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MEASURING THE IMPACT AND RELEVANCE OF FEEDBACK ON
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I dedicate this dissertation and all that comes from it to my wife and life-long companion Donna. While I studied and wrote about relationships, you taught me how to have them. While I engaged in philosophical discourse and waxed eloquent about love and commitment, you taught me what true love and commitment looks like and feels like. And when I could not see the way ahead, you showed me. Every day I am a better person because you are in my life. Thank you Donna, I love you. We did it!

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Abstract

Despite decades of research, the key components of effective psychotherapy continue to be debated. Evidence-based practice has gained prominence and there is increasing demand from managed care and other payees that specific behavioral health problems be treated with psychotherapy interventions or techniques whose efficacy is supported by research. However, research conducted over the past decade suggests that no one counseling model or intervention reliably produces superior results and that there exists common or contextual features of all counseling that are most predictive of therapeutic outcome. This study explored whether routinely administered limited participant feedback provided to therapists at an Army Substance Abuse Outpatient Treatment Program improved treatment outcomes for participants who provided feedback on their functioning at weekly intervals using the 4-item Outcome Rating Scale (ORS). Subjects were 300 active-duty male and female soldiers randomized into a feedback group ($N = 150$) and a control group ($N = 150$). Eighteen Department of the Army civilian therapists participated by providing group psychotherapy to the participants.

The study design intentionally did not proscribe therapists' behavior; the only change in the regular treatment process was therapists' knowledge of weekly progress graphs derived from ORS results for participants in the feedback condition. As predicted, participants whose

therapists received weekly feedback showed both better treatment attendance and treatment outcomes than did participants where feedback was not provided to therapists. The results suggest that instead of limiting measurement of treatment outcome to the end of treatment (traditional efficacy studies), therapists' access to systematic feedback from the client's perspective of the treatment experience throughout the treatment experience can have a significant positive influence on the course of treatment itself. Results further emphasize the need for additional outcome-based research.

Chapter 1: Introduction

Psychotherapy is a complex phenomenon and identification of the key components of effective psychotherapy continues to be fiercely debated over 89 years since psychotherapy as a construct was first introduced by Freud (Wampold, 2001).

Evidence-based practice is increasingly cited as the key factor in determining positive therapeutic outcome for clients receiving behavioral healthcare. The operating premise is that some counseling approaches or techniques are accepted as supporting growing efforts to contain costs through managed care. These counseling approaches or techniques carry the distinction of being considered “evidence based.” In the past decade, however, the pendulum is beginning to swing again as research is suggesting that in fact no counseling model reliably produces superior results and that it is the common or contextual features of counseling that are most predictive of positive therapeutic outcome.

Recent studies have added to the growing literature documenting the positive impact of feedback on treatment retention and outcome across a wide variety of therapies. Among therapies that are most used for treating the substance abusing population are cognitive behavioral, family/marital, rational emotive, and reality based therapies. Available research shows that access to the participant’s experience of progress and the client-therapist alliance can as much as double the effects of treatment and improve client

retention and treatment cost-effectiveness (Miller, Duncan, Brown, Sorrell, & Chalk, 2006). Client retention and effectiveness of treatment could represent millions of dollars in savings that are currently being spent on substance abuse treatment. This problem is not unique to civilian populations, but also affects special populations like the U.S. Army.

In many clinics across this Nation, the practice is to match clients to therapists based on expediency, caseload numbers, and in some cases gender. As research and new dialogue pressure behavioral health professionals to move away from therapist-lead interventions toward client-directed therapy, the focus begins to shift to how the client views the treatment experience. According to Horvath (1994), ratings of the treatment experience provided by the client have been stronger predictors of treatment outcomes than ratings provided by the therapist. Further research is necessary to determine the efficacy of client-directed outcome management to improve the therapeutic experience and response to treatment.

To be most useful, outcome data should be captured as close to the source as possible, including direct data capture from clients themselves. Abstract information has become a treatment resource and it is becoming increasingly focused on outcomes. Clinical guidelines are being developed to standardize care for specific client populations. Client preferences and perceptions of the treatment experience need to be known in order to effectively plan individualized care.

The purpose of this study was to determine if routinely administered limited participant feedback provided to therapists of the Army Substance Abuse Program would improve treatment outcomes for participants.

Significance of the Study

Most professionals in the behavioral health field agree that behavior change is the key outcome measurement. Capturing and using clinical outcome data is critical to understanding how to efficiently and effectively produce desired behavior change. The theory governing this study is that when subjects provide systematic limited feedback to their therapists, the information will provide motivation for the client and the therapist to have a discussion about the feedback thereby enhancing the therapeutic alliance and producing positive treatment results and desired behavior change. Improved treatment outcomes should result in more soldiers recovering from their substance use problems and returning to duty at a quicker rate. This would mean less money and resources being spent on processing administrative separations as well as training these soldiers' replacements. Enhanced treatment outcomes and increased retention result in an overall improvement in Army operational readiness.

Chapter 2: Review of the Literature

A broad overview of outcome-based psychotherapy research is discussed in this chapter. First, literature demonstrating the efficacy of psychotherapy is presented. Second, an effectiveness study is described. This section is followed by a discussion of research relating to factors common to all effective psychotherapeutic approaches. The fourth major section of this chapter consists of studies describing the importance of the therapeutic alliance. Literature related to the therapeutic alliance in terms of treatment considerations with the following special populations are then presented: group settings, substance abuse, and the United States Army. Following a discussion of research on systematic client feedback will be a look at three outcome instruments. The chapter will conclude with a caution about therapeutic allegiance.

Researchers and psychotherapists have been involved in a long and contentious debate on the nature of change. What is it exactly that causes clients to change? If we could define and quantify it, then we could become much more effective as therapists. We could save countless hours of fruitless therapy and untold dollars, not to mention the savings in human misery. Before we address the issue of why people change in therapy, it might first be prudent to ask the question, based on current evidence, “does psychotherapy work at all?”

Efficacy Studies

Efficacy studies are high in internal validity and grounded in random, controlled trials. Such studies are the bedrock of evidence-based practice. Efficacy studies do not always lend themselves to a real-world context. Eysenck (1952, 1965), for example, shook the field of psychotherapy with his claim that 75% of “neurotics” got better regardless of whether or not they received therapy based upon his interpretation of six randomized controlled (efficacy) studies.

Despite the later findings of Garfield and Bergin (1971) supporting the effectiveness of psychotherapy in a review of 72 studies of psychological and pharmacological treatments, Eysenck’s (1952, 1965) conclusions persisted. They eventually gave birth to a widespread perception of the inefficacy of psychotherapy which became part of conventional wisdom, even within the helping professions.

The following statement to the Colorado State Legislature in regard to the value of psychotherapy would be repeated to graduate students for decades: “a third of the people get better, a third of the people stay the same, and a third of the people get worse, irregardless [sic] of the treatment to which they are subjected” (Ellis, 1977). As later research would clearly reveal, Ellis (1977) could have made a more accurate statement: people get better, regardless of the therapeutic approach.

Smith and Glass's (1977) seminal review of psychotherapy outcome studies was the first attempt to meta-analytically test whether any particular type of therapy was superior to another. They found that the average client receiving therapy was better off than 75% of the untreated control subjects. Ironically this is the same percentage (75%) that Eysenck had repeatedly used to discredit the need for psychotherapy.

Smith and Glass (1977) identified and collected all studies they could find that tested the effects of counseling and psychotherapy, determined the magnitude of effect of each therapy in each study, and compared the effects of different types of therapy. They selected 500 studies for inclusion in their meta-analytic review, coding and statistically integrating 375 studies. They excluded drug therapies, hypnotherapy, bibliotherapy, occupational therapy, milieu therapy, and peer counseling. They also rejected sensitivity training, marathon encounter groups, consciousness-raising groups, and psychodrama. They included dissertations and analogue studies (where therapy either lasted only a few hours or therapists were relatively untrained).

The effect sizes of the separate studies became the dependent variable, whereas the independent variables consisted of 16 features of the study, as follows:

- 1) Type of therapy employed
- 2) Duration of therapy in hours

- 3) Whether it was group or individual therapy
- 4) Number of years of experience of the therapist
- 5) Whether clients were neurotic or psychotic
- 6) Age of clients
- 7) IQ of clients
- 8) Source of the subjects (whether solicited, institutionalized, or volunteers)
- 9) Therapist training (education, psychology, or psychiatry)
- 10) Social and ethnic similarity of therapists and clients
- 11) Type of outcome measure taken
- 12) Number of months after therapy that the outcomes were measured
- 13) Reactivity or “fakeability” of the outcome measure
- 14) Date of publication of the study
- 15) Form of the publication
- 16) Internal validity of the research design

Reliability of measurement was determined by comparing the coding of 20 studies by the two authors and four assistants. Agreement exceeded 90% across all categories. Data analysis consisted of four parts: 1) descriptive statistics for data as a whole; 2) descriptive statistics for the comparison of therapy and outcome types; 3) descriptive statistics for a subset of studies in which behavioral and non-behavioral therapies were

compared in the same study, and 4) regression analysis (Smith & Glass, 1977). Consistent with the findings of Luborsky, Singer, and Luborsky (1975), few important differences in effectiveness could be established among the many diverse types of psychotherapy, and no difference in effectiveness was observed between behavioral and non-behavioral approaches (Luborsky et al., 1975).

Hundreds of studies conducted over the past 30 plus years show that the average treated person is at least 80% better off than the person who does not receive treatment at all (Lambert & Bergin, 1994). From the results of decades of randomized controlled studies, we can conclude that psychotherapy is indeed effective for most people.

Once we accept that research consistently supports the efficacy of psychotherapy, we can turn our attention to examining what makes it effective for the client we are treating in the setting in which we treat him/her.

Effectiveness Studies

While efficacy studies are carried out in highly controlled research settings, often utilizing a manualized approach and strict control measures in a sterile environment, effectiveness is assessed in a real-world context by practitioners working directly with the client in front of them.

Historically, much of the psychotherapy research conducted has supported the notion that some counseling approaches or techniques are

more effective than others. Consistent with this premise, psychotherapy proponents have long supported the practice of matching certain client problems with specific counseling models as the most effective way of conducting therapy (Sexton, Schofield, & Whiston, 1997). This research served to inform counseling practice for years and has formed the basis of an evidence-based model of counseling that has dominated the field since the 1990s. In the past decade, conflicting studies are emerging suggesting that research conducted over the past 30 years, in fact, has not found any one model, method, or package of techniques to be reliably superior to any other (Wampold, Mondin, Moody, et al., 1997).

Wampold and Brown (2005) studied outcome variability attributable to therapists in clinical practice by analyzing 6,146 clients seen by approximately 581 therapists. Multilevel statistical procedures were used with therapists as an independent variable. Taking into account severity level of the clients' illnesses, the authors found 5% of variance to be due to the therapists.

If research bears out that psychotherapy is effective, yet no model, method, or package of techniques can be proven to be reliably superior to another, then what actually accounts for the improvement? It would be logical to consider that in light of no evidence to support the supremacy of one accepted approach over another, there must be underlying factors common to all of them that contribute to outcome. Rosenzweig (1936) laid

the groundwork for a model involving common factors many decades before the advent of managed care or evidence-based practice.

Common Factors and Psychotherapy Research

Common factors are generally defined as those active elements present in all psychotherapy approaches that effect change (Grencavage & Norcross, 1990). As early as 1936, Rosenzweig made the observation that there were common factors underlying therapeutic change—basically all psychotherapeutic ideologies produced similar results (positive and negative). He prefaced his article with a famous quote from Lewis Carroll’s *Alice in Wonderland* (Carroll et al., 1865), often repeated in subsequent articles referring to Rosenzweig’s (1936) seminal work on common therapeutic factors, which masterfully summed up his thesis—“At last the Dodo said, ‘Everybody has won, and all must have prizes’.”

Rosenzweig (1936) maintained that if all therapeutic approaches produced similar results, then therapeutic results would not be a reliable guide to the validity of a given theory. He wondered if the factors alleged to be operating in a given therapy could be identical to those that actually were operating and, more importantly, if the factors that actually were operating in several different therapeutic approaches might have more in common with each other than those factors alleged to be operating in a given theory.

Rosenzweig (1936) explored this line of inquiry further by hypothesizing that unrecognized and unconscious processes may be the

means by which therapeutic effects are actually achieved. Recognizing certain therapies are better indicated than others for specific types of problems and for the sake of argument, he wondered what accounted for research results showing apparently diverse forms of psychotherapy to prove successful in similar cases.

Rosenzweig (1936) concluded the following three constructs were common to all theories, reducing the power of differences between different forms of psychotherapy: 1) the operation of implicit factors, such as catharsis and the undefined effect of a good therapist's personality; 2) the formal consistency of a therapeutic ideology as a basis for reintegration; and 3) an alternative problem formulation of psychological events combined with the interdependence of personality organization. Rosenzweig's work gave birth to the phrase "dodo bird verdict."

Luborsky et al. (1975) expounded upon Rosenzweig's groundbreaking work. In a seminal review encompassing a tally of the outcomes of all reasonably controlled comparison studies of psychotherapies with each other, and with other treatments, Luborsky et al. (1975) found that the psychotherapies reviewed not only were effective, but also generally equivalent in terms of their outcomes, and decreed that the dodo bird verdict was correct—it was true that "all had won and all must have prizes."

Luborsky et al. (1975) summarized the studies separately for each of the main types of comparisons that had been conducted (e.g., group vs. individual psychotherapy; time-limited vs. unlimited psychotherapy; client centered vs. other traditional psychotherapies; and behavior therapy vs. psychotherapy. Each type of comparison was scored with the number of studies in which treatments were significantly better or worse, or a “tie,” which was defined as being not significantly different statistically.

Luborsky et al. (1975) concluded: 1) all psychotherapies produce a high percentage of benefit; 2) a high percentage of clients who go through any of the psychotherapies gain from them; 3) the “dodo bird verdict” does not apply when comparing psychotherapies with other forms of treatment (e.g., pharmacological approaches); and 4) there are only a few especially beneficial matches of type of treatment and type of client (e.g., behavior therapies may be especially suited for the treatment of circumscribed phobias and psychosomatic conditions respond best to medication regimens in combination with psychotherapy rather than a singular treatment).

Lambert (1986) considered the general effects of therapy and factors identified as causing therapeutic improvement. He concluded that spontaneous remission accounts for approximately 40% of therapeutic improvement; expectancy (placebo effects) 15%, technique 15% and common factors, approximately 30%. Spontaneous remission was considered to be those factors that are part of the client, such as ego strength

and aspects of the client's environment that assist in recovery efforts regardless of therapeutic participation. Placebo effects were seen as improvement that results from the clients' beliefs that they are being treated with a specific and credible treatment technique. Techniques are those factors that are unique to specific therapies, such as cognitive behavioral therapy, biofeedback, etc. Common factors represent several variables found in numerous therapies regardless of the therapist's theoretical orientation (encouragement, empathy, etc.).

Building upon Lambert, Luborsky, and Rosenzweig's earlier work, Duncan, Hubble, and Miller (1997), significantly broadened the base of the common factors. According to Duncan et al. (1997), the four common factors are: client/extratherapeutic factors; relationship factors; placebo, hope, and expectancy; and model/technique factors.

Common factor one: client/extratherapeutic factors.

Extratherapeutic factors consist of the client's strengths, supportive elements in the environment, and even chance events. They are what the clients bring to the therapeutic relationship and what influences their lives outside it. Examples of these factors are persistence, faith, a supportive family member, a new job, etc. (Hubble, Duncan, & Miller, 1999).

Many therapists, especially the inexperienced, imagine that their techniques are the most important factor contributing to therapeutic outcome. Contrary to this belief, outcome is determined to a great degree by

the client and events that occur outside therapy—not the therapist or the techniques used by the therapist. In a review of the literature, Lambert (1992) concluded that as much as 40% of the improvement psychotherapy clients experience is attributable to client variables and extra-therapeutic influences.

The importance of client factors in psychotherapy outcome was highlighted in a series of case studies reported by Strupp (1980a, 1980b, 1980c, 1980d). In each study, the same therapists in time-limited psychotherapy saw two clients. In each instance, one of the clients was seen as having a successful outcome and the other was considered a treatment failure. Although each therapist was seen as having good interpersonal skills, a different relationship developed with the two clients. In all four cases, the clients who had successful outcomes appeared more willing and able to have a meaningful relationship with the therapist. The clients who did not improve in therapy did not relate well to the therapist and kept the interactions between them superficial.

Several extratherapeutic factors influence the rate of client improvement. Clients come to therapy with disorders that have persisted for various lengths of time. There may be underlying personality disorders present in different clients. Each client presents with a unique nature, strength, and quality of social support that affects change in different ways for different clients (Andrews & Tennant, 1978).

Common factor two: relationship factors.

Relationship factors are those critical or core conditions conceptualized as accurate empathy, positive regard, non-possessive warmth, and congruence or genuineness. Relationship factors are probably the most frequently studied of the four common factors, with empirical findings suggesting that they account for approximately 30% of client improvement (Lambert, 1992). Few counseling professionals would argue the importance of relationship skills to the development and maintenance of an effective therapeutic alliance.

The value of the therapist's relationship skills has been demonstrated in several studies. Miller, Taylor, and West (1980) investigated the effectiveness of various behavioral approaches aimed at helping problem drinkers control their alcohol consumption. They found a strong relationship between empathy and client outcome obtained from 6 to 8 month follow-up interviews used to assess drinking behavior. Therapists' rank on empathy correlated ($r = .82$) with client outcome. These results suggest that empathy on the part of the therapist (or how that empathy is perceived by the client) could account for as much as 67% of the variance in the effectiveness of the therapist, as defined by client outcome with regard to drinking behavior.

Najavits and Strupp (1994) studied 16 practicing therapists who were identified as "more effective" or "less effective" using time-limited

dynamic psychotherapy with an outpatient population. Clients' outcome scores and lengths of stay in treatment determined therapist effectiveness. Multiple measures of outcome were used and completed by clients, therapists, independent observers, and the therapists' supervisors. Results revealed that the more effective therapists showed more positive behaviors (e.g., warmth, alliance) and fewer negative behaviors (e.g., attacking, blaming) than did the less effective therapists.

Warmth, understanding, and affirmation were included among the positive behaviors identified. Negative behaviors included belittling and blaming, ignoring and negating, as well as attacking and rejecting. Therapists were differentiated almost entirely by nonspecific (relationship) factors rather than specific (technical) factors (Najavits & Strupp 1994). These findings suggest that the therapist's ability to demonstrate basic capacities of human relating could very well play a central role during an effective psychotherapeutic intervention (Asay & Lambert, 1999).

Common factor three: expectancy and placebo effects.

Over the past 30 years, research has addressed the importance of expectancy and placebo effects in client change. Lambert (1992) suggested that this factor, which he claims accounts for approximately 15% of the variance in client change, is as important to the change process as technique factors. Frank (1973) argued that the therapeutic enterprise itself carries a strong expectation that the client will be helped. He suggested that an

underlying factor unites all the seemingly different approaches to psychotherapy and even other forms of healing, such as the placebo in medicine and various types of religious cures. Having the hope that something can be done to help them can be a powerful motivator for people needing to change.

Common factor four: technique and model factors.

While some researchers argue for common factors as the principal mediators of change, most still argue for technique and model factors. Many research studies have aggressively investigated the role of model-based, technical interventions. Specific interventions are often studied in the context of comparative outcome studies. Comparative studies, it has been said, avoid the ethical problems in no-treatment, wait-list, and placebo controls, while providing information about the effectiveness of one technique or orientation in relation to others (Jones, Cumming, & Horowitz, 1988).

Through the use of comparative studies, many clinicians who were convinced of the singular abilities of their models and related interventions have seen numerous disappointing results returned. In many comparative studies completed to date, little evidence exists to suggest the superiority of one school or technique over another. Specific techniques are estimated to account for only about 15% of the improvement in psychotherapy clients (Lambert, 1992).

The Therapeutic Alliance

Carl Roger's Person-centered approach to psychotherapy placed a very high value on the role of the relationship between the therapist and client in terms of effective therapy. As early as the 1950's, Rogers famously emphasized the relationship between therapist and client as key because many problems experienced in adulthood result from negative early relational experiences. Rogers believed through a caring therapist showing positive aspects such as unconditional positive regard, congruence and empathy, the client might then be able to develop a new sense of self and therefore be better able to achieve their full potential (Rogers, 1951).

Duncan, Miller, and Sparks (2004) describe the therapeutic alliance as the relational bond, along with goal and task agreement, between the therapist and client. A meta-analysis of research conducted over the last several decades has found that a combination of the client's rating of the relationship and experience of change in the initial stages of treatment is a highly reliable predictor of the outcome of therapy (Miller, Duncan, Brown, Sparks, & Claud, 2003). The factors that seem most important to effective counseling are a level of skillfulness (defined as competence, rather than experience), cognitive complexity, and an ability (and willingness) to relate and relationally match with the client with whom they are working (Sexton, 1999).

According to Luborsky et al. (1988), and Sexton and Whiston (1994), of all the techniques, client-therapist characteristics, and procedures studied, the counseling relationship remains the most significant factor in successful counseling without equivocation. Research has confirmed that the key to any successful therapeutic endeavor is the development of an open, mutual, trusting, and collaborative relationship. Failure to form a quality relationship is associated with poor outcomes, premature termination, and client non-compliance with treatment goals and objectives (Alexander & Luborsky, 1986).

Research by Tracey (1977) supported counseling outcomes as more or less dependent upon the development of a complementary relationship pattern between a client and a therapist. Because, according to current research, client involvement remains one of the most important in-session variables, this area of relational interaction requires much more in-depth research.

Castonguay, Goldfried, Wiser, Raue, and Hayes (1996) examined the therapeutic alliance in cognitive therapy. They compared the impact of the therapist's focus on distorted cognitions (a treatment variable unique to cognitive therapy) and two variables common to other forms of treatment (therapeutic alliance and client emotional involvement). Clients in this study received either cognitive therapy alone or cognitive therapy with medication. Four experienced therapists who conducted cognitive therapy

according to the guidelines of manualized treatment rendered the treatment to these clients.

Two common variables, therapeutic alliance and a client's emotional experiencing, were both related to improvement. At the same time, the variables considered unique to cognitive therapy, thinking distorted thoughts and negative emotions, were positively related to presenting symptoms reoccurring after therapy. The researchers suggested that these findings were likely attributable to the therapist's attempts to repair strains in the therapeutic alliance. They speculated that the therapists increased their efforts to persuade their clients to accept the validity of the cognitive therapy rationale or they treated alliance strains as manifestations of the client's distorted thoughts that needed to be challenged (Castonguay et al., 1996).

Connors, DiClemente, Carroll, & Longabaugh, (1997) documented the independent contribution of the therapeutic alliance to treatment participation and outcomes among alcoholic outpatients. Ratings of the working alliance, whether provided by client or therapist, were significant predictors of treatment participation and drinking behavior during the treatment and 12-month period post-treatment.

Grencavage and Norcross (1990) reviewed 50 articles in search of terms related to common factor constructs. The authors found 27 terms that were used to describe conceptualizations of common factors (e.g.,

“common” was also referred to as nonspecific, universal or effective, while “factors” were sometimes referred to as elements, components, or principles). The majority of study authors, 56%, used “therapeutic alliance” as the term to conceptualize the construct of common factors.

The National Institute of Mental Health’s Treatment of Depression Collaborative Research Project (TDCRP) 1989 was an investigation of treatment outcomes of 239 outpatients with Major Depressive Disorder who were randomly assigned to one of four 16-week treatment conditions. Four approaches were evaluated (Cognitive Behavioral Therapy [CBT], Interpersonal Therapy [IPT], Drug, and Placebo). Results indicated: 1) no difference in outcome among these approaches; 2) the client’s rating of the alliance at the second session was the best predictor of outcome across conditions; and, 3) the treatment model accounted for 0% of the variance in successful treatment outcome, whereas the therapeutic alliance accounted for 21% of the variance in successful treatment outcome (Elkin et al., 1989).

The Therapeutic Alliance: Special Considerations

Special consideration one: group therapy.

Burlingame et al. (2002) identified three frequently used constructs to capture aspects of the therapeutic relationship in a group setting: climate, cohesion, and alliance. Group cohesion has been described as the group’s attractiveness to the participants, and a sense of belonging and inclusion (Corey, 1990) and has been related to desired outcomes (Burlingame et al.,

2002). Group climate has been defined as a property of the group that impedes or facilitates the ability of an individual to reach a goal. Group therapeutic alliance is defined as the participant's "perceptions of the therapist's attitudes, feelings, and behaviors toward the respondent as well as toward other group members" (Marziali et al., 1999).

In a study of 12 time-limited psychotherapy groups, with a total of 90 nonpsychotic outpatients, Budman et al., (1989) explored the relationships between cohesion, alliance, and treatment outcome. Findings indicated that cohesion and alliance were related concepts that appear to have strong relationships with improved self-esteem and reduced symptoms for clients in these groups.

Marziali, Munroe-Blum, and McCleary (1997) studied the contribution to outcome of two group-process factors, group cohesion and group therapeutic alliance, in a randomized controlled treatment trial for borderline personality disorder. Group members from four time-limited groups of an experimental model of group psychotherapy completed measures of group cohesion and group alliance at pre-specified intervals during the 30-session therapy. Outcome was measured in terms of psychiatric symptoms, social adaptation, and indicators of behavioral dysfunction. The results indicated cohesion and alliance were directly correlated and separately contributed to outcome on most of the dependent measures. Stepwise regression analyses showed, however, that when

compared with cohesion ($r = .51$), alliance accounted for more outcome variance on the dependent measures ($r = .80$).

Gillaspy et al. (2002) found that group alliance and cohesion are related, but only the clients' ratings of the alliance were associated with self-reported improvement of psychological functioning on outcome measures. The authors also found that group alliance may be the best predictor of desired outcome for substance abusers in a residential treatment setting.

The role of the therapeutic alliance was described by Glass and Arnkoff (1988), who examined common and specific factors in client descriptions and explanations of change. Clients were treated in one of three structured group therapies or an unstructured therapy group. The approach in each group was based on a different theory of change and differed in both content and focus. Findings revealed that all groups placed considerable emphasis on group process and relationship factors. The authors suggested that the role of common group process factors (relationship factors) was at least as important to the clients as the specific therapy program itself.

The empirical evidence of the impact of relationship factors in psychotherapy is substantial. These factors play a significant part in psychotherapeutic change and outcome (Asay & Lambert, 1999).

Conversely, client perceptions of the therapeutic alliance were not related to outcomes of early in-treatment measures of therapeutic alliance

(Working Alliance Inventory), group cohesion (California Psychotherapy Alliance Scale for Group), or group climate (Group Climate Questionnaire) during a study of the ability to predict outcome in a 16-session dynamic psychotherapy group for adults with major depression (Crowe & Grenyer, 2008). The study did highlight that client perceptions of conflict and group members' ability to work actively and purposefully in treatment did predict outcome. It can be hypothesized that group-as-a-whole perceptions influenced individual perceptions of clinical improvement.

Special consideration two: military environment.

Clinical practice in the military differs greatly from civilian clinics. Fitness and suitability for continued military service must be determined when a member presents with Axis I and/or Axis II diagnoses.

The military client's goals for treatment such as continued military service may not be feasible. A number of factors not present in civilian settings impact the therapeutic alliance in military treatment settings.

There is a perception held by many service members that receiving mental health services may be damaging to one's military career (Bray et al., 2003). Kennedy and Zillmer (2006) assert that the military rank of the therapist is a key variable. Typically, the most common therapeutic relationship in the military is between an officer as the therapist and an enlisted member as the client.

Limits to confidentiality adversely affect the therapeutic alliance. In the military, complex ethical concepts of confidentiality are challenged further by consideration of “mission impact” and “need to know.” When the Commander has mandated a military member for treatment, certain information will be shared with the referring commander. There are restrictions on confidentiality that exceed the mandatory reporting in civilian treatment facilities concerning threats to harm oneself or others, and knowledge of child abuse. Mandatory reporting in the military also includes spouse abuse, any criminal or illegal behavior (e.g., use of illicit drugs), the determination of whether or not a service member is fit for duty (Kennedy & Zillmer, 2006) and until very recent changes to legislation and military regulations, “Don’t ask, Don’t tell” was the official United States policy on homosexuals serving in the military from December 21, 1993 to September 20, 2011 (Don’t Ask, Don’t Tell, Don’t Pursue, 1993).

While the U.S. Army adhered to the policy of “Don’t Ask, Don’t Tell,” the soldier’s efforts in therapy toward change were often impeded by his/her reluctance or inability to disclose the important core issue of sexual orientation during the therapeutic encounter.

At the time of this writing, recent legislation (H.R.2965 - Don’t Ask, Don’t Tell Repeal Act of 2010) repeals this law and Army policy has been written to implement the law. Yet, in spite of these recent developments, the stigma of homosexuality continues. Combine this with the stigma of

seeking mental health services, and the barriers to developing an effective and trusting therapeutic alliance are formidable.

The effect that the repeal of “Don’t Ask, Don’t Tell” will have on treatment is currently unknown. Cultural understanding and multicultural sensitivity will be critical therapeutic skills affecting the therapeutic alliance. The United States military is very culturally diverse. Military members hail not only from varying backgrounds from within the United States, but also may be citizens of other countries (Kennedy and Zillmer, 2006).

Special consideration three: substance abuse population.

Several key randomized controlled outcome studies have been conducted on substance abusers. The Cannabis Youth Treatment Project (Dennis et al., 2004) and Project Match (Project Match Research Group, 1997) are two important randomized clinical trials studying the therapeutic alliance with this population.

The Cannabis Youth Treatment Project was a randomized field experiment studying 600 adolescent marijuana users between the ages of 12-15 years with significant comorbidities including emotional, physical, legal, social, and/or academic problems. The participants were randomly assigned to one of six treatment groups. The first group was exposed to Motivational Enhancement Therapy (MET) and Cognitive Behavioral Therapy (CBT) for five weeks. The second group received MET plus CBT

for 12 weeks, while the third group received Family Support Network, CBT, and MET for 12 weeks. The fourth group received MET and CBT for five weeks. The fifth received Adolescent Community Reinforcement therapy for 12 weeks, and the sixth group received Multidimensional Family Therapy (MDFT) for 12 weeks (Dennis et al., 2004).

Data analysis revealed the treatment approach accounted for little more than 0% of the outcome variance, yet alliance ratings predicted premature dropout, substance abuse/dependency post-treatment, and cannabis use at three and six-month follow-up (Dennis et al., 2004). One can conclude from these results that early change is a robust predictor of outcome, and that the best predictor of outcome is the client-rated therapeutic alliance.

Project Match, utilized three different treatment approaches (CBT, 12-Step, and Motivational Interviewing). The multisite randomized clinical trial evaluated 1,726 client participants for changes in drinking patterns in two parallel study groups (alcohol dependent clients who received outpatient therapy and clients who received aftercare therapy following inpatient or day hospital treatment) at nine clinical research units around the country. Twenty-five therapists administered the therapy over a 12-week period. Results indicated no difference in outcome between these approaches. Data also revealed the client's rating of the therapeutic alliance to be the best predictor of treatment participation, drinking behavior during

treatment, and drinking at 12-month follow-up (Project Match Research Group, 1997).

Systematic Client Feedback

There appears to be little doubt that the relationship between the therapist and the client is crucial to the outcome of therapy. If the relationship is positive and/or effective, chances of achieving treatment goals and objectives are greatly enhanced. If the relationship is negative and/or ineffective, chances of achieving treatment objectives and goals are greatly diminished.

Information accumulated to date clearly illuminates the need for further research that examines this relationship between the two principal participants in the therapeutic endeavor. Some therapists have the natural ability to bond with all different personality types, whereas other therapists have to work at it. The same could be said for the client. Personality, character, temperament—these components and many more are unique to the person seeking services as well as to those providing services.

The therapeutic alliance or relationship is a difficult construct to assess. However, some studies have shown that providing ongoing feedback to therapists can result in lower dropout rates and improved treatment outcomes (Lambert, Okiishi, Finch, & Johnson, 1998). Lambert et al. (2001) found that when therapists were provided feedback about client progress (as seen from the client's perspective), treatment outcome

improved relative to clients in the control condition. Twice as many clients in the feedback group achieved clinically significant or reliable change and only one-third as many were classified as “deteriorated” by the end of the treatment. These findings are consistent with those of Smith and Glass (1977) as well as Luborsky et al. (1975).

While studying the effects of providing therapists with feedback on 609 psychotherapy clients divided into four groups (two experimental and two controls), Lambert et al. (2001) administered the Outcome Questionnaire (OQ) pre-treatment. Feedback was provided in the form of progress graphs. Visually distinctive colored (red, yellow, white, or green) quarter-inch paste-on dots were placed on progress graphs. These dots corresponded to a statement regarding client progress. The therapist was provided with the graph and colored dot each time a subsequent OQ was administered prior to a treatment session. The thrust of the study was to determine whether or not systematic client feedback provided to therapists improved the outcome for those clients who were predicted to be failures.

Hansen, Lambert, and Forman (2002) report that 57.6% to 67.2% of clients show improvement given approximately 12.7 treatment sessions. Using naturalistic data, the average number of sessions received in a database of over 6,000 clients was fewer than five, with only a 20% rate of improvement, suggesting on average that clients do not receive the

treatment they need in order to improve, nor do they recover at rates seen in some clinical trials research.

Brown et al. (1999) studied 2,000 therapists and clients, finding that therapeutic relationships in which no improvement occurred by the third visit did not, on average, result in improvement over the entire course of treatment. Data from Hansen et al. (2002) and Brown et al. (1999) suggest that optimal therapy should consist of an average of 15 sessions, and that early efforts should be focused on establishing/improving the therapeutic relationship.

The general trajectory of change in successful therapy is highly predictable (Brown et al. 1999; Hansen & Lambert, 2003; Haas, Hill, Lambert, & Morrell, 2002; Howard, Kopta, Krause & Orlinsky, 1986; Howard, Moras, Brill, Martinovich, & Lutz, 1996; Smith, Glass, & Miller, 1980; Steenbarger, 1992; Whipple et al. 2003). Measures of client progress and experience of the therapeutic alliance can be used to determine the appropriateness of the current treatment, assess the need for further treatment, and prompt a clinical consultation for clients who are not progressing at expected rates (Howard et al., 1996).

Reese, Norsworthy, and Rowlands (2009) investigated the use of a continuous feedback assessment system using the Partners for Change Outcome Management System (PCOMS; Miller, Duncan, Sorrell, & Brown, 2005) by studying a sample of psychotherapy clients in a university

counseling center ($N = 74$) and a sample of psychotherapy clients in a community-based graduate training clinic ($N = 74$). PCOMS consists of two brief measures that are used to track client progress in therapy during each session. The Outcome Rating Scale (ORS; Miller, Duncan, Brown, Sparks, & Claud, 2003) consists of four items and measures client outcome, and the Session Rating Scale (SRS; Duncan et al., 2003) also consists of four items and measures the therapeutic session.

The ORS was administered and scored at the beginning of each session and the SRS was administered and scored at the end of each session. Results indicated therapists who used PCOMS with their clients (feedback group) showed statistically significant treatment gains compared to the treatment-as-usual group (no-feedback condition), and clients in the feedback condition were more likely to experience reliable change in fewer sessions. Analysis showed approximately 50% of feedback condition clients demonstrated reliable change after the 7th session (graduate training clinic) or 9th session (university counseling center). The effects of continuous feedback extended to all clients in the feedback condition, not just to those at risk for a negative outcome.

While feedback has consistently demonstrated improvement in individual psychotherapy outcomes, no previous studies had examined the effect of client feedback on couple therapy until Anker, Duncan, and Sparks (2009) investigated the effects of providing treatment progress and alliance

information to both clients and therapists during couple therapy. Using a sample of 205 Scandinavian heterosexual couples ($N = 410$) at a community family counseling clinic, couples were randomly assigned to a treatment-as-usual (TAU) group or feedback group. Couples in the feedback condition demonstrated significantly greater improvement than those in the TAU condition at post-treatment. The feedback couples also achieved nearly 4 times the rate of clinically significant change, maintained a significant advantage on the primary measure at 6-month follow-up, and attained a significantly lower rate of separation or divorce.

While Anker, Duncan, and Sparks (2009) used the Partners for Change Outcome Management System (PCOMS; Miller, Duncan, Sorrell, & Brown, 2005) with a sample of 205 Scandinavian heterosexual couples, Reese, Toland, Slone, and Norsworthy (2010) replicated the Anker et al. study to determine whether the effectiveness of client feedback would extend to couple therapy with a sample from the United States. Clients were 46 heterosexual couples ($N = 92$) that received couples therapy during the course of an academic year at a graduate training clinic for a marriage and family therapy master's degree program. Therapists were graduate trainees under supervision. The study focused on the effectiveness of using PCOMS with couples in psychotherapy as compared with a TAU control condition. Results from the randomized couple clinical trial conducted in a naturalistic setting indicated that couples in the feedback condition demonstrated

statistically significantly more improvement compared with couples receiving treatment as usual and that improvement occurred more rapidly. Also, 4 times as many couples in the feedback condition reported clinically significant change by the end of treatment. Couples in the feedback condition also reported higher levels of marital satisfaction at post-treatment, and a greater percentage of marriages were intact at follow-up when compared with marriages in the TAU condition. These findings for PCOMS with couples are consistent with previous studies that focused on individual therapy (Miller, Duncan, Brown, Sorrell, & Chalk, 2006; Reese et al., 2009).

Whipple et al. (2003) found that clients at risk for a negative or null outcome were less likely to deteriorate, more likely to stay longer, and twice as likely to achieve a clinically significant change when their therapists had access to outcome and alliance information. Lambert et al. (2001) maintains that the main effect of feedback is to keep clients who are not on track in treatment longer.

Instruments.

Thus the question becomes how to assess the relationship, or alliance, between client and therapist to ensure that the client progresses in treatment. The answer points toward a method to deliver systematic feedback. The Outcome Questionnaire-45 and the Outcome Questionnaire-30 are two measures suited for use in psychotherapy outcome research.

Outcome Questionnaire 45 (OQ-45).

The OQ-45 (Lambert et al., 1996) is a 45-item self-administered screening and outcome assessment tool developed to measure client psychotherapy progress. The OQ-45 assesses the following three domains: symptom distress, interpersonal relations, and social role. The measure's internal consistency (.93) and test-retest reliability (.84) are high (Lambert, Burlingame, Umphress, Hansen, Vermeersch, Clouse, & Yanchar, 1996). Additional studies have further documented the instrument's ability to identify and improve the chances of success in cases at risk for a negative or null outcome (Lambert, Whipple, Smart, Vermeersch, Nielsen, Hawkins, 2001; Whipple, Lambert, Vermeersch, Smart, Nielsen, Hawkins, 2003).

Outcome Questionnaire 30 (OQ-30).

The OQ-30 is a brief, standardized, self-report instrument derived from the OQ-45. The thirty items for the OQ-30 were chosen from the OQ-45 based on their individual sensitivity to change as estimated from a large scale study of clients undergoing treatment in a variety of settings (Vermeersch, Lambert, & Burlingame, 2000). The OQ-30 is constructed of items that address commonly occurring problems and symptoms across a wide variety of disorders. Like the OQ-45, it taps into the following domains: symptomatic distress, social relationships, and quality of life. It also measures work functioning.

Ellsworth, Lambert, and Johnson (2006) compared the level of agreement between the OQ-45 and the OQ-30. While their study showed high levels of agreement in measurement of client outcomes, the OQ-45 emerged as a more accurate and clinically useful method for providing therapists with feedback about their clients' predicted treatment outcomes.

Outcome Rating Scale (ORS).

Although it is important to ensure that outcome-informed treatment is valid and reliable, it is equally important to consider the process of collecting and using outcome data. The process must be user-friendly for both the therapist and the client (Johnson & Shaha, 1996). It is not news to any therapist on the front lines of treatment that the number of forms, authorizations, and other oversight procedures has exploded in recent years.

Few therapists have the time or resources to devote to the repeated administration, scoring, and interpretation of lengthy structured interviews or other standardized measures. For example, Brown et al. (1999) found that the majority of practitioners did not consider any measure or combination of measures practical if it/they took more than five minutes per session to complete, score, and interpret.

After experimenting with a number of outcome and alliance measures across a variety of treatment contexts (e.g., community mental health agencies, case management facilities, residential treatment centers), the Institute for the Study of Therapeutic Change (ISTC) found that similar

tolerance levels (i.e., 5 minutes) apply to clients as well as therapists (Duncan et al., 2004; Miller, Duncan, Brown, Sparks, & Claud, 2003).

Duncan et al. (2004) reports that clients quickly tire of measures that lack obvious face validity and require more than a few minutes to complete or appear to take away from time spent with the therapist. Low treatment compliance rates are the most frequent result (Miller, Duncan, Brown et al., 2003). Given the time pressures operating in today's treatment environments, therapists routinely decline to use whatever data or feedback the lengthier outcome tools could make available. Currently in primary healthcare settings, where total treatment contact can average less than 10 minutes per visit or when behavioral health services are delivered via the Internet or telephone, the need for feasible outcome management tools has become increasingly more essential (Fisher, 2003; Levine, 2004). For these reasons, an "ultra-brief" measure for outcome research is needed.

The ORS (Duncan & Miller, 2000) is just such a brief instrument. It is used for measuring client psychotherapy outcomes, and is moderately correlated to the OQ-45. It can be used to obtain feedback in real time. It is a four-item self-report instrument requiring less than a minute to complete and score that was developed as an alternative to the much lengthier OQ-45 (Lambert et al., 1996). Like the OQ-45, the ORS assesses changes in functioning, interpersonal relationships, and social role performance with just four items. The advantage to the ORS is ease of use, immediate

feedback, increased compliance, improved face validity, and savings in time and energy (Miller et al., 2003).

Therapeutic Allegiance

Researchers have long debated the importance of therapeutic allegiance, or the therapist's belief in and support of a particular therapy or instrument. The term arose out of debates for and against the conclusion that all brands of therapy produce similar outcomes across diverse populations. Luborsky, Singer, and Luborsky (1975) noted that when a particular treatment outperformed another in terms of efficacy, the difference could usually be attributed to therapeutic allegiance on the part of the research team.

McLeod (2009) held that the influence of therapeutic allegiance upon clinical outcomes has received attention, but there has been little research investigating the mechanisms underlying allegiance and outcome. He postulates that researchers influence allegiance in several ways. First, allegiance is influenced through the quality of treatment delivery. Investigators who hold an allegiance to a particular treatment may be especially motivated to learn the subtleties and nuances of the treatment passing this knowledge on to clinical staff. Second, allegiance may affect adherence and competence, which is defined as the extent to which a therapist delivers a treatment as designed. Third, the quality of therapist training may explain how a researcher's allegiance produces better

outcomes. Fourth, investigators are more likely to choose therapists who are more motivated to provide the therapy of choice (McLeod, 2009).

In the current study, I attempted to control for therapeutic allegiance to the instrument used to collect study data. Several client self-report outcome instruments were discussed in this review. Some are better known than others and some are preferred (or not preferred) over others. This was the compelling reason for designing a study that provided indirect progress reports, or limited feedback, for the therapists through the use of the progress graphs and different colored squares as opposed to providing direct feedback through the instrument itself.

Summary of Literature Review Findings

This review of the literature focused on differences and similarities of efficacy and effectiveness studies. These two words are usually synonymous although efficacy usually applies to clinical trials or research settings studies whereas effectiveness applies more to “real world” study settings. Factors common to all psychotherapies were explored. The therapeutic alliance was highlighted as the key factor in client change. Special populations of interest to this study included participants in group therapy, military members, and clients being treated for substance abuse. Finally, systematic feedback, which allows for ongoing communication between client and therapist regarding the alliance, was discussed along with different outcome measures and a brief discussion on therapeutic

allegiance. From a comprehensive review of outcome literature, it can be concluded that, with a few exceptions, no one approach works better than another—factors common across all accepted psychotherapies account for change. The client’s view regarding process and outcome is critical to the therapeutic process and because feedback from the client is essential for decision-making, outcome measurement is vital.

Hypotheses

Based upon this review of the literature it is apparent that an effective therapeutic alliance between the client and the therapist is essential. Many questions remain unanswered as to what is necessary to develop and enhance this relationship. We have seen promising results from studies designed to examine the inner workings of the therapeutic alliance and a theme is emerging that points to the therapist receiving feedback provided by the client.

This study drew upon the previously presented research by using a client feedback tool (ORS) that could be completed in less than a minute and scored just as quickly. The goal was to provide some insight into the effect of feedback from the client’s perspective given to the therapist in a limited and systematic fashion. I hypothesized that this feedback would serve to inform the therapeutic relationship therefore enhancing treatment outcomes demonstrated by higher ORS scores and greater treatment

participation in the form of increased attendance for participants assigned to the experimental group.

Hypothesis 1.

Participants in the Feedback group will have a lower treatment dropout rate than those whose therapists did not receive feedback about participants' functional status.

Hypothesis 2.

Participants whose therapists received systematic feedback on participant's functioning level will have better treatment outcomes than participants in the control group (non-feedback condition).

Chapter 3: Method

Participants

Participants were 300 soldiers enrolled in treatment at Ft. Hood's Army Substance Abuse Outpatient Treatment Program (ASAP) between August 2007 and November 2008. The majority of participants in the study were referred to the ASAP program by their commanders, typically after some type of alcohol or drug related misconduct (e.g., positive urinalysis, DUI, domestic violence incident while intoxicated).

As shown in Table 1, race/ethnicity of the sample closely paralleled that of the overall U.S. Army and U.S. populations with the majority Caucasian (58%), African American and Hispanic nearly equivalent at 16 and 15 percent respectively, with other ethnicities representing 10 percent of the sample (U.S. Census Bureau, 2012).

Table 1

Participant Population Characteristics

	Study	Army	U.S.
Race/Ethnicity	Population	Population	Population
White	58%	62%	64%
African American	16%	20%	13%
Hispanic	15%	11%	16%
Other	10%	7%	7%

Table 2 shows a majority of participants were males (89%) ages 20 to 50 with a mean age of 27. Sixty-two percent of participants had never married or were currently separated or divorced. Although 80 percent of the participants were junior enlisted soldiers with rank of E-4 or below, nearly two-thirds had at least one combat deployment. Alcohol was the primary substance involved in participants' referral problems (67%), with cannabis (14%) and cocaine (12%) the two next most prevalent substances seen in referrals to the ASAP program.

Table 2

Participant Demographic Characteristics

Age in years	Frequency	Percentage
20-25	141	47%
26-30	96	32%
31-35	30	10%
36-40	24	8%
41-45	6	2%
46-50	3	1%
Gender		
Male	266	88.7%
Female	34	11.3%

Table 2 (Continued)	Frequency	Percentage
<i>Participant Demographic Characteristics</i>		
Race/Ethnicity		
White	172	57.3%
African American	50	16.7%
Hispanic	47	15.7%
Other	31	10.3%
Marital Status		
Never Married	129	43%
Married	114	38%
Separated	28	9.3%
Divorced	29	9.7%
Rank		
Enlisted	236	78.7%
NCO*	62	20.6%
Senior NCO/ Officers	2	0.7%
Deployment Status		
Deployed at least once	185	61.7%
No deployments	109	36.3%
Referring Substance		
Alcohol	203	67.7%
Cannabis	41	13.7%

Cocaine	35	11.7%
Other	21	6.9%

Note. * NCO = Non-commissioned Officer

Measures

Outcome Rating Scale (ORS).

The ORS (Duncan & Miller, 2000, 2003) is a four-item self-report instrument developed to measure client psychotherapy outcomes (Appendix A). Duncan and Miller (2000, 2003) developed the ORS as a brief alternative to the Outcome Questionnaire 45.2 ([OQ] Lambert, Hansen, et al., 1996) and specific items on the ORS were adapted from the three domains of client functioning assessed by the OQ-45.2, which include individual, relational, and social.

To assess client functioning in these three areas, Duncan and Miller's (2000, 2003) instrument uses a visual analog format and instructs clients to place a hash mark on the corresponding 10 centimeter line, with marks to the left representing lower functioning and marks to the right indicating higher functioning. Most respondents take less than one minute to complete the instrument (Duncan and Miller, 2000). ORS scores range from 0 to 40 with higher scores indicating better functioning. In a Miller, Duncan, Brown, et al. study (2003), the mean ORS score for the non-clinical sample ($N = 77$) was 27.9 and 19.6 for the clinical sample ($N =$

435). In a much larger clinical sample, 21,834 individuals seeking treatment at an international employee assistance program, the mean ORS score was almost identical (19.58 versus 19.6) to that found in Miller, Duncan, Brown, et al. (2003) smaller sample. Miller and Duncan (2004) used cumulative normative data to set 25 as the ORS clinical cutoff score, which falls at the 77th percentile of the non-clinical sample.

The psychometric properties of the ORS have been well-documented. Internal consistency of the ORS is quite good and compares favorably to the OQ-45.2, while its test-retest reliability and, in particular, its concurrent validity is less impressive (Miller, Duncan, et al. 2003; Biescad, et al. 2008). Internal consistency (Cronbach's coefficient alpha) for ORS has ranged from a low of .79 (Brown, 2004) to a high of .97 (Bringinghurst et al., 2006), while its test-retest correlations range from .53 (Miller, Duncan, et. al., 2004) to .81 (Bringinghurst et al., 2006). Miller, Brown, Duncan, et al. (2003), found a .58 correlation between the ORS and OQ-45 in their initial investigation of the validity of the ORS using a mixed clinical (outpatient mental health) and nonclinical (graduate) sample. Biescad et al. (2008), again using the OQ-45 as a criterion measure, found correlations of .69 for inpatient clinical samples and .64 for nonclinical samples. In this same study, Biescad et al. (2008) found a -.73 correlation between the ORS and Beck Depression Inventory and a -.59 correlation between ORS and Symptom Checklist-90. Miller, Duncan, Brown et al.

(2003) also showed that the ORS is sensitive to change in therapy outcomes studies. In their clinical sample pre- and post-ORS scores were significantly different (19.6 vs. 25.7, $p < .05$) while, importantly, scores for the non-clinical sample remained relatively stable over time (27.9 vs. 29.4).

Computerized ORS.

The computerized version of the ORS (ASIST) was used in this study with permission of its developers (Figure 1). Under the supervision of a research assistant, who was a licensed therapist, participants used a mouse to place marks along the 10 centimeter line, again with marks to the left indicating low levels of functioning and marks to the right indicating higher levels of functioning. After the participant had placed their four marks on the appropriate lines they would click the DONE button and proceed to the therapy group room. The computer program automatically scored the instrument. This ensured there would be no interference, miscalculations, or tampering with the score results. The participant did not see the results generated by the ASIST computer program. Any results the participant may have seen would come from their therapist if their therapist chose to share the results with them.

Intake session for J0001

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

Individually:
v
(Personal well-being)

Interpersonally:
v
(Family, close relationships)

Socially:
v
(Work, school, friendships)

Overall:
v
(General sense of well-being)

Done

Figure 1. Computerized Version of ORS.

The computerized version of the Outcome Rating Scale (ORS) uses a set of algorithms derived from previous ORS research and normative samples to draw trajectories of change for individual clients. Subsequent ORS scores are then compared against the anticipated change trajectories which allows clinicians to identify clients who are making progress and those "at risk" for a negative outcome or treatment dropout.

Each 10 CM line represents how the participants viewed themselves doing in one of four life areas: Individually (personal well-being); Interpersonally (family and close relationships); Socially (work, school, and friendships); and Overall (general sense of well-being). Marks to the left

represented low levels of functioning and marks to the right indicated high levels of functioning. It was expected that the instrument could be completed in a minute or less.

Figure 2 provides a fictitious client example to illustrate scoring and interpretation using the ORS computerized system.

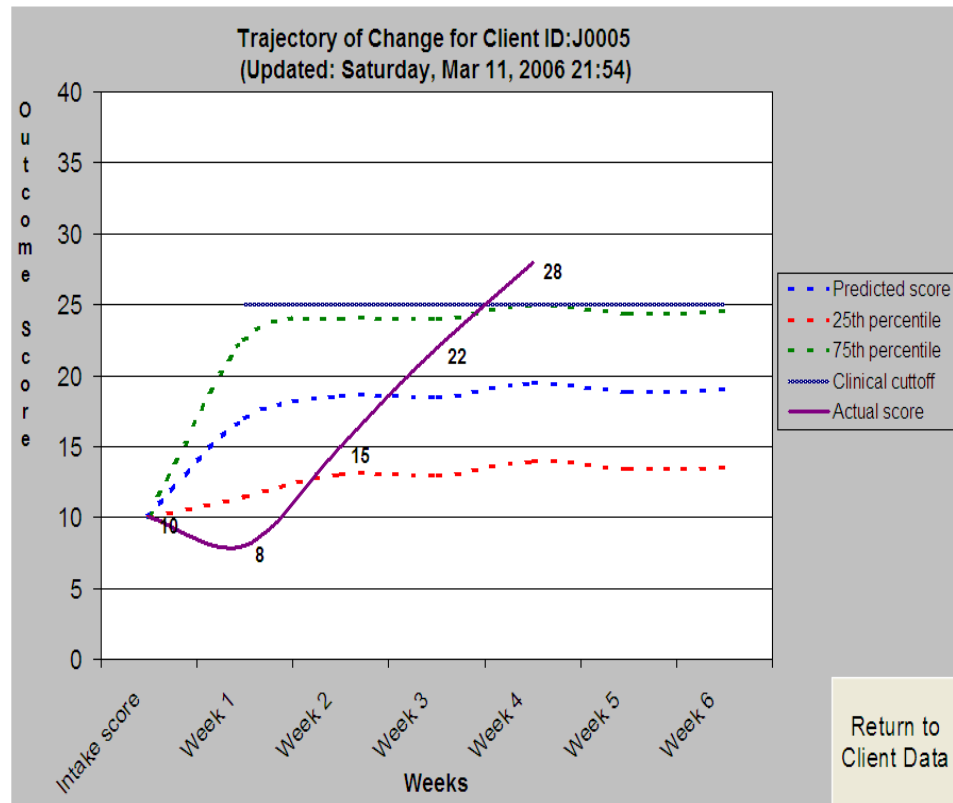


Figure 2. ORS Trajectory of Change Graph.

Figure 2 shows an ORS graph with an initial ORS score (intake score) of 10. The middle (blue) dotted line represents the expected trajectory (predicted score) of change for participants whose score at intake on the ORS is 10. The bottom (red) dotted line corresponds to the 25th percentile and the top (green) dotted line corresponds to the 75th percentile.

The graph visually depicts the distribution of actual scores above and below the expected trajectory of progress over time. The solid horizontal (blue) line at 25 represents the clinical cutoff score for the ORS. Scores falling above the clinical cutoff score are characteristic of individuals not seeking treatment and scores below 25 similar to people who are in need of treatment (Duncan et al., 2003). The remaining solid line (purple) designates the participant's actual score from session to session.

The example participant's score at the first session (8) is below the 25th percentile (bottom red-dotted line). Based on this score, the participant's therapist would receive a "red" square on the participant's progress graph for week 1 (Figure 3), warning of the potential for premature drop out and an increased risk for a negative or null outcome should therapy continue unchanged. The second session score (15) is above the 25th percentile, but remains below the expected trajectory of change (middle blue-dotted line). The therapist would receive a yellow square on the participant's progress graph for week 2. By session three, the participant's ORS score (22) has risen above the expected trajectory of change line but remains below the 75th percentile (top green-dotted line). As a result, the therapist would receive a blue square for week 3 on the participant's progress graph. By session four, the participant's ORS score (28) rose above the 75th percentile prompting a green square to be placed on the participant's progress graph (Figure 3).

In the current study, therapists were not provided actual trajectory of change graphs as depicted above (Figure 2). Rather, at each session therapists were provided with a graph that used the different colors described above to indicate one of four different stages of progress which corresponded to where the participant's ORS score that week fell on his or her predicted change trajectory (Figure 2).

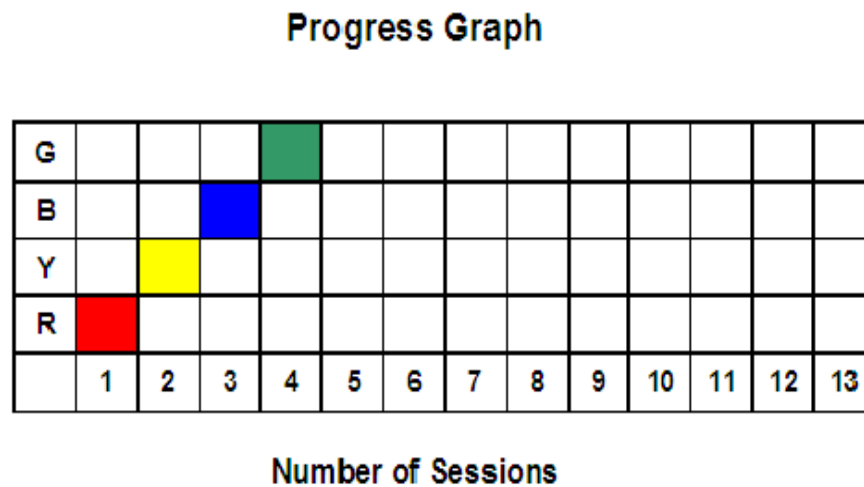


Figure 3. Participant's Progress Graph.

A legend accompanied the participant progress graph and included the following descriptive or interpretative statements:

- (1) **Green Square:** "The client is functioning in the normal range. Consider successful termination."
- (2) **Blue Square:** "The rate of change the client is making is in the adequate range. No change in the treatment plan is recommended."

(3) **Yellow Square:** “The rate of change the client is making is less than adequate. Consider altering the treatment plan by intensifying treatment, shifting intervention strategies, and monitoring progress especially carefully. This client may end up with no significant benefit from therapy.”

(4) **Red Square:** “The client is not making the expected level of progress. Chances are the client may drop out of treatment prematurely or have a negative treatment outcome. Steps should be taken to carefully review this case and decide upon a new course of action such as referral or a higher level of care. The treatment plan should be reviewed with the client. Consideration should also be given to staffing this case with the treatment team. The client’s readiness for change may need to be re-assessed.”

Procedures.

Soldiers seeking treatment at Ft. Hood’s ASAP clinic, whether self-referred or otherwise, completed a triage inventory (Appendix B) followed by a clinical interview with one of six triage therapists. If the triage process indicated the soldier likely met criteria for substance abuse or dependence or was at a high risk for further substance-related problems, a comprehensive assessment was then completed, and if treatment was indicated the soldier was arbitrarily assigned to one of 18 primary therapists

and a weekly therapy group. All soldiers that were enrolled in therapy between August 2007 and November 2008 were eligible for participation in this study. Before assignment to a therapist, a research assistant and witness met with each soldier to elicit participation in the study. During this meeting, the research assistant explained the details of the study and obtained informed consent for study participation (Appendix C) from those soldiers who chose to participate in the study.

Participation in this study was completely voluntary and had no impact on the soldier's eligibility for substance abuse counseling. The full range of services that this clinic offered could be obtained regardless of study participation. If a soldier agreed to participate in the study, he or she was randomly assigned to one of two groups (feedback or control) through the use of a computerized random number generator. Participants were told they were participating in a study to examine the effects of client feedback on therapy outcome. Study participants were not informed of their group assignment at any time during the course of the study. Each group had 150 subjects randomly assigned. There were 18 therapists that participated, all of whom were Department of the Army civilian employees. Therapists were informed that the purpose of the study was to test the effects of client feedback on treatment outcome and that they could expect to receive feedback on approximately half of their clients.

At the conclusion of each therapy session therapists were given participant progress graphs for those participants in their therapy group who were in the treatment condition. No attempts were made to manage the therapists' actions in relation to the feedback they received with one exception: Therapists were asked to not disclose to participants whether or not participants were in the feedback or control group. The study design did not include tight experimental controls such as treatment manuals or close monitoring of therapists' behaviors. Nor was a record kept of whether participants were receiving medication or other concomitant treatments. In this regard, the intervention tested in this study was minimal, but consistent with the intent to examine findings in routine clinical practice.

By design, the study attempted to impose as little as possible on the manner in which therapists practice therapy and in a way that would be consistent with using systematic feedback in routine practice. The atmosphere of the research setting was one of minimal control and intrusion. The study was designed to be high in ecological validity and applied in a field-based setting, even though it did include randomization in the assignment of participants into groups.

The Clinical Director provided clinical oversight and review for the clinical functioning of the Department of Substance Abuse Services. Clinical supervision was provided in weekly treatment team meetings that were attended by the therapist staff, Clinical Director, and a staff physician

who had expertise in addiction medicine. Individual supervision was provided to the therapists on an as needed basis, and at least twice per month. Therapists routinely sought supervision on complex cases.

Chapter 4: Results

Preliminary Analyses

A series of chi-square analyses were conducted to examine whether feedback and control group participants differed across important demographic variables. Groups did not differ significantly by gender, $\chi^2(1, N = 300) = 0.00, p = 1.00$ (feedback and control groups had identical number of males and females, 133 and 17 respectively), ethnic composition, $\chi^2(7, N = 300) = 6.88, p = .44$, or marital status, $\chi^2(3, N = 300) = 2.64, p = .45$. There were also no significant differences in military rank, $\chi^2(9, N = 300) = 11.50, p = .24$, or deployment history, $\chi^2(2, N = 300) = 3.77, p = .52$ between groups. Likewise, feedback and control groups did not differ significantly in substance used, $\chi^2(7, N = 300, p = .39$, or age, $t(298) = 0.51, p = .61$.

Non-participants.

Thirty-seven of the 300 participants failed to participate in even one therapy session after completing their initial intake. Twice as many of these non-participants were in the control group than in the feedback group (25 versus 12). Given this large discrepancy between group classifications for non-participants, follow up analyses were conducted to assess whether the groups of non-participants differed in initial level of dysfunction (as measured by ORS intake score) or across various demographic or descriptive variables such as gender or primary substance used. The control

and feedback non-participants did not significantly differ on ORS Intake Score, $t(35) = 0.72$, $p = .48$ (control group mean = 19.03, SD = 9.88, feedback group mean = 21.36, SD = 7.59), suggesting initial level of dysfunction did not account for the differing non-participation rate. Likewise, there were no significant differences found in a series of chi-square analyses comparing feedback and control non-participants' race/ethnicity, gender, deployment status, rank, or primary substance. Feedback and control non-participants also did not differ significantly in age, $t(35) = -1.24$, $p = .23$. However, a significant difference in marital status between feedback and control non-participants was found, $\chi^2(3, N = 37) = 9.10$, $p = .03$. Of 14 married participants within both groups, 12 were in the control group versus only 2 in the feedback group. Although this difference in marital status exists, there is no obvious reason why married soldiers would be less likely to follow up with recommended treatment.

Major Analyses

Hypothesis 1: *Participants in the feedback group will have a lower treatment dropout rate than those whose therapists did not receive feedback about participants' functional status.* As predicted, a significant difference was found in session attendance between participants in the feedback and control groups, $t(261) = -2.91$, $p < .01$. Participants in the feedback group attended an average of 4.05 ($SD = 1.75$) treatment sessions, while

participants in the control group averaged just 2.98 ($SD = 1.94$) treatment sessions.

Table 3 compares the rates at which participants in the feedback and control groups dropped out of treatment. Sixty-seven percent of feedback participants remained in treatment through five therapy sessions compared to only 45% of those in the control group. When comparing dropout rates across sessions, the largest differences between feedback and control participants occurred after the 1st and 2nd sessions. Sixteen percent of the control group participants dropped out after the 1st session compared to only 9% of the feedback participants. After the 2nd session 14% of the remaining control group participants dropped out of treatment compared to only 6% of the remaining feedback participants. The differences in dropout rate between the two groups were minimal after the 3rd session (10% for feedback, 12% for control) and only slightly larger after the 4th session (8% for feedback, 13% for control).

Table 3

Comparison of Total Treatment Sessions Attended (Feedback v. Control Groups)

Sessions	Feedback			Control	
	Attended	# Attending	Dropout Rate	# Attending	Dropout Rate
1		138	-	125	-
2		125	9%	105	16%
3		117	6%	87	14%
4		103	10%	73	12%
5		92	8%	56	13%
Total Dropout %			33%		55%

Note. For the feedback group, 138 of 150 participants who agreed to participate in the study attended their initial treatment session. For the control group, 125 of 150 participants who agreed to participate in the study attended their initial treatment session.

Hypothesis 2: *Participants whose therapists received systematic feedback on participant's functioning level will have better treatment outcomes than participants in the control group (non-feedback condition).*

Before assessing the effect of patient feedback on treatment outcome, I first examined whether feedback and control group participants differed on the

Outcome Rating Scale (ORS) administered during intake process, prior to treatment proper (and client feedback's potential benefit to treatment outcome). No significant difference was found on intake ORS between feedback and control groups, $t(298) = 1.64$, $p = .05$. The mean intake ORS score for the feedback group was 22.29 ($SD = 9.81$) and 20.44 ($SD = 9.72$) for the control group.

While there was no statistically significant difference between the two groups when comparing intake ORS scores, the results were close enough to significance ($p=.10$) to warrant a more robust analysis than a series of t-tests would provide for testing differences between the groups for session one through five ORS scores. Therefore, after removal of all cases with missing values for ORS scores, a series of one-way analysis of covariances (ANCOVAs) were completed using group membership (control and feedback) as the independent variable and intake ORS score as the covariate. As shown in Table 4, no significant differences were found between the feedback and control ORS scores for Sessions 1 and 2. However, starting with Session 3, a significant difference was found between feedback and control ORS scores (means scores were 27.72 and 23.03 respectively), and there continued to be significant differences in ORS scores at Sessions 4 and 5.

Table 4

ANCOVA Comparing Feedback and Control Group ORS Scores at Session One through Five

	Feedback ^a		Control ^b		<u>F</u>
	mean	(SD)	mean	(SD)	
Session 1	24.80	10.08	21.09	9.13	1.27
Session 2	26.16	9.00	23.53	9.96	0.35
Session 3	27.72	9.41	23.03	10.21	4.36*
Session 4	29.15	8.93	24.53	9.81	4.76*
Session 5	30.26	7.86	25.64	10.33	5.74*

Note. * $p < .05$ ** $p < .01$ *** $p < .001$. $n^a = 92$ $n^b = 56$.

Covariate: Intake ORS score.

Commander and therapist perception of participants' treatment progress was also used to assess the relationship between participant feedback and treatment outcomes. Both therapist and commander treatment outcome ratings occurred at the end of the participant's treatment during a final treatment team meeting. Both were global ratings of participants treatment outcome with the therapist endorsing "good", "fair", or "poor" and the commander endorsing either "satisfactory" or "unsatisfactory". Tables 5 and 6 provide results of therapist and commander treatment outcome ratings. Both commanders, $\chi^2(1, N = 263) = 28.06, p < .001$, and

therapists, $\chi^2(2, N = 263) = 18.66, p < .001$, rated feedback group participants as showing significantly more improvement in treatment than those in the control group.

Table 5

Therapists' Ratings of Participant Treatment Outcome

	Feedback Group	Control Group
Good	59 (43%)	34 (27%)
Fair	57 (41%)	42 (34%)
Poor	22 (16%)	49 (39%)

Table 6

Commanders' Rating of Participant Treatment Outcomes

	Feedback Group	Control Group
Satisfactory	113 (82%)	64 (51%)
Unsatisfactory	25 (18%)	61 (49%)

Chapter 5: Discussion

This study examined whether psychotherapy outcomes could be enhanced by patients providing systematic feedback about their personal, social, and occupational functioning to their therapists. Participants were 300 Soldiers referred to the Fort Hood, Texas Army Substance Abuse Program. Duncan and Miller's (2004) Outcome Rating Scale (ORS) was the measure used to assess and communicate participant functioning status to therapists. Study participants were mostly young male soldiers who were required to participate in treatment after an alcohol-related incident (e.g. drunk driving, public intoxication) or after testing positive for illicit drugs on a biochemical analysis.

Soldiers who agreed to participate in the study were randomly assigned to either feedback/treatment or non-feedback/control condition. Preliminary analyses showed that these two groups were similar across important demographic characteristics, including age, gender ratio, race/ethnicity, military rank, marital status, deployment history, and substance type involved in their treatment referral. Initial analyses also showed that participants in the two groups had similar levels of dysfunction or distress at onset of treatment as measured by their ORS intake scores. Participants completed the ORS prior to each psychotherapy group session and results for those in the Feedback condition (but not control condition) were then provided to their therapists. This was the study's only

manipulation of the treatment process; otherwise, no attempt was made to structure or proscribe how therapist provided treatment to participants.

The current study provided additional support to the growing research base (e.g., Duncan & Miller, 2000; Miller, Duncan, Brown, Sorrell, & Chalk, 2006) showing substantial improvements in treatment adherence and outcome when therapists have access to systematic feedback from their patients regarding the outcome of therapy. In this study participants who provided their therapists with regular feedback about how they were progressing both remained in treatment longer and received more benefit from their treatment. By the 5th therapy session, over half (55%) of the participants in the non-feedback condition had dropped out of treatment whereas only a third (33%) of the participants in the feedback condition had dropped out of treatment. The discrepancy in dropout rates between the two groups was most pronounced earlier in treatment—16% of the non-feedback group stopped attending treatment after the 1st session compared to only 9% of participants in the feedback group. After the 2nd session 14% more of the non-feedback group stopped treatment versus 6% of the feedback participants. There was minimal difference in dropout rates after 3rd session (12% for non-feedback group vs. 10% for feedback group).

Analysis of covariance (ANCOVA) was used to test whether participants in the feedback group (those whose therapists received systematic feedback) demonstrated greater treatment outcome as measured

by the ORS scores than did those participants in the control group. This analysis supported the hypothesis that the feedback group did experience significantly higher scores for sessions 3, 4, and 5.

Hansen, Lambert, and Forman (2002) documented improvement in 58% to 67% of clients in an average of 12.7 sessions. In the present study, 74% of the clients in the treatment group and 71.4% of the control group improved in only 5 sessions. Hansen et al. (2002) and Brown et al. (1999) recommended an optimal number of sessions as 15; however, the present study has demonstrated that fewer sessions can be beneficial when feedback is provided to therapists by the clients. Again, this is in contrast to studies by Reese et al. (2009) in which feedback was found to significantly improve treatment outcomes but in 7 to 9 sessions. The effectiveness of feedback in the fewer sessions of this study is a key finding in applicability to the military setting in which it is essential to return personnel to duty as soon as possible.

Therapists and commanders also rated participants in the feedback group as showing more treatment benefit than participants in the control group. Therapists rated 116 of 138 (84%) of the feedback group participants as showing “fair” or “good” treatment outcome compared to rating only 76 of 124 (61%) control group participants as having “fair” to “good” treatment outcomes. Because therapists were aware of participant assignment to feedback or control group response, bias may be a

confounding factor in their ratings. Biased ratings were less likely with commanders since they were blind to participant assignment to feedback or control conditions. Commanders were asked to rate whether their soldiers had completed treatment “satisfactory” or “unsatisfactory”. Commanders rated 113 of 138 (82%) of the participants in the feedback group as having “satisfactory” treatment outcome while only rating 64 of 125 (51%) control group participants as having a “satisfactory” treatment outcome.

Limitations

One of the primary limitations of this study was failure to assess whether different therapists differentially influenced participant treatment adherence and outcome. Absent treating therapist as another independent variable and assessing whether therapist had a main or interaction effect on outcome measures, we cannot be certain that the random assignment of participants to one of the 18 therapists involved in the study successfully controlled for therapist influence.

Because the primary measure of treatment outcome was the self-report instrument ORS, which does not include means to control for response sets like social desirability, we were not able to determine whether participants provided an inaccurate assessment of their levels of distress. Including other measures of treatment outcomes, particularly commander ratings, does allow us to have more confidence in the validity of the positive relationship found between feedback and treatment outcome.

Implications for Practice

The findings of this study document that limited feedback provided to therapists by clients of their perceptions of their treatment progress is effective in improving outcomes when compared to clients whose therapists did not receive the feedback. These findings have applicability to practice in that the feedback is provided in a small amount of time on a limited number of aspects of well-being, and over fewer sessions. Thus for clinics that have large patient loads and a need to facilitate short-term results, the method is ideal.

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Appendix A: Outcome Rating Scale (ORS)

ID# _____
Session # _____ Date: _____

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

Individually:
(Personal well-being)

I-----I

Interpersonally:
(Family, close relationships)

I-----I

Socially:
(Work, School, Friendships)

I-----I

Overall:
(General sense of well-being)

I-----I

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Appendix B: TRIAGE INSTRUMENT

For use of this form see AR 40-66; the proponent agency is OTSG

1. DATE: (YYYYMMDD)	2. NAME OF COMMANDER:
3. SEX:	4. UNIT TELEPHONE NUMBER:
5. YOUR REASON FOR COMING IN:	HAVE YOU HAD A COMBAT DEPLOYMENT? YES _____ NO _____ HOW HAVE YOU ADJUSTED FROM DEPLOYMENT? GOOD FAIR POOR IS YOUR PROBLEM TODAY RELATED TO DEPLOYMENT? YES _____ NO _____
6. DATE OF LAST ALCOHOL USE: (YYYYMMDD) HOW MUCH?	
7. DATE OF LAST DRUG USE: (specify drugs) (YYYYMMDD) HOW MUCH?	
8. ARE YOU CURRENTLY HAVING ANY DIFFICULTY WITH THE FOLLOWING? (check all those that apply, if they don't apply, please put N/A)	
a. BREATHING	e. DELUSIONS/HALLUCINATIONS
b. NAUSEA	f. SEIZURES
c. TREMORS	g. DEPRESSION
d. PAINS (please Specify):	h. OTHER (please Specify):
9. HAVE YOU EVER BEEN ENROLLED IN AN ALCOHOL OR OTHER DRUG PROGRAM? IF YES, PLEASE GIVE DATES ENROLLED AND A BRIEF SUMMARY OF WHY YOU WERE ENROLLED.	
10. WHAT ALCOHOLIC BEVERAGES OR OTHER DRUGS DO YOU PRESENTLY USE, to include Supplements (dietary/muscle building), Herbal and Over the Counter (OTC) Medicine?	
a. WHICH ONES ARE CAUSING YOU THE MOST PROBLEMS?	
b. HOW IS IT AFFECTING YOUR WORK?	
c. HOW IS IT AFFECTING YOUR FAMILY LIFE?	
d. HOW IS IT AFFECTING YOUR PERSONAL LIFE?	
e. DO YOU SMOKE? YES _____ NO _____ IF YES, HOW MUCH? _____ FOR HOW LONG? _____ f. DO YOU USE SMOKELESS TOBACCO? YES _____ NO _____ IF YES, HOW MUCH? _____ FOR HOW LONG? _____ g. DO YOU WANT ASSISTANCE IN STOPPING THE USE OF TOBACCO PRODUCTS? YES _____ NO _____	
PATIENT IDENTIFICATION (for typed or written entries five: Name – last, first, middle; grade; date; hospital or medical facility)	

FORM 8000, FEB 2003

EDITION OF NOV 1991 IS OBSOLETE

11. DO YOU PRESENTLY NEED TO CONTINUE DRINKING OR USING OTHER DRUGS SO YOU CAN AVOID HAVING THE SHAKES, DEPRESSION OR OTHER UNCOMFORTABLE FEELINGS?
12. DO YOU NEED TO DRINK OR TAKE OTHER DRUGS TO HELP YOU COPE? YES _____ NO _____ IF YES, PLEASE EXPLAIN:
13. a. ARE YOU CONTEMPLATING SUICIDE? YES _____ NO _____ IF YES, PLEASE EXPLAIN: b. HAVE YOU EVER CONTEMPLATED SUICIDE IN THE PAST? YES _____ NO _____ IF YES, PLEASE EXPLAIN:
14. ARE THERE ANY OTHER COMMENTS YOU WISH TO MAKE?
15. HAVE YOU EVER BEEN PHYSICALLY, EMOTIONALLY OR SEXUALLY ABUSED? YES _____ NO _____ IF YES, PLEASE EXPLAIN:
16. HAVE YOU EVER BEEN PHYSICALLY, EMOTIONALLY OR SEXUALLY ABUSIVE? YES _____ NO _____ IF YES, PLEASE EXPLAIN:
THIS SECTION FOR COUNSELOR USE ONLY
1. PATIENT STATUS (<i>Circle One</i>): Routine Acute
2. IMMEDIATE SERVICE PROVIDED:
3. DISPOSTITION:
4. COUNSELOR'S SIGNATURE:

DA FORM 8000, FEB 2003

Appendix C-1: Informed Consent - HIPAA

UNIVERSITY OF OKLAHOMA NORMAN CAMPUS INSTITUTIONAL REVIEW BOARD

AUTHORIZATION TO USE or DISCLOSE PROTECTED HEALTH INFORMATION FOR RESEARCH

*An additional Informed Consent Document for Research Participation
may also be required.*

Title of Research Project: **Measuring the Impact and Relevance of Feedback
on the Treatment Experience**

Principal Investigator: **Donald L. Schuman**

IRB Number:

Address: **Department of Substance Abuse Services (DSAS),
C. R. Darnall Army Medical Center, Ft. Hood, TX.**

Phone Number: **(254) 287-5246**

If you decide to join this research project, University of Oklahoma (OU) researchers may use or share (disclose) information about you that is considered to be protected health information for their research. Protected health information will be called private information in this Authorization.

Private Information To Be Used or Shared. Federal law requires that researchers get your permission (authorization) to use or share your private information. If you give permission, the researchers may use or share with the people identified in this Authorization any private information related to this research from your medical records and from any test results. Information, used or shared, may include all information relating to any tests, procedures, surveys, or interviews as outlined in the consent form, medical records and charts, name, address, telephone number, date of birth, race, and government-issued identification number.

Purposes for Using or Sharing Private Information. If you give permission, the researchers may use your private information to determine the effectiveness of feedback on treatment success or failure for clients enrolled into the Army Substance Abuse Program (ASAP).

Other Use and Sharing of Private Information. If you give permission, the researchers may also use your private information to develop new procedures or commercial products. They may share your private information with the

research sponsor, the OU Institutional Review Board, auditors and inspectors who check the research, and government agencies such as the Food and Drug Administration (FDA) and the Department of Health and Human Services (HHS). The researchers may also share your private information with the BAMC/WHMC Institutional Review Board.

Confidentiality. Although the researchers may report their findings in scientific journals or meetings, they will not identify you in their reports. The researchers will try to keep your information confidential, but confidentiality is not guaranteed. Any person or organization receiving the information based on this authorization could re-release the information to others and federal law would no longer protect it.

YOU MUST UNDERSTAND THAT YOUR PROTECTED HEALTH INFORMATION MAY INCLUDE INFORMATION REGARDING ANY CONDITIONS CONSIDERED AS A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

Voluntary Choice. The choice to give OU researchers permission to use or share your private information for their research is voluntary. It is completely up to you. No one can force you to give permission. However, you must give permission for OU researchers to use or share your private health information if you want to participate in the research and if you revoke your authorization, you can no longer participate in this study.

Refusing to give permission will not affect your ability to get routine treatment or health care from OU.

Revoking Permission. If you give the OU researchers permission to use or share your private information, you have a right to revoke your permission whenever you want. However, revoking your permission will not apply to information that the researchers have already used, relied on, or shared.

End of Permission. Unless you revoke it, permission for OU researchers to use or share your private information for their research will expire one year from the date of the end of the study. You may revoke your permission at any time by writing to:

Privacy Official
University of Oklahoma
1000 Stanton L. Young Blvd., STE 221, Oklahoma City, OK 73117
If you have questions call: (405) 271-2511

Giving Permission. By signing this form, you give OU and OU's researchers led by Donald L. Schuman, permission to share your private information for the research project called Measuring the Impact and Relevance of Feedback on the Treatment Experience.

Subject Name:

Signature of Subject
or Parent if Subject is a child

Date

Or

Signature of Legal Representative**

Date

**If signed by a Legal Representative of the Subject, provide a description of the relationship to the Subject and the Authority to Act as Legal Representative:

OU may ask you to produce evidence of your relationship.

A signed copy of this form must be given to the Subject or the Legal Representative at the time this signed form is provided to the researcher or his representative.

Appendix C-2: Informed Consent - OU

FEEDBACK STUDY

INFORMED CONSENT-CLIENT

Description of the Study

I have been invited to participate in this research project designed to measure feedback.

I understand that I must meet the following criteria to participate in this study:

- I must be between the ages of 18 and 59
- I must be receiving substance abuse services from the Ft. Hood Substance Abuse Rehabilitation Department
- I must volunteer for the study

If I choose to participate in this study, I agree to fill out a short survey prior to each of my weekly group counseling sessions. This should take less than 1 minute. If I discontinue therapy for any reason, information I have provided on the surveys up to that point may be used for the research. Before I sign this consent, I will have the opportunity to speak with a research assistant and have all of my questions answered.

Costs and payments to the Participant

There are no costs or payments associated with this study.

Risks/Benefits to Participants

I understand that there are minimal risks associated with this study. If I experience any discomfort from answering any of the questions, I will discuss this with the therapist giving me the survey or my primary therapist.

Confidentiality

I understand that any information I provide in regard to this study will be kept confidential and will not be reported in any way that personally identifies me. Records will reference my identity only by using an alpha/numeric identity code. I understand that all written records will be maintained in a locked file drawer.

Participants Right to Withdraw from the Study

I understand that I may refuse to participate in this study, and I may choose to discontinue participation in this study at any time. If I refuse to participate, or choose to stop my participation, I will neither be penalized in any way, nor will this affect my right to continue therapy in any way. Should I choose to withdraw, all

data collected from me up to that point may be used, but no further study data will be collected.

Voluntary Consent by Participant

I have read the preceding consent form, and I fully understand the contents of this document and voluntarily consent to participate. I understand that consent ends at the conclusion of the study. All of my questions concerning the research have been answered. I hereby agree to participate in this research study.

Printed Participant's
Name

Signature

Date

Printed Witness' Name

Signature

Date

Appendix C-3: Informed Consent - BAMC

BROOKE ARMY MEDICAL CENTER INFORMED CONSENT DOCUMENT—CLIENT (ICD Template Version 4, Jul 02)

Measuring the Impact and Relevance of Feedback on the Treatment Experience.

PRINCIPAL INVESTIGATOR

Donald L. Schuman, LCSW, LCDR, Chief, Department of Substances Abuse Services, Carl R. Darnall Army Medical Center, Fort hood, Texas, 76544

If you choose not to participate in this research study, your decision will not affect your eligibility for care or any other benefits to which you are entitled.

DESCRIPTION/PURPOSE OF RESEARCH

You are being asked to consider participation in this research study. The purpose of this study is to assess the effectiveness of feedback during treatment.

This study could enroll up to 240 subjects from the Department of Substance Abuse Services, Carl R. Darnall Army Medical Center, Fort Hood, Texas, over a period of approximately nine months to ensure 180 participants complete the study.

During your participation in this study, you will be asked to make approximately 8-10 outpatient visits with your primary treatment counselor/group. These visits are part of your standard clinical care and not associated with the research. It will be necessary for you to return to this clinic every week for these sessions. The intent of this study is not to change normal treatment protocol, and only asks you to provide survey information prior to your treatment visits. Information from your survey may or may not be provided to your counselor (depending on which study plan you are in). The object of this study is to evaluate the outcome of your treatment.

You have been selected to participate in this study because you have been identified to be at possible risk of having a substance use problem, and you may meet criteria for a substance use disorder.

PROCEDURES

You will undergo the following procedures: If you consent to participate in the study, you will be asked to complete a simple four-question survey on a computer prior to each of your weekly group sessions. It is expected that you will be able to complete this survey in a minute or less.

You will be randomly assigned to one of 2 study plans. Randomization is a process like flipping a coin and means you will have a chance of being assigned to either of the

plans. Regardless of the plan to which you are assigned, you will complete the same survey. The difference is that your feedback may or may not be actively used during your treatment. However, at the completion of the study, all feedback will be used in the data analysis to compare the treatment response of participants in both study plans.

RISKS OR DISCOMFORTS

It is not anticipated that you will experience any discomfort by completing the computer survey. The questions on the survey are neither intrusive nor invasive. In the unlikely event that you experience discomfort, a research assistant (who is also a licensed counselor) will be with you while you complete the survey. When you have finished completing the survey, you will go directly to your group room where your group therapist will be available.

BENEFITS

There is no guarantee you will receive any benefit from this study other than knowing that the information gained from this study may help future clients.

PAYMENT (COMPENSATION)

You will not receive any compensation (payment) for participating in this study.

ALTERNATIVES TO PARTICIPATION

The alternative to participating in this study is not to participate. Participation in this study is completely voluntary and has no impact on your eligibility for substance abuse counseling. The full range of services this clinic offers will continue to be available to you whether or not you participate in this study. You have the right to choose not to participate in this study or discontinue your participation at any time.

CONFIDENTIALITY OF RECORDS OF STUDY PARTICIPATION

Records of your participation in this study may only be disclosed in accordance with federal law, including the Federal Privacy Act, 5 U.S.C.552a, and its implementing regulations. DD Form 2005, Privacy Act Statement - Military Health Records, contains the Privacy Act Statement for the records.

By signing this consent document, you give your permission for information gained from your participation in this study to be published in medical literature, discussed

for educational purposes, and used generally to further medical science. You will not be personally identified; all information will be presented as anonymous data.

Your records may be reviewed by the U.S. Food & Drug Administration (FDA), other U.S. government agencies, and the Brooke Army Medical Center (BAMC), or University of Oklahoma Institutional Review Boards.

Complete confidentiality cannot be promised, particularly for military personnel, because information regarding your health may be required to be reported to appropriate medical or command authorities.

ENTITLEMENT TO CARE

In the event of injury resulting from this study, the extent of medical care provided is limited and will be within the scope authorized for Department of Defense (DoD) health care beneficiaries.

Your entitlement to medical and dental care and/or compensation in the event of injury is governed by federal laws and regulations, and if you have questions about your rights as a research subject or if you believe you have received a research-related injury, you may contact the Carl R. Darnall Army Medical Center, Lawyer/Judge Advocate, (254) 286-7339 or Brooke Army Medical Center Protocol Coordinators, (210) 916-2598 or Brooke Army Medical Center Judge Advocate General, (210) 916-2031, or the University of Oklahoma – Norman Campus Institutional Review Board (OU-NC IRB) at (405) 325-8110.

The University of Oklahoma is listed above because the investigator is a PhD candidate with the school and is required to seek approval through and allow access of information to its Institutional Review Board (IRB).

VOLUNTARY PARTICIPATION

The decision to participate in this study is completely voluntary on your part. No one has coerced or intimidated you into participating in this project. You are participating because you want to. The Principal Investigator or one of his associates has adequately answered any and all questions you have about this study, your participation, and the procedures involved. If significant new findings develop during the course of this study that may relate to your decision to continue participation, you will be informed.

You may withdraw this consent at any time and discontinue further participation in this study without affecting your eligibility for care or any other benefits to which you are entitled. Should you choose to withdraw, you must notify in writing the principal investigator, or the research assistant who gives you the survey each week prior to your group session. It is important to understand that you are only withdrawing from participation in the study. You are not withdrawing from treatment. To withdraw from treatment you must speak with your primary counselor.

The principal investigator may terminate your participation in this study at any time if he feels this to be in your best interest in terms of your treatment.

CONTACT INFORMATION

Principal Investigator (PI)

The Principal Investigator or a Research Assistant will be available to answer any questions you may have concerning procedures throughout this study. The Principal Investigator for this study is Donald L. Schuman. He can be contacted at (254) 287-2892 or donald.schuman@us.army.mil. You are encouraged to contact the researcher if you have any questions.

If you have any questions about your rights as a research participant, you may contact the Carl R. Darnall Army Medical Center, Lawyer/Judge Advocate, (254) 286-7339, the Brooke Army Medical Center (BAMC) Protocol Coordinators, (210) 916-2598 or the Brooke Army Medical Center Judge Advocate General, (210) 916-2031. In addition, you may contact the University of Oklahoma – Norman Campus Institutional Review Board (OU-NC IRB) at (405) 325-8110 or irb@ou.edu.

Your consent to participate in this study is given on a voluntary basis. All oral and written information and discussions about this study have been in English, a language in which you are fluent.

You will be given a copy of this information to keep for your records. If you are not given a copy of this consent form, please request one.

Voluntary Consent by Participant

I have read the preceding consent form, and I fully understand the contents of this document and voluntarily consent to participate. I understand that consent ends at the conclusion of the study. All of my questions concerning the research have been answered. I hereby agree to participate in this research study.

_____ Printed Participant's Name	_____ Signature	_____ Date
_____ Printed Witness' Name	_____ Signature	_____ Date