agency; a female Professional Counselor with one year of experience in the field, all at the participating agency; and a female Professional Counselor with 15 years of experience, all with the participating agency. Each new client of participating counselors over several months was provided an informed consent form educating them about Feedback Informed Treatment and was given an opportunity to ask questions. Clients had the opportunity to refuse to engage in this process.

If the client consented to participate, FIT was integrated into each treatment session and consisted of two brief scales that measure robust predictors of therapeutic success. These two scales were (1) The Outcome Rating Scale (ORS), which assessed the
client's therapeutic progress (through ratings of psychological functioning and distress) and the client's perceived benefit of treatment and (2) The Session Rating Scale (SRS), which assessed the client's perception of the client-counselor alliance (i.e., the quality of the relational bond with the counselor and whether the counselor shares his or her therapeutic objective). The professional counselor administered the ORS at the beginning of the one-on-one treatment session, and the SRS was administered toward the end of the session. Client ratings for each measure were discussed on a session-by-session basis to maintain the client's engagement in treatment, optimize the client-counselor alliance, and provide a means for transitioning into the treatment session by focusing on client-identified concerns.

Two of the counselors used FIT and two of the counselors did not use FIT. All of the participants took the University of Rhode Island Change Assessment (URICA) at the beginning of the first session of the study, those who were still participating retook the URICA at 30 days and 60 days if possible. This is a brief scale to measure the stage of change of the client. The SRS and ORS took under two minutes to complete and the URICA took under 10 minutes to complete. The scores on the URICA were compared to determine whether the clients who were given FIT proceeded further through the Stages of Change than those not given FIT. Data was intended to be analyzed to determine whether the use of FIT improved scores on the URICA over time, however the sample was too small to run inferential statistics. In addition, if client ratings on FIT were very low, the counselor may have chosen to modify the type and amount of treatment. The scales were completed individually and kept by the professional counselor. Names were
not placed on the scale forms; each client was assigned a random number which was on the scales. Data was collected for a period of three months.

Research Design

In this study the independent variable (FIT) was manipulated by the researcher, however, there was not random assignment to groups making this a quasi-experimental non-equivalent control group design. Fit was given to the participating clients every session. In the initial session only the SRS was given as there was no progress to report on the ORS. During the following sessions the ORS and SRS were given if possible. The ORS was given at the beginning of the counseling session and the SRS at the end. The URICA was given at the initial counseling appointment, at 30 days, and at 60 days if the client was still in services. A convenience sample was used for this study; new clients of four mental health counselors participated. The independent variable had two levels: completed FIT and did not complete FIT. The dependent variable had three levels: initial level of change, level of stage of change at one month, and level of change at three months. The independent variable was nominal and the dependent variable was ratio. In order to compare URICA scores t-tests were to be utilized, however the sample was too small to run inferential statistics.

Description of participants

All participants were new general population clients of four professional counselors at a community counseling center with two locations in the suburbs of Toledo, Ohio. Participants ranged in age from 18-50 and were not be limited by race, ethnicity, or gender. New clients 18 to 80 who were seen by the participating professional counselors were offered the opportunity to participate. There were a total of 14 clients asked to
participate in the study. It was expected that approximately 10 participants would agree to be part of the study, however only six agreed. Some of the reasons given for not participating were the client didn’t ever fill out “surveys,” they were uninterested, or in some cases may have been too ill. Participants were provided basic information about Feedback Informed Treatment and the research process while in their individual sessions. Consent was explained by the professional counselor via both written and verbal communication. Each client who opted to participate signed a consent form and returned it to their respective professional counselor before participating in the study.

Training on the instruments was provided by the developer of the study who has studied FIT extensively. Over a period of several months, during supervision, counselors who are participating were asked to learn about and practice using the ORS and SRS to ensure their competency.

All participants were new clients of four professional counselors at community mental health center in a small Midwestern city near Toledo, Ohio. Ages of the participants were 18, 20, 23, 25, 30, and 55. Four of the participants in the total sample were male (66.7%) and two were female (33.3%). The males were 18, 20, 30, and 55. The ages of the females were 23 and 25. The mean age was 28.5 with a Standard Error of 5.56. The median was 24 and the Standard Deviation (SD) 13.64. The range was 37.
Table 1

Demographic Information for Sample

<table>
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<th>Variable</th>
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<tr>
<td>Graduate School</td>
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</tbody>
</table>

Sampling procedures

The sample was a non-probability convenience sample. This is also called opportunity sampling. In this type of sampling participants were chosen due to their availability and motivation to participate in the study (Creswell, 2008). This type of
sampling calls into question validity of the study. External validity in this study is limited to similar samples to the community counseling center in a small Midwestern city.

A convenience sample was be used for this study. The independent variable had two levels: completed FIT and did not complete FIT and is a nominal variable. The dependent variable had two levels: level of stage of change at one month and at two months and is a ratio variable.

**Data Collection**

In order to maintain confidentiality of the clients the completed assessments were separated from the consent forms and demographic forms. Every participant was assigned a number that was not associated with any information about the client and was not their client number for Behavioral Connections of Wood County. All information was stored in a locked office of one of the researchers in a locked file cabinet.

**Instrumentation**

The instruments were used to assess the client’s satisfaction with treatment (ORS) and the therapeutic relationship (SRS). The URICA was used to assess the client’s stage of change.

**Feedback informed treatment.**

FIT is a feedback method that consists of the SRS and ORS. These instruments measure the client’s satisfaction with treatment and the therapeutic relationship. They are very brief and are designed to be used and discussed every session with the client. Shaw and Murray (2014) assert that previous measures were too long to be feasible for use in every session. FIT is transtheoretical and transdiagnostic.
FIT consists of two standardized forms (the Session Rating Scale [SRS] and the Outcome Rating Scale [ORS]) that measure client’s satisfaction with treatment (Duncan et al., 2007). Both assessments arose from the necessity for ultra-brief instruments to consistently collect feedback from clients in counseling (Duncan et al., 2003; Miller, Duncan, Brown, Sparks & Claud, et al., 2003).

**Outcome Rating Scale (ORS).**

The ORS is a measure of the client’s progress in counseling and perceived value of treatment that will be given to the client at the beginning of every counseling session (Bringhurst, Watson, Miller, & Duncan, 2006). The counselor reviews the scores with the clients immediately. The ORS was developed to be a short form of the Outcome Questionnaire 45.2 (OQ-45.2), a 45-item scale that assesses functioning of the client throughout counseling (Miller et al., 2003). The OQ-45.2 is a widely-used outcome measure with a test-retest reliability of .84, internal consistency of .93, and moderate to high validity between it and other assessments (Bringhurst et al., 2006). However, a disadvantage of the OQ-45.2 is the number of questions; it is not feasible for most clinicians to administer and interpret an instrument of this length every session (Bringhurst et al., 2006; Campbell & Hemsley, 2009).

The four items on the ORS come from the areas of client functioning on the OQ 45.2 that forecast positive treatment outcome: individual, relational, and social and overall functioning (Miller et al., 2003). The ORS is a visual analog scale that takes approximately two minutes to complete and score (Campbell & Hemsley, 2009). The client marks on a ten-centimeter line toward the left to indicate more difficulty and to the right to indicate less difficulty in an area (Bringhurst, et al. 2006).
Campbell and Hemsley (2009) and Miller et al. (2003) assert that reliability estimates (using Cronbach’s coefficient alpha) for the ORS are $\alpha= .87-.96$ depending on the population studied, demonstrating that the reliability compares favorably with the OQ-42.5 when it is studied with various populations despite the assumption that a measure with four items would be less reliable than one with 45 items. According to Bringhurst et al. (2006) the ORS showed a test-retest reliability of .80.

According to Miller et al. (2003) there is moderate concurrent validity (Pearson product-moment correlations = .59) between the ORS and the OQ-45.2 showing that the ORS was moderately related to the standard in measurement in this area. The ORS has a construct validity of .59 between the ORS and OQ-45.2 (Reese et al., 2009). According to Miller et al. (2003) the feasibility, or the actual use, of the ORS (compliance rate of 89%) was much better than that of the OQ-45.2 (compliance rate of 25%). Miller et al. (2003) state that brief visual analog scales have face validity which is missing with longer measures. Although the ORS has been determined to be valid, reliable, and highly feasible the ORS has the same disadvantages as many brief self-report assessments: what is construed from the measure is dependent on how accurate the client is in reporting their functioning and there is no way to assess such things as socially desirable responses (Bringhurst et al., 2006; dMiller et al., 2003).

Shaw and Murray (2014) describe the development of the ORS by Miller and Duncan to answer the need for a very brief outcomes assessment to gather client feedback in counseling. The developed it after using the OQ-45 in their practices and finding a need for a shorter measurement (Seidel, Andrews, Owen, Miller, & Buccino, 2017). The ORS has four categories which assess client functioning since the previous session:
Personal Wellbeing, Interpersonal relationships, social functioning, and overall functioning. The client marks on a 10-centimeter line, with left being the worst functioning and right being the best functioning, indicating their feelings about the above. Using a metric ruler, the counselor measures where the client has marked on the line, measuring from 1 to 10 with 1 being the lowest score and 10 being the highest (Shaw & Murray, 2014). Therefore, the highest score possible is 40 on the ORS (Seidel, Andrews, Owen, Miller, & Buccino, 2017). The counselor interprets the ORS based on a score out of 40. There are no specific categories used to interpret the scores but the cutoff scores set by the developer are 25 for the SRS and 35 for the ORS (Seidel et al., 2017).

**Session Rating Scale (SRS).**

The SRS is an analog questionnaire given to the client at the end of the counseling session that measures the client’s perception of the alliance between the client and counselor (Shaw & Murray, 2014). Crichton (2001) defines an analog scale as, “a measurement instrument that tries to measure a characteristic or attitude that is believed to range across a continuum of values and cannot easily be directly measured.” The counselor reviews the scores with the client immediately. There is a great deal of research showing that the depth of the therapeutic alliance is a strong forecaster of positive alterations in the client’s behavior (Duncan et al., 2007). In addition, they assert that when clients rate the alliance it is much more predictive of outcome than when counselors rate the alliance. Three items on the scale measure on a continuum the client’s perception of whether they felt heard, understood and valued; whether the topics of conversation were what the client wanted to talk about; whether the client is responding to the counselor’s approach; and how the client perceived the entire session’s
effectiveness (Duncan et al., 2007). The client marks on a ten-centimeter line toward the left to indicate less satisfaction and to the right to indicate more satisfaction in an area. The SRS takes two minutes to complete and score (Shaw & Murray, 2014).

According to Duncan et al. (2003), in spite of the importance of understanding the depth of the therapeutic alliance, up until the SRS there were no specific measures of the therapeutic alliance that were appropriate for use in every therapeutic session. They explain that several measures influenced construction of the SRS: The Working Alliance Inventory (WAI) (Horvath, 1981), the Session Evaluation Questionnaire (Stiles, 1980), and the Empathy Scale (Duncan et al., 2003). In their study Duncan et al. (2003) compared the SRS to the 19-item Revised Helping Alliance Questionnaire (HAQ-II) (Luborsky et al., 1996), an extensively used assessment of the therapeutic alliance. The coefficient alpha for the HAQ II was .90. Even though it would be expected that the reliability of a 4-item measure would be significantly lower than that of a 19-item measure, internal consistency reliability of the SRS was α=.88 (Duncan et al., 2003). The total scores on the SRS and the subscale scores show a high internal consistency. Duncan et al. (2003) assert that items on the SRS correlate highly and therefore the SRS can be considered a global assessment of alliance. Test-retest reliability (Pearson’s r) for the HAQ-II was .63 and the SRS .64 (p < .01) (Duncan et al. 2003).

Concurrent validity was determined using the Pearson product-moment correlation and was .48 (p < .01), showing that the SRS and HAQ-II measure the same construct (Duncan et al. 2003). Construct validity was shown through a correlation of .29 (p < .01); this shows that the SRS performs similarly to other alliance assessments. Miller et al. (2003) state that brief visual analog scales have face validity which is missing with
longer measures. The SRS was found to be feasible, having been used 96% of the time; the WAI was utilized 29% of the time. Miller et al. (2003) and Campbell and Hemsley (2009) report that the instrument has a solid reliability, adequate validity, and high feasibility.

Duncan et al. (2003) state that in their research clients were two times more apt to drop out of counseling and three times more likely to have a null or negative outcome if their counselor did not use the SRS. According to Miller et al. (2003) the SRS has the same disadvantages as many brief self-report assessments: what is construed from the measure is dependent on how accurate the client is in reporting their functioning and there is no way to assess such things as socially desirable responses.

*University of Rhode Island Change Assessment (URICA).*

The TTM, or stages of change model, provides a foundation for presenting constructive interventions to aid the client in making beneficial alterations in their behavior. In order to measure the client’s stage of change in this study the University of Rhode Island Change Assessment (URICA) (McConnaughy, et al., 1983), a 32-item self-report survey, will be used (Norcross et al., 2011). According to Boswell, Sauer-Zavala, Gallagher, Delgado, and Barlow (2012) the URICA is the most commonly used measure of the stages of change in use in counseling, measuring precontemplation, contemplation, action, and maintenance. Averaging the contemplation and action scales results in a score for the preparation stage. Overall readiness to change can also be calculated. In completing the URICA respondents provide answers to a questionnaire in which they circle a number from 1 to 5 with 1 being *strongly disagree* with the statement and 5 being *strongly agree* with the statement. The factor structure and psychometric traits have been
duplicated in numerous research studies (Boswell et al. 2012). Boswell et al. (2012) report that the URICA has good internal consistency (Cronbach’s alpha = .82). Numerous experimental studies have been conducted showing consistency with the TTM, and concurrent and discriminant validity (Tambling & Ketring, 2014).

To score this instrument the clinician adds up the answers for the questions related to precontemplation, contemplation, and action (URICA Score Sheet, n.d.) to get a total. There are seven questions that relate to each category so the means are calculated by dividing the total for each category (Precontemplation, Contemplation, Action, and Maintenance) by seven. The readiness for change score is computed by adding the means of contemplation, action, and maintenance and subtracting the mean for precontemplation. The readiness for change score is then compared to the group means for precontemplation, contemplation, and action.

Variables

The variables of interest in this study were: (a) the independent variable was a grouping variable- are you receiving FIT or are you not receiving FIT and this is a nominal variable (b) URICA- the continuous dependent variable- it is a ratio variable.

Procedures

The planned procedures were approved by the Institutional Review Board (IRB) at The University of Toledo. Procedures also conformed to the American Counseling Association’s Code of Ethics (2014).

The sample was chosen according to willingness to participate and convenience. All participants were required to sign informed consent if they wanted to participate in the study. The control group was the new clients of two counselors at a community
mental health center in a small Midwestern town near Toledo, Ohio. The intervention group was the new clients of two other counselors at the same community mental health center.

The control group was not given FIT and the intervention group was given FIT during the counseling process. All participants were given the URICA at the initial appointment and at 30 days and 60 days when possible. The URICA scores were to be compared to determine if the use of FIT helped clients move through the Stages of Change more quickly than if FIT was not used, however the sample was too small to run inferential statistics.

**Research Question**

The following research question was addressed in this study:

The general research question was, “Is there a statistically significant difference in the URICA scores at 30 days and 60 days versus the scores at the start of the study in clients who do complete FIT assessments and clients who do not complete FIT assessments?”

Specific RH₁: Clients who have completed FIT assessments will rate themselves statistically significantly (p < .05) higher on the URICA at 30 days and 60 days than clients who have not completed FIT assessments.

Specific RH₀: There will be no statistically significant difference on overall URICA rating at 30 days and 60 days between clients who have completed FIT assessments and clients who have not completed FIT assessments.
Data analysis

The variables of interest in this study were: (a) receiving FIT or not receiving FIT- the nominal independent variable and (b) URICA- the continuous dependent variable. The independent variable was measured by two FIT instruments, the ORS and SRS. Both instruments have four categories and they are measured from the least amount of a quality (such as the counselors approach being a good fit) to the greatest amount of a quality on an analog scale. The URICA is a Likert-scale with the respondent reading statements and choosing a number for categories from strongly disagree to strongly agree.

The participants were divided into two groups: one group received FIT, the other did not. A change score was to be calculated for each group (Time 2 minus Time 1). The average amount of change between the two groups was to be computed to see if the group that received treatment (FIT) progressed further through the stages of change than the group that didn’t. Calculations were to be done to see if scores persist or change over time. Student’s t-tests were to be used in all situations. The t-test, “…analyzes the difference between the means of the two groups, to determine whether the difference is significant- that is, whether the difference of two points can, or cannot, be attributed to chance errors made in selecting the participants” (Mertler & Charles, 2005, p. 105).

Statement of Limitations

Internal validity “has to do with conditions present in the participants or their environment while the experiment is in progress” (Mertler & Charles, 2005, p. 325). One disadvantage to the quasi-experimental non-equivalent control group design is the lack of
random assignment to groups resulting in a threat to internal validity of differential selection of participants and potential selection bias (Mertler & Charles, 2005).

Creswell (2008) asserts that threats to internal validity in this type of study were history; maturation; regression; selection; mortality; and the interaction of selection and maturation, history, and instrumentation. On the SRS, ORS, and URICA testing was a threat to internal validity because the assessments were given to the participants more than once. One limitation was that the study took place over time allowing for different reactions by each group to historical events (selection-history threat). The length of the study also allowed for factors other than the independent variable to affect the results and opened the possibility of attrition, which occurred in the study (Mertler & Charles, 2005). Selection-maturation threats may have occurred if the two groups were different in their rates of progression through the stages of change for a reason that was not the independent variable, or FIT. Selection-testing could have been another threat to internal validity. The threats to procedures were in testing as a pre-and post-test were to be used. Social threats to internal validity were unlikely as the participants did not know who was in each group and they did not have access to each other.

In this study the threats to internal validity present were that the counselors, at times, acknowledged forgetting to give the instruments during the sessions. In addition, if a client was in crisis it was not appropriate to stop the session to administer the assessments. Appointments were not able to be made on a routine weekly basis due to the caseloads of the counselors so consistent data was not obtained. In some cases clients were transferred to another counselor or group before the study was completed.
Summary

Counselors must be able to produce change in their clients (Stoltz & Kern, 2007). Counselors are in need of immediate feedback from clients so that they can change the method of counseling they are using, change how the counseling is given (how many times per month or week), or possibly terminate counseling altogether. The FIT protocol offers immediate feedback about the client’s progress since the last session and the client’s satisfaction with the current session. The URICA offers information about stage of change. This study looked at whether completing the FIT protocol affected stage of change of the client. This study was to assist in determining whether using FIT assists clients in progressing through the stages of change and therefore helps in obtaining better counseling outcomes.
Chapter Four

Results

Introduction

This study originally was designed to evaluate whether giving Feedback Informed Treatment (FIT) questionnaires to mental health clients in a community counseling center would increase the speed with which they passed through the Stages of Change (as measured by the University of Rhode Island Change Assessment (URICA)). Due to circumstances, which will be detailed in Chapter five of this document, a sample (n) of six participated and incomplete data for the participants was obtained. Therefore, descriptive statistics were utilized as the sample size did not warrant the use of inferential statistics.

In this study the independent variable (FIT) was manipulated by the researcher, however, there was not random assignment to groups making this a quasi-experimental non-equivalent control group design. The URICA was intended to be given at the initial counseling appointment, at 30 days, and at 60 days. Where possible this was done, however all of the participants only completed one follow up URICA, either at 30 days or 60 days. A convenience sample was used for this study; new clients of four mental health counselors participated. The independent variable had two levels: completed FIT and did not complete FIT. The dependent variable was intended to have three levels: initial level of change, level of stage of change at one month, and level of change at three months. The independent variable was nominal and dependent variable was ratio.

Six clients agreed to participate in the study, 14 were asked to participate. Clients who did not choose to participate verbalized they don’t fill out “surveys,” they didn’t
want to participate, or may have been too ill to want to participate. Of the six participants, three were given the FIT questionnaires. This was part of the original design. The other three received counseling as usual but not FIT questionnaires. All of them were given the initial URICA. Two participants were able to be given the URICA at 30 days and the four other participants were able to be given the URICA at 90 days.

The data for this study was run with the Statistical Package for the Social Sciences (SPSS). Descriptive statistics were run and analyzed by the researcher.

**Explanation of Descriptive Statistics**

Descriptive statistics are used to present, organize, and summarize the data in a study. They form the foundation of every quantitative statistical analysis as they determine whether the data forms a normal bell curve shape or what shape it represents (Trochim, 2006). Descriptive statistics are being used for this study due to the small sample (n) size of six. Due to the small sample size inferences about the population are not able to be made from the data. According to Mertler and Charles (2005) a sample of at least 30 is necessary to infer information about the population from the sample.

Measures of central tendency, or the mean median, and mode, are the most common descriptive statistics (Trochim, 2006). The mean is the average of a group of numbers. In order to calculate the mean one adds the values and divides by the number of values. It is sensitive to outliers unlike the median, or the score at the exact center of the group of values that are arranged in order. If there are an even number of values, the median is the mean of the two middle scores. The mode is the value occurring most often in the group of values.
Dispersion describes how the values are dispersed around the central tendency. The range and standard deviation are measures of dispersion. The range is calculated by subtracting the lowest value from the highest value. Because the range can be affected by outliers, the standard deviation is a more accurate measure of dispersion. To obtain the standard deviation the square root of the sum of the squared deviations from the mean is divided by the number of values minus one; it indicates the dispersion of scores from the mean. It is calculated as the square root of the variance and is considered the most accurate measure of dispersion (Mertler & Charles, 2005). The variance is the distance of a grouping of numbers from their mean or how far a set of numbers are spread out.

**Descriptive Statistics for Study Sample**

The URICA Readiness for Change score was calculated by adding the means of the Contemplation, Action, and Maintenance scores and subtracting the mean of the Precontemplation score. The Readiness for Change score was then compared to the group means for the Precontemplation Stage (9.3), the Contemplation Stage (11.0), and the Action Stage (12.6). When scoring the URICA the Readiness for Change score obtained is compared to the group means for the stages above and whichever group mean is closer to the Readiness for Change score is the stage the client is in. The initial URICA readiness for change scores were 7.7 (Precontemplation), 7.9 (Precontemplation), 9 (Precontemplation), 9.4 (Precontemplation), 11.8 (Contemplation), and 13.6 (Action). The mean was 9.9, median was 9.2, multiple modes exist, standard deviation 2.22, and variance 5. The range was 5.9.

The males had initial URICA Readiness for Change scores of 7.7, 7.9, 9.0, and 9.4. The mean of the male scores was 8.5 and the median 8.45. The variance was .687
and the standard deviation .8287. The range was 1.7. The client who was 18 had an initial URICA score of 9.0. The client who was 20 had an initial URICA score of 9.4. The client who was 30 had an initial score of 7.7 and the client who was 55 an initial score of 7.9.

The females had initial URICA Readiness for Change scores of 11.8 and 13.6. The mean and median were 12.7. The variance was 1.620 and standard deviation 1.27. The range was 1.8. The female whose age was 23 had an initial URICA score of 13.6 and the client who was 25 had an initial score of 11.8.

The participants who identified as Christians (two males and two females) had initial URICA Readiness for Change scores of 9.0, 9.4, 11.8, and 13.6. The participant (male) who identified as other for religion had an initial URICA score of 7.9 and the participant (male) who identified as having no religion had an original URICA score of 7.7. 2 males and 2 females identified as Christian, and 1 male other, 1 male none.

Table 2

<table>
<thead>
<tr>
<th>Initial URICA Readiness for Change score</th>
<th>Gender</th>
<th>Age</th>
<th>Race</th>
<th>Religion</th>
<th>Education</th>
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<tbody>
<tr>
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<tr>
<td>7.9</td>
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<td>Other</td>
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</tr>
<tr>
<td>9.0</td>
<td>Male</td>
<td>18</td>
<td>Caucasian</td>
<td>Christian</td>
<td>Some High School</td>
</tr>
<tr>
<td>9.4</td>
<td>Male</td>
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</tr>
<tr>
<td>11.8</td>
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<td>25</td>
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<td>Christian</td>
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</tr>
<tr>
<td>13.6</td>
<td>Female</td>
<td>23</td>
<td>Caucasian</td>
<td>Christian</td>
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</table>
The descriptive statistics for the initial URICA Readiness for Change scores for Christians were calculated. Only one participant acknowledged other and none for religion so descriptive statistics were not calculated. The mean initial URICA score for Christians was 10.95 with a standard error of 1.08. The median was 10.6 and the variance was 4.65. The standard deviation was 2.16 and the range was 4.6.

Level of education was compared to initial URICA Readiness for Change scores. Those who acknowledged being high school graduates and as having some college had descriptive statistics calculated; the one person who had some high school (URICA Readiness for Change score of 9.0) did not as descriptive statistics cannot be run on one person. The initial URICA scores for high school graduates were 7.7, 9.4, and 11.8. The mean of the initial URICA scores for high school graduates was 9.63 with a standard error of 1.189. The median was 9.4 and variance was 4.24. The standard deviation was 2.06 and range 4.1. For participants having some college the initial URICA scores were 7.9 and 13.6. The mean of the initial URICA Readiness for Change scores with some college was 10.75 and the standard error 2.85. The median was 10.75 and variance 16.25. The standard deviation was 4.03 and range 5.7.

Two participants took the 30-day URICA and the Readiness for Change scores were 12.3 and 13.7. Both 30 day URICA Readiness for Change scores were collected from females. The mean was 13, median was 13, and standard deviation was 9.90. The variance was .98. Multiple modes exist. The range was 1.4. Both participants were Christian, Caucasian, and one was a high school graduate and one had some college. The participant with the initial score of 11.8 had a 30-day score of 12.3. The client with the initial score of 13.6 and a 30-day score of 13.7.
Table 3

*Demographics for 30-day URICA Readiness for Change scores*

<table>
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<tr>
<th>30-day URICA Readiness for Change score</th>
<th>Gender</th>
<th>Age</th>
<th>Race</th>
<th>Religion</th>
<th>Education</th>
</tr>
</thead>
<tbody>
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<td>Caucasian</td>
<td>Christian</td>
<td>High School Graduate</td>
</tr>
<tr>
<td>13.7</td>
<td>Female</td>
<td>23</td>
<td>Caucasian</td>
<td>Christian</td>
<td>Some College</td>
</tr>
</tbody>
</table>

Four male participants took the 60-day URICA and Readiness for Change scores were 8.9, 9.6, 9.6, and 11.7. The mean was 9.95, median 9.6, and mode 9.6. The standard deviation was 1.21 and variance was 1.47. The range was 2.8. Multiple modes exist. The participant with the initial URICA Readiness for Change score of 9 had a 60-day score of 11.7. The participant with the initial URICA Readiness for Change score of 7.7 had a 60-day score of 9.6. The participant with the initial URICA Readiness for Change score of 7.9 had a 60-day score of 8.9 and the participant with the initial URICA Readiness for Change score of 9.4 had a 60-day score of 9.6.

Table 4

*Demographics for 60-day URICA Readiness for Change scores*

<table>
<thead>
<tr>
<th>60-day URICA Readiness for Change score</th>
<th>Gender</th>
<th>Age</th>
<th>Race</th>
<th>Religion</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.9</td>
<td>Male</td>
<td>18</td>
<td>Caucasian</td>
<td>Christian</td>
<td>Some High School</td>
</tr>
<tr>
<td>9.6</td>
<td>Male</td>
<td>30</td>
<td>Caucasian</td>
<td>None</td>
<td>High School Grad.</td>
</tr>
<tr>
<td>9.6</td>
<td>Male</td>
<td>20</td>
<td>Caucasian</td>
<td>Christian</td>
<td>High School Grad.</td>
</tr>
<tr>
<td>11.7</td>
<td>Male</td>
<td>18</td>
<td>Caucasian</td>
<td>Christian</td>
<td>Some High School</td>
</tr>
</tbody>
</table>
As the table shows the trend of Readiness to Change scores was upward for both groups. This may indicate counseling was working to move clients through the Stages of Change but in this very small sample, from which no inferences can be made, FIT did not appear to move clients more quickly through the Stages of Change.

Table 5

Descriptive Statistics and Scores on Assessments

<table>
<thead>
<tr>
<th>Client</th>
<th>Reason</th>
<th>FIT Given</th>
<th>Initial URICA</th>
<th>30 day URICA</th>
<th>60 day URICA</th>
<th>Mean</th>
<th>Range</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Transferred</td>
<td>No</td>
<td>9.0</td>
<td>n/a</td>
<td>11.7</td>
<td>10.35</td>
<td>2.7</td>
<td>1.91</td>
</tr>
<tr>
<td>2</td>
<td>Left Counseling</td>
<td>No</td>
<td>7.7</td>
<td>n/a</td>
<td>9.6</td>
<td>8.65</td>
<td>1.9</td>
<td>1.34</td>
</tr>
<tr>
<td>3</td>
<td>Moved</td>
<td>No</td>
<td>11.8</td>
<td>12.3</td>
<td>n/a</td>
<td>12.05</td>
<td>.50</td>
<td>.35</td>
</tr>
<tr>
<td>4</td>
<td>Put in jail</td>
<td>Yes</td>
<td>13.6</td>
<td>13.7</td>
<td>n/a</td>
<td>13.65</td>
<td>.10</td>
<td>.07</td>
</tr>
<tr>
<td>5</td>
<td>Transferred</td>
<td>Yes</td>
<td>7.9</td>
<td>n/a</td>
<td>8.9</td>
<td>8.4</td>
<td>1.0</td>
<td>.71</td>
</tr>
<tr>
<td>6</td>
<td>Transferred</td>
<td>Yes</td>
<td>9.4</td>
<td>n/a</td>
<td>9.6</td>
<td>9.5</td>
<td>.20</td>
<td>.14</td>
</tr>
</tbody>
</table>

Summary of Results

Results of the descriptive statistical analyses are presented above. Inferential statistical analyses were not run due to the limited size of the sample; therefore, the research questions were not addressed. However, there is an upward trend in the Stages of Change scores for all clients. The trend is greater for clients who did not receive FIT, although no inferences can be made from this information. The results will be discussed in Chapter Five.
Chapter Five

Discussion

The purpose of this study was to determine if using Feedback Informed Treatment (FIT) moved counseling clients through the Stages of Change more quickly than not using FIT. It was believed FIT would move clients through the Stages of Change more quickly. If FIT moved counseling clients through the Stages of Change more quickly, the study would have provided further evidence that the use of FIT would benefit clients, who presumably would have better outcomes; payers, who don’t have to pay for clients who repeat counseling due to early termination; and counselors, who would have increased confidence that what they are doing works.

Demographic information was collected to allow the researcher to provide further information about the gender, age, race, religion, and level of education of the participants. The demographic information was presented in Chapter 4 along with the basic demographics of the participants who filled out the initial University of Rhode Island Change Assessment (URICA), the 30-day URICA, and the 60-day URICA.

The research question was, “Is there a statistically significant difference in the URICA scores at 30 days and 60 days versus the scores at the start of the study in clients who do complete FIT assessments and clients who do not complete FIT assessments?” It was postulated there would be a statistically significant difference in URICA scores at 30 days and at 60 days versus the scores at the start of the study in client who did complete FIT assessments and those who did not complete FIT assessments.
The variables of interest in this study were: (a) receiving FIT or not receiving FIT - the nominal independent variable and (b) URICA - the continuous dependent variable. The independent variable was measured by two FIT instruments, the ORS and SRS. Both instruments have four categories and they are measured from the least amount of a quality (such as the counselors approach being a good fit) to the greatest amount of a quality on an analog scale. The URICA is a Likert-scale with the respondent reading statements and choosing a number for categories from strongly disagree to strongly agree.

In this study the independent variable (FIT) was manipulated by the researcher, however, there was not random assignment to groups making this a quasi-experimental non-equivalent control group design. The URICA was given at the initial counseling appointment for all six participants, at 30 days for two of the participants, and at 60 days for the four other participants. A convenience sample was used for this study; new clients, who were willing to participate, of four mental health counselors participated. In order to compare URICA scores t-tests were to be utilized.

The participants were divided into two groups: one group received FIT, the other did not. A change score was to be calculated for each group (Time 2 minus Time 1). The average amount of change between the two groups was to be computed to see if the group that received treatment (FIT) progressed further through the Stages of Change than the group that didn’t. Calculations were to be done to see if scores persist or change over time. Student’s t-tests were to be used in all situations. The t-test, “…analyzes the difference between the means of the two groups, to determine whether the difference is
significant— that is, whether the difference of two points can, or cannot, be attributed to chance errors made in selecting the participants” (Mertler & Charles, 2005, p. 105).

Conclusions

A review of the literature implied advantages for counseling clients who participated in FIT (Anker et al., 2009; Duncan, 2012; Duncan & Miller, 2008; Lambert & Shimowaka, 2011; Miller et al., 2005; Reese et al., 2009; Taratovsky, n.d). Studies have found use of the Stages of Change in counseling allows the counselor to adapt their methods to the needs of the client, therefore benefiting the client (Dozois, Westra, Collins, Fung, & Garry, 2004; Mander, Wittorf, Klingberg, Teufel, Zipfel, & Sammet, 2014). The advantages of FIT in moving clients through the Stages of Change more quickly has not been studied. This study tried to examine the effects of FIT on the clients’ movement through the Stages of Change.

Based on the results of this study, the author was unable to determine that FIT assisted clients in moving through the Stages of Change more quickly. The data did not provide the information desired due to the low sample size of six. While all clients completed the initial URICA, in only two cases did clients complete the URICA at 30 days, and in the other four cases the clients completed the URICA at 60 days. Therefore, inferential statistics were not run.

All participants were new clients of four professional counselors at community mental health center in a small Midwestern city near Toledo, Ohio. Ages of the participants were 18, 20, 23, 25, 30, and 55. Males comprised two-thirds of the sample and females one-third of the sample. The sample mean is 28.5. The standard error of 5.57 indicates that the population mean would probably be within 5.57 of the sample mean.
The median was calculated by arranging the ages in order and dividing the third and fourth ages by two. It is 24 and indicates the exact center of the distribution of scores. The Standard Deviation (SD) of 13.64 indicates the dispersion of scores around the mean. The range (47) is the highest scores minus the lowest score and is not a good measure of dispersion in the case due to the outlying value of 55. The skewness of 1.97 indicates that the normal curve around the mean will be skewed due, again, to the outlier. The standard error of .85 is indicative of the likely variances between sample values and their equivalent population measures. The kurtosis of 4.11 indicates an outlier is present and the curve is flat as the participants vary. The variance of 185.9 demonstrates that the set of numbers (ages) is spread out.

The entire sample identified as Caucasian. Four of the clients identified as Christian (66.7%), one as Other (16.7%), and one as having no religion (16.7%). One client had Some High School (16.7%), Three were high school graduates (50%) and two had some college (33.3%).

The URICA Readiness for Change scores, calculated by adding the means of the Contemplation, Action, and Maintenance scores and subtracting the mean of the Precontemplation score, were compared to the group means for the Stages of Change. The mean scores for the Stages of Change are as follows: Precontemplation (9.3), Contemplation (11.0), and Action (12.6). Scores are not calculated for the Maintenance Stage. The initial URICA readiness for change scores were 7.7 (Precontemplation), 7.9 (Precontemplation), 9 (Precontemplation), 9.4 (Precontemplation), 11.8 (Contemplation), and 13.6 (Action). The average score, or mean was 9.9. The median of 9.2 was calculated by arranging all the initial URICA scores in order and dividing the sum of the two middle
scores by two. Multiple modes exist because no two scores are the same. The standard deviation of 2.2234 indicates the dispersion of scores around the mean. The variance of 5.44 indicates the scores are not too spread out around the mean. The range of 5.9 is the highest score minus the lowest score.

The males had initial URICA Readiness for Change scores of 7.7, 7.9, 9.0, and 9.4. The initial mean URICA Readiness for Change scores for the males was 8.5 and the median 8.45. There are no outliers so the mean and median scores were similar. The variance of .69 indicates the numbers are grouped together and not spread out. The standard deviation is the most accurate measure of dispersion and at .83 demonstrates the scores are not widely dispersed. The range is valuable information in this case as there are no outliers.

The females had initial URICA Readiness for Change scores of 11.8 and 13.6. The mean and median were 12.7; they are equal because only two scores exist in this set of data. The variance was 1.62. It is not meaningful in the case of only two scores. The standard deviation of 1.27 demonstrates scores are not widely spread around the mean. The range is 1.8 and is calculated by subtracting the lowest score from the highest score. Skewness and kurtosis were not calculated due to having only two scores.

Four participants identified as Christians (two females and two males) and one male identified as having no religion a one whose religion was other. Descriptive statistics were calculated only for Christians as none and other only had one participant. The mean initial URICA score of 10.95 for Christians is an average of all the scores. The standard error was 1.08 showing the likelihood that there are variances between sample values and their equivalent population measures. The variance of 4.65 represents how
spread out the scores were. The standard deviation of 2.16 shows how dispersed the scores were.

Level of education was compared to initial URICA Readiness for Change scores. Those who acknowledged being high school graduates and as having some college had descriptive statistics calculated; the one person who had some high school (URICA Readiness for Change score of 9.0) did not as descriptive statistics cannot be run on one person. The mean (or average) of the initial URICA scores for high school graduates was 9.63 with a standard error of 1.19. The median was 9.4, close to the mean as there were no outliers. The variance of 4.24 indicates scores were spread out around the mean. The standard deviation was 2.06, indicating the dispersion of scores around the mean. For participants having some college the initial URICA scores were 7.9 and 13.6. The mean of the initial URICA Readiness for Change scores with some college was 10.75 and the standard error 2.85. The median was 10.75 (the same as the mean due to only having two scores) and variance 16.25. The standard deviation was 4.03 and range 5.7.

Two participants (both female) took the 30-day URICA and the Readiness for Change scores were 12.3 and 13.7. Both 30 day URICA Readiness for Change scores were collected from females. The mean and median were 13 (they were equal because there are only two scores) and standard deviation was 9.90 indicating how close the data points are to the mean. The variance was .980 representing that the scores are not very spread out. Multiple modes exist. The range was 1.4. Both participants were Christian, Caucasian, and one was a high school graduate and one had some college. The participant with the initial score of 11.8 had a 30-day score of 12.3. The client with the initial score of 13.6 and a 30-day score of 13.7.
Four male participants took the 60-day URICA and Readiness for Change scores were 8.9, 9.6, 9.6, and 11.7. The mean was 9.95, median 9.6, and mode 9.6. The median and mode are the same because when listed in order the two middle scores are the same. The standard deviation was 1.21 and variance was 1.47. The range was 2.8. Multiple modes exist. The participant with the initial URICA Readiness for Change score of 9 had a 60-day score of 11.7. The participant with the initial URICA Readiness for Change score of 7.7 had a 60-day score of 9.6. The participant with the initial URICA Readiness for Change score of 7.9 had a 60-day score of 8.9 and the participant with the initial URICA Readiness for Change score of 9.4 had a 60-day score of 9.6.

**Implications for Counselors**

Although no inferences can be made from the results of this study about the use of FIT and if using FIT moves clients through the Stages of Change more quickly, other studies show the benefits of using FIT with counseling clients (Anker, Duncan & Sparks, 2009; Duncan, 2012; Duncan & Miller, 2008; Lambert & Shimowaka, 2011; Miller, Duncan, Sorrell, & Brown, 2005; Reese, Norsworthy, & Rowlands, 2009; Taratovsky, n.d.). Researchers have shown feedback given by the client on therapeutic alliance and progress, which is immediately sought and received by the counselor in session, has been shown to lead to statistically significant therapeutic progress and therefore increased commitment to the counseling process (Reese et al., 2009). Also, studies have found use of the Stages of Change in counseling allows the counselor to adapt their methods to the needs of the client, therefore benefitting the client (Dozois, Westra, Collins, Fung, & Garry, 2004; Mander et al., 2014). Moving quickly through the Stages of Change is an
advantage because patient suffering is decreased and the use of financial resources is minimized, both for the client and the payer.

With one-third to one-half of counseling clients not experiencing treatment gains and 50% leaving counseling before their goals are met, it is imperative counselors find ways to improve these results (Duncan, Miller & Hubble, 2007; Duncan, 2012; Hatchett, 2011). Ogrodniczuk, Joyce, and Piper (2005) report clients who terminate counseling prematurely describe a reduction in therapeutic improvement and more emotional distress than they presented with, they also access mental health services two times as much as those who do not terminate prematurely. This presents a financial burden for mental health services payers and the client themselves who are expected to pay copays and deductibles. Information about a way to improve outcomes and lower premature termination, such as discovering using FIT moves clients through the Stages of Change more quickly, would be valuable to clients, payers, and counselors. The information gathered for the literature review of this study highlights the importance of replication of this study of whether FIT moves clients through the Stages of Change more quickly with a larger sample.

Limitations

The first, and most crucial, limitation to this study was sample size. The researcher was restricted to recruiting new clients of four counselors at a community counseling center in the Midwest, near Toledo, Ohio. During the study period in this community counseling center counselors were not frequently assigned new clients, which were required for the study. The reasons for this could be that only four counselors were involved in the study and two were part-time and two were full-time, all four had
caseloads that were already almost full. In addition, the community counseling center uses a walk-in procedure for new clients and all new clients, if assigned to counseling, are assigned to numerous counselors throughout the agency, not just the four participating counselors. The small sample size lowered the power, preventing the ability to detect differences between the groups if they were present, thus eliminating the ability to run inferential statistics.

In some instances, the clients walk in to the clinic when they are in crisis. Either due to interventions (coping mechanisms) provided by the assessment clinician or due to the healing effect asking for help at an initial appointment has on the client, the crisis sometimes passes and they don’t return for their first scheduled appointment with a counselor and never do reschedule.

Along the same lines clients at community counseling centers are vulnerable to forgetting the appointment that has been scheduled for them. Many community counseling clients are seriously mentally ill, often making it difficult for them to manage appointments. Some clients are not fully oriented, especially to time, and forget appointments.

Many clients who walk in to Behavioral Connections of Wood County have just been released from the psychiatric hospital. The hospital, in an effort to coordinate treatment, will usually set up an appointment for assessment and at the same time set up appointments for counseling and whatever other services are needed. Many previously hospitalized patients are seriously mentally ill and may miss appointments for the reasons detailed in the paragraph above. It is not uncommon for clients to have been hospitalized against their will for suicidal ideation, homicidal ideation, or the inability to care for
themselves. In these cases, clients are often resistant to further treatment as they are angry about their hospitalization against their will.

Logistics, specifically transportation, are often a barrier for clients of community mental health centers like Behavioral Connections of Wood County. Once a client has engaged in services if they have Medicaid, which many community counseling clients do, they can be assisted with transportation to the community counseling center. However, if they are recently released from the hospital they might never have transportation to attend the original assessment.

In some cases, the potential client gets negative feedback after the assessment from family members for seeking out counseling. This might be especially true for certain cultural groups whose ethic includes keeping personal and family issues within the family and not discussing issues outside of the confines of the home such as Hispanics and those of Asian origin.

Not infrequently, courts will require a client to come in for an assessment. In this case, all the client may hear is “assessment,” however, the assessment clinician, as part of their job, will set the client up with necessary appointments. The counselor who is assigned will then be informed through a referral they are getting a new client. This may prevent a counselor from accepting another new client due to the size of their caseload. The client, in the meantime, does not intend to follow up for counseling because they were only court-mandated for an “assessment.” The client may indeed be required to go back to court and in turn follow all the recommendations of the assessment clinician but by the time the court date occurs the client has not shown up for their original counseling appointment and the clinician has gone through the steps to discharge the client. The
counselor in the meantime may have been restricted from taking new clients, believing the court-ordered client would appear for counseling. In addition, in spite of the recommendations of the assessment clinician, the client may not be required to come back for counseling and may not desire to.

Those who come in for their first appointment, which they are court-ordered to complete, often do not continue if they go back to court and are not mandated to counseling. They also may attend the first appointment and not return until they are mandated, which could be months later.

Even if clients were scheduled with the participating counselors, they often are scheduled weeks after their assessment appointment due to coordinating the schedules of the counselor and client. Due to the time frame of the study, which took place over three months, new clients were often not scheduled with one of the participating counselors during the study period.

Incomplete data was obtained from the clients who did take part in the study in part because some of them never came back after the first appointment or prematurely terminated further into the counseling process. Approximately 50% of clients leave counseling prematurely, a statistic born out in this study (Duncan, Miller & Hubble, 2007; Duncan, 2012; Hatchett, 2011). Clients may drop out of counseling at any point during the counseling process. As was discussed in Chapters One and Two of this paper, premature termination of counseling is a major problem in counseling in general. No-shows are an issue with initial appointments and any appointment thereafter. Due to the time restraints of the study when clients no-showed and were unable to be rescheduled quickly data was unable to be collected from them.
In processing the study with the participating counselors, they reported difficulty with using FIT and the URICA as the study required. In the initial appointment with their new clients the counselors reported they were able to administer the SRS and URICA successfully. As the data shows, all six clients completed the initial URICA. However, after the first appointment they found that they might not have a client rescheduled for two to four weeks and the URICA was supposed to be administered at 30 days and 60 days. That time period did not leave much time to administer FIT between the administrations of the URICA. In addition, they reported they would at times forget to administer FIT or the URICA because the client came in and began talking immediately. At other times they reported the client was having a crisis and it would not have been appropriate to interrupt the session to fill out the forms.

**Threats to internal validity.**

Mertler and Charles (2005) state internal validity “has to do with conditions present in the participants or their environment while the experiment is in progress” (p. 325). One disadvantage to the quasi-experimental non-equivalent control group design is the lack of random assignment to groups (the use of intact groups) resulting in a threat to internal validity of differential selection of participants and potential selection bias (Mertler & Charles, 2005, Trochim, 2006). This threat is based upon the potential that the groups were different to begin with and did not show differences because of the manipulation of the independent variable.

Other threats to internal validity were Selection-History Threat which is attributed to anything that the two groups experience in a different way between the pre- and post-tests. Selection-maturation threats may have occurred if the two groups were different in
their rates of progression through the Stages of Change for a reason that was not the independent variable, or FIT. The Selection-Testing Threat occurs when groups learn in different ways from the pre-test. Selection-Mortality Threat occurs due to varying nonrandom attrition during the time of the study. The length of the study may have allowed for factors other than the independent variable to affect the results and open the possibility of attrition (Mertler & Charles, 2005). Selection-Regression Threat could have happened if one group had more outlying scores on the pre-test than the other group. On the SRS, ORS, and URICA testing is a threat to internal validity because the assessments were given to the participants more than once. The threats to procedures were in testing as a pre-and post-test were used. Social threats to internal validity are unlikely as the participants will not know who is in each group and will not have access to each other. Creswell (2008) asserts another threat to internal validity in this design was the interaction of selection and maturation, history, and instrumentation.

**Threats to external validity.**

Mertler and Charles (2005) assert that threats to external validity in this study were population validity, personological variables, and ecological validity. Population validity is “the degree of similarity among (1) the sample used in a study, (2) the population from which it was drawn, and (3) the target population to which results are to be generalized” (p. 326). The more alike the three are the more confident the researcher can be in generalizing their results. Personological variables refers to how study results can relate well to some individuals and not well to others (Mertler and Charles, 2005). Ecological validity “refers to the situation, physical or emotional, that exists during the experiment” (Mertler & Charles, 2005, p. 326).
External variables may were issue in this study. External validity was compromised as the sample studied was people from a large county in a Midwestern state, near Toledo, Ohio. As a result, the sample was homogeneous in socio-economic status, race, and ethnicity; these results may not generalize to other populations. In addition, the sample size was small (6 participants). The instruments used in this study were all self-report assessments and relied on the honesty of the participant in filling out the assessments not to give socially desirable responses.

**Recommendations for Further Research**

Counselors are increasingly being held to standards of “proving” that counseling is working, especially in the era of managed care. Increasingly, payer sources are requiring evidence of successful treatment in order to reimburse providers (Office of Inspector General, 2000). The Office of the Inspector General (2000) also points out that “return on investment” and “accountability” are the way of the future in mental health reimbursement. Therefore, the information that could be gathered from this study will be crucial in the future of the counseling profession.

Most of the research on outcomes supports the idea that using an outcomes measurement is a positive addition to counseling (Anker et al., 2009; Duncan, 2012; Duncan & Miller, 2008; Lambert & Shimowaka, 2011; Miller et al., 2005; Reese et al., 2009; Taratovsky, n.d.). In addition, research supports the Stages of Change as a robust manner in which to evaluate client progress and change one’s methods based upon the client’s Stages of Change and the client’s outcomes information (Dozois et al., 2004; Mander et al., 2014). Duncan et al. (2007) assert commitment to the counseling process and a positive result from counseling is foretold by early progress through the Stages of
Change in the client. Although outcomes and adjusting counseling style to the Stages of Change are both positive ways to improve counseling, there is no research in the area of correlating the use of outcomes with movement through Stages of Change in the client. Therefore, future researchers should replicate the study using the same measurement instruments, however take steps to ensure that the sample size will be large enough.

The length of time the study is run should be a consideration as using only new clients requires some time for participating counselors to increase their case load. It is also recommended that the time between URICA administrations is extended to allow for more administrations of the ORS and SRS so that it could be better determined whether FIT is actually causing the increased speed of the client through the Stages of Change. For example, the URICA could be given at 45 and 90 days or even 60 and 120 days into the counseling, depending on the practicality of the time increase in the study.

There is room in this study design for qualitative information about whether or not the counselors made changes in their counseling style based upon information from the SRS and ORS. If this information could be incorporated with the information from the current study design the study would be even more helpful to clinicians. Further feedback from the clients and counselors regarding their feelings about the use of FIT would be helpful. There was no regular assessment procedure for feedback to be included in the study.

An effort should be made to expand the demographics of the sample. In this sample only Caucasians participated. Minorities were not represented; demonstrating the theory works in a variety of cultures would improve the study. Increasing the sample size may automatically eliminate this problem.
Information about the mental health issue the client is being treated for could improve this study. If this information was gathered as part of the demographics it could be put into categories and coded into the data. The limitation to this would be determining if illnesses are “more serious” and may result in the inability of the client to follow through with appointments and a greater tendency to have crises. Ideally there would be a category for more serious mental illnesses such as schizophrenia and those that are more easily managed such as anxiety without panic attacks.

Future researchers could look at each individual client and the speed of the improvement made in their URICA scores. The study as it is designed assesses the clients as a whole and does not focus on the advancement of a specific client.

Other future research could take a look at clients who haven’t engaged in the FIT process and those clients who now receive it. This could be a retrospective study using data from clients who have gone through the counseling process without the use of FIT comparing them to current clients who are given FIT.

In conclusion, allowing clients to provide feedback on FIT and its individual impact would improve this study. Using only quantitative procedures to evaluate the benefits of the use of FIT limits the study. In some cases, participants may not have actually moved through the Stages of Change more quickly but may feel that they benefited greatly from FIT. Perhaps FIT encouraged them to stick with counseling and not prematurely terminate; perhaps they feel they got a better result due to the use of FIT. Providing time for debriefing with the researcher, or even the counselor, would offer much more information about the use of FIT in the counseling process, increasing the usefulness of the data.
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## Appendix A

### Demographic Form

**Demographic Information**

<table>
<thead>
<tr>
<th>Gender:</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td>____</td>
<td></td>
</tr>
<tr>
<td>Race:</td>
<td>Caucasian</td>
<td>African-American</td>
</tr>
<tr>
<td></td>
<td>Native-American</td>
<td>Other</td>
</tr>
<tr>
<td>Religious Affiliation:</td>
<td>Christian</td>
<td>Muslim</td>
</tr>
<tr>
<td>Education Level:</td>
<td>8th grade or below</td>
<td>Some high school</td>
</tr>
<tr>
<td></td>
<td>Some college</td>
<td>Bachelor’s Degree</td>
</tr>
</tbody>
</table>
Appendix B

Consent Form to Participate in Research

Department of School Psychology,
Higher Education, & Counselor Education
HSHS Bldg., Room 3100
University of Toledo, Mail Stop 119
2801 W. Bancroft St.
Toledo, Ohio 43606
Phone: 419-530-2718
419-530-7879

ADULT RESEARCH SUBJECT - INFORMED CONSENT FORM

Feedback Informed Treatment: Building Strong Alliances

Principal Investigator: Christopher Roseman, Ph.D., PC, 419-530-4064
Other Investigators: Tamara Harden, M.A., PC/CR, 419-872-2419
Clancy Yeager, PCC-S, LICDC-S 419-872-2419
Julie Moebius, PC 419-872-2419
Tiffany Sullivan, PC 419-872-2419

Purpose: You are invited to participate in the research project entitled, Feedback Informed Treatment: Building Strong Alliances, which is being conducted at the University of Toledo under the direction of John Laux, Ph.D. The purpose of this study is to see if Feedback Informed Treatment empowers the client to provide constructive feedback to the professional counselor which, in turn, produces desired clinical results in a more efficient manner.

Description of Procedures: This research study will take place in Perrysburg and Bowling Green, Ohio, and will take approximately 3-5 minutes to complete during each counseling session. This study will continue for a period of one year. You will be asked to complete various questionnaires which you will evaluate. After you have completed your participation, the research team will debrief you about the data, theory and research area under study and answer any questions you may have about the research.
**Potential Risks:** There are minimal risks to participation in this study, including loss of confidentiality. Answering the questionnaires might cause you to feel upset or anxious. If so, you may stop at any time.

**Potential Benefits:** The only direct benefit to you if you participate in this research may be that you will learn about how research studies are run and may learn more about Feedback- Informed Treatment. Others may benefit by learning about the results of this research.

**Confidentiality:** The researchers will make every effort to prevent anyone who is not on the research team from knowing that you provided this information, or what that information is. The consent forms with signatures will be kept separate from responses, which will not include names and which will be presented to others only when combined with other responses. Although we will make every effort to protect your confidentiality, there is a low risk that this might be breached.

**Voluntary Participation:** Your refusal to participate in this study will involve no penalty or loss of benefits to which you are otherwise entitled and will not affect your relationship with Behavioral Connections. In addition, you may discontinue participation at any time without any penalty or loss of benefits.

**Contact Information:** Before you decide to accept this invitation to take part in this study, you may ask any questions that you might have. If you have any questions at any time before, during or after your participation, or psychological distress as a result of this research, you should contact a member of the research team: John Laux, Ph.D., 419-530-4705 or Tamara Harden, M.A., 419-872-2419.

If you have questions beyond those answered by the research team or your rights as a research subject or research-related injuries, the Chairperson of the SBE Institutional Review Board may be contacted through the Office of Research on the main campus at (419) 530-2844.

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

**SIGNATURE SECTION – Please read carefully**

You are making a decision whether or not to participate in this research study. Your signature indicates that you have read the information provided above, you have had all your questions answered, and you have decided to take part in this research.

The date you sign this document to enroll in this study, that is, today's date must fall between the dates indicated at the bottom of the page.
<table>
<thead>
<tr>
<th>Name of Subject (please print)</th>
<th>Signature</th>
<th>Date</th>
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<tbody>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Name of Person Obtaining Consent</td>
<td>Signature</td>
<td>Date</td>
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This Adult Research Informed Consent document has been reviewed and approved by the University of Toledo Social, Behavioral and Educational IRB for the period of time specified in the box below.

Approved Number of Subjects: ________________