

*Article 23*

**Client-Based Assessment:  
A Fast Track to Better Outcomes**

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*Shouldn't I be telling you what I think?* — Molly, 10-year-old client

In a classic article from the business literature, Levitt (1975) described how various industries, from railroads to Hollywood, suffered dramatic reversals in fortune when they became product-oriented versus customer-oriented. For example, movie moguls were caught totally off guard by the television industry because they wrongly saw themselves in the movie rather than entertainment business. Movie executive Darryl Zanuck boldly claimed that television would never last beyond six months because people would quickly tire of staring at a tiny box every night (Lee, 2000). This arrogant lack of foresight eventually forced the closure of once powerful studios and bankrupted numerous high rollers in the movie trade.

As counselors, we can fall into a similar trap of acting as if we are in the counseling business rather than the business of change. The field's focus on the means of producing change (i.e., models and techniques), rather than the client's actual experience of change, has been and continues to be on the wrong track. This article urges counselors to avoid the fate of a product orientation by using client-based assessment to guide the counseling process. After a quick review of research, two practical tools are described and illustrated.

The goal is to provide enough information for you to immediately apply these tools in your own practice.

### **The Role of Clients, Alliance, and Feedback**

Successful counseling results largely from two “common factors” that operate regardless of the practitioner’s theoretical orientation—the client and the client-counselor relationship. After reviewing hundreds of studies, Asay and Lambert (1999) concluded that client factors, which include the client’s strengths, resources, and opinions, account for 40% of the positive change that occurs in counseling. The client-counselor relationship, or “alliance,” is the second most important ingredient, accounting for 30% of the change. Alliance refers to the client’s experience of respect, collaboration, and validation from the practitioner. In short, client involvement appears to be the centerpiece of good counseling.

Research also shows that: (a) clients and practitioners often differ when it comes to evaluating the effectiveness of treatment (Greenberg, Bornstein, Greenberg, & Fisher, 1992); (b) clients are more accurate in predicting outcomes than practitioners (Bachelor & Horvath, 1999); and (c) the client’s early experience of change and alliance are strong predictors of outcomes (Haas, Hill, Lambert, & Morrell, 2002). These findings urge us to: (a) assess clients’ perceptions of change (outcome) and adjust services accordingly; and (b) assess clients’ perceptions of us and our services (alliance) and make related adjustments.

Client-based assessment promotes consumer-driven practice, and legitimizes our services to clients, supervisors, regulatory agencies, and insurance companies. In discussing culturally competent practice, Ridley (2005) recommends collaborating with minority clients who “often enter counseling feeling powerless” and “gain a sense of empowerment and ownership of the counseling process when they participate” (p. 107). Tailoring counseling goals and services to clients, instead of imposing our preferred goals and methods, is a consistent theme in the multicultural literature (Sue & Sue, 2008). Obtaining feedback and adjusting services accordingly

are part and parcel to client-based assessment and culturally competent practice. The remainder of the article describes two practical tools for obtaining outcome and alliance feedback during every counseling session.

### **Monitoring Outcome and Alliance: The Outcome and Session Rating Scales**

Obtaining formal client feedback on outcome and alliance can as much as double a counselor's effectiveness (Lambert et al., 2003). Although several feedback measures have appeared in the literature, most are designed for research and are too time-consuming for everyday use. The need for quick, practical measures led to the development of the Outcome Rating Scale (ORS; Miller & Duncan, 2001) and Session Rating Scale (SRS; Johnson, Miller, & Duncan, 2000). These tools assess research-identified elements of outcome and alliance from the client's perspective and, in most situations, can be administered in about one minute. Both scales use a visual analog format of four 10-centimeter lines, with instructions to place a mark on each line with low estimates to the left and high estimates to the right. The four 10-cm lines add to a total score of 40.

The ORS is administered at the beginning of, or just before, every session to assess the client's perception of: (1) individual (personal) well-being; (2) interpersonal well-being (family, intimate relationships); (3) social satisfaction with work, school, and peers; and (4) overall well-being—all valid indicators of successful outcomes (Lambert et al., 1996). The total score is the sum of the client's four marks to the nearest millimeter measured by a centimeter ruler or 10-cm template. Forty is the highest possible score, and scores in the 20's or below indicate significant distress.

The SRS is completed at the end of the session to assess alliance. It obtains client feedback on the counselor and session in regard to: (a) relationship and respect; (b) goals and topics; (c) approach or method; and (d) overall effectiveness—key aspects of an effective alliance (Bachelor & Horvath, 1999). As with the ORS, the SRS is scored by adding all four lines (0-34 = poor alliance;

35-38 = fair; 39-40 = strong). The main purpose of the SRS is to detect and correct emerging alliance problems. Low scores should be welcomed and discussed in a candid, non-defensive way with clients.

The Child-ORS (CORS; Duncan, Miller, & Sparks, 2003) and Child-SRS (CSRS; Duncan, Miller, Sparks, & Johnson, 2003) are designed for children 12 and under, and use simpler language and smile/frown faces to assess the same general areas as the ORS and SRS. When caregivers such as parents and teachers are involved, they should complete the same outcome scale given to the child. For example, if the child completes the CORS, then the parent, teacher, and other involved adults would also complete the CORS. This allows for comparison and exploration of similarities and differences among people's ratings. All versions of the ORS and SRS are free for individual use and may be downloaded from the Institute for the Study of Therapeutic Change at <http://www.talkingcure.com>.

The ORS and SRS have demonstrated adequate reliability and validity, and have resulted in higher success rates in several counseling settings (Duncan, Miller, & Sparks, 2004). In addition to alerting counselors to the type of relationship the client wants, the SRS provides immediate feedback that allows us to follow up and address alliance problems right when they occur. For example, when a client rates an SRS item 9 or below, we can follow-up by asking for clarification and direction (e.g., "What can I do differently to make things better next time?"). The ORS may prompt similarly useful discussions (e.g., "Based on your ratings, it looks like things haven't changed much over the past week. How willing are you to try something really different to make things better?"). These measures can be used in conjunction with other methods of evaluating services, such as emotional and behavioral inventories, checklists, interviews, and observations (Murphy, 2008). In addition to ensuring for responsive services and valid indicators of counselor and counseling effectiveness, client-based assessment enhances client involvement and strengthens the all-important alliance.

## **Putting the ORS and SRS into Action**

This section uses sample scripts to illustrate the ORS and SRS with various clients and counseling scenarios. It is important to explain the measures in plain language versus technical jargon, and to make them a relaxed and routine part of the helping process.

### ***Introducing the ORS at the First Meeting***

*General introduction.* As I mentioned when we spoke on the phone last week, I will be asking you to complete two forms about how you think things are going out there and in our meetings. To make the most of our time together and get the best outcome, we need to make sure we're on the same page about how you are doing and how our meetings are working. Your answers will help us stay on track. Will that be ok with you?

*Introduction to a child.* Here is that paper with the smiley and frowny faces that I was talking about earlier. This form tells me how you're doing and it only takes about a minute. Can you give it a try?

### ***Discussing ORS Results***

*General discussion.* From your ORS, it looks like you're experiencing some real problems. Or: Your total score is 15. Things must be pretty tough for you. What's going on? Or: From your score, it looks like you're doing okay. Why do you think you were referred for counseling?

*Discussion with parent.* Your ratings tell me you're quite concerned about your daughter, especially about her personal well-being and school. Does this make sense with what you are thinking? Or: Your rating on the CORS is 34, which indicates that you see her doing pretty well overall, but that you have some concerns with her school performance or behavior. Is that accurate?

In many cases, counselors will need to help clients connect their experience with their ORS marks, and consider what needs to happen to make things better.

*General discussion.* I need your help to understand what this mark (pointing to a mark on one of the ORS scales) means in your

life. Does the stress from missing your father explain your mark on the Individual (or other) scale? What needs to happen for that mark to move just a little bit to the right?

*Discussion with child's teacher.* It sounds like talking out in class and talking back to you when you correct him are your biggest concerns about William. Are those the things that explain your mark of 2.4 on the School scale? Is there anything else that accounts for your mark on the School scale? What would need to happen for your mark to move one or two centimeters to the right?

### ***Introducing the SRS at the First Meeting***

*Introduction to an adult.* Let's take a minute here and fill out a form that asks your opinion about our work together. It's like taking the temperature of our meeting today. Your feedback will help me stay on track and be useful to you. Will you help me by filling out the form?

*Introduction to a child.* Before we wrap up, I want to ask you to fill out another form that has faces on it. This one deals with how you think I am doing. That's right—you get to grade me! Can you help me out with this?

### ***Discussing SRS Results***

When SRS results are uniformly high (9 or above in each category), the practitioner can simply acknowledge this and invite any other comments or suggestions from the client. Since people tend to rate alliance measures highly, the practitioner should address any hint of a problem on the SRS. Anything less than a total score of 36 (or under 9 in any area) may signal a concern and warrant discussion.

*High SRS score discussion.* Okay, these marks are way over here to the right, which suggests that we're on the same page, that we are talking about things that are important to you, and that today's meeting was right for you. Please let me know if I get off track at any point during our work together, okay?

*Low SRS score discussion.* Let me see how you think we are doing. Okay, seems like I am missing the boat somewhere here. Thanks for being honest and giving me a chance to change things to make it work better for you. Was there something else I should have

asked about or done to make this meeting better for you? What was missing here?

The counselor's non-defensive acceptance of alliance problems, and willingness to make adjustments, speak volumes to the client and usually turn things around quickly. The best practitioners are those who elicit and candidly discuss alliance problems when warranted. The SRS provides a practical and systematic way to address alliance problems right when they occur instead of waiting until things reach the point of no return—when the client shuts down or drops out.

### ***Later Meetings***

Each meeting compares the current ORS with previous ratings. ORS scores serve as discussion prompts to engage clients in discussing their progress and future plans. When scores increase even just a little, practitioners should give clients credit for the change and explore their role in it, as well as using other methods to empower progress.

*General ORS progress discussion.* Wow, your marks on the personal well-being and overall lines really moved—about 4 cm to the right each! Your total increased by 8 points. That's quite a jump! How did you do it?

*General ORS progress discussion with parent.* Okay, your rating of Maria improved to a 24, which is 4 points higher than it was at our last meeting. What have you done differently to make things better with Maria? Did you learn anything new about yourself or Maria during this? Where do you think we should go from here?

When scores take a big dive, or lower scores remain unchanged, we need to discuss what to do differently in order to improve the situation.

*General slow or no progress discussion.* Okay, so things haven't changed since the last time we talked. What do you make of that? Should we be doing something different here, or should we just hang in there and see if things change next week?

When ORS or SRS ratings remain low across two or more consecutive counseling sessions, we can initiate a discussion along the following lines:

*General discussion of consecutively low ORS scores.* These scores suggest that we need to try something pretty different to make things better. What could you do that might be different enough to make a difference?

*General discussion of consecutively low SRS scores.* These scores haven't changed for the past three weeks. If our meetings aren't helping, I wonder what we can do to shake things up and try something different, even if that means switching to another counselor who might be more effective with you. What do you think?

Establishing a culture of feedback begins with the counselor's respect for the client's input, and willingness to allow client feedback to guide the helping process. The practitioner's ongoing interest in client feedback speaks volumes about his or her commitment to the client and the quality of service. As illustrated in the scenarios above, client-based assessment puts clients in the driver's seat and ensures for responsive, accountable services. Refer to Duncan et al. (2004), and Murphy and Duncan (2007), for additional examples and information on using the ORS and SRS with adults and children.

## **Conclusions**

Integrating client-based assessment into everyday practice has doubled the effectiveness of counselors in some settings (Lambert et al., 2003). The fact that these measures can be completed in one minute makes them very practical for busy counselors who want to evaluate their services. In contrast to squeezing clients into one-size-fits-all approaches, client-based assessment encourages us to conduct counseling "one client at a time," adjusting our approach on an ongoing basis in response to client feedback. I urge you to put clients first by incorporating client-based assessment into your everyday practice.

## References

- Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, S. D. Miller, & B. L. Duncan, (Eds.), *The heart and soul of change: What works in therapy* (pp. 33-55). Washington, DC: American Psychological Association.
- Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B. L. Duncan, & S. D. Miller, (Eds.), *The heart and soul of change: What works in therapy* (pp. 133-178). Washington, DC: American Psychological Association.
- Duncan, B., Miller, S., & Sparks, J. (2003). *Child outcome rating scale*. Chicago: Authors. Retrieved January 31, 2007, from <http://www.talkingcure.com/>
- Duncan, B., Miller, S., & Sparks, J. (2004). *The heroic client*. San Francisco: Jossey-Bass.
- Duncan, B., Miller, S., Sparks, J., & Johnson, L. (2003). *Child session rating scale*. Ft. Lauderdale, FL: Authors. Retrieved January 31, 2007, from <http://www.talkingcure.com/>
- Greenberg, R. P., Bornstein, R. F., Greenberg, M. D., & Fisher, S. (1992). A meta-analysis of antidepressant outcome under “blinder” conditions. *Journal of Consulting and Clinical Psychology, 60*, 664-669.
- Haas, E., Hill, R. D., Lambert, M. J., & Morrell, B. (2002). Do early responders to psychotherapy maintain treatment gains? *Journal of Clinical Psychology, 58*, 1157-1172.
- Johnson, L. D., Miller, S. D., & Duncan, B. L. (2000). *Session rating scale 3.0*. Chicago: Authors. Retrieved January 31, 2007, from <http://www.talkingcure.com/>
- Lambert, M. J., Burlingame, G. M., Umphress, V., Hansen, N. B., Vermeersch, D. A., Clouse, G. C., & Yanchar, S. C. (1996). The reliability and validity of the Outcome Questionnaire. *Clinical Psychology and Psychotherapy, 3*, 249-258.

- Lambert, M. J., Whipple, J. L., Hawkins, E. J., Vermeersch, D. A., Nielsen, S. L., & Smart, D. W. (2003). Is it time for clinicians routinely to track patient outcome? A meta-analysis. *Clinical Psychology, 10*, 288-301.
- Lee, L. (2000). *Bad predictions*. Rochester, MI: Elsewhere Press.
- Levitt, T. (1975, September—October). Marketing myopia. *Harvard Business Review*, 19-31.
- Miller, S., & Duncan, B. (2001). *Outcome rating scale*. Chicago: Authors. Retrieved January 31, 2007, from <http://www.talkingcure.com/>
- Murphy, J. J. (2008). *Solution-focused counseling in schools* (2<sup>nd</sup> ed.). Alexandria, VA: American Counseling Association.
- Murphy, J. J., & Duncan, B. L. (2007). *Brief intervention for school problems: Outcome-informed strategies* (2<sup>nd</sup> ed.). New York: Guilford Press.
- Ridley, C. R. (2005). *Overcoming unintentional racism in counseling and therapy: A practitioner's guide to intentional intervention* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage.
- Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse: Theory and practice* (5th ed.). New York: Wiley.