The Session Rating Scale Manual: 
A Practical Approach to Improving Psychotherapy 
Lynn D. Johnson, Ph.D.
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Introduction

The Session Rating Scale is a tool for tracking the client’s perception of the therapeutic relationship. Generally the patient's rating of alliance is strongly correlated with outcome, so we have developed this scale as a means of tracking that. I acknowledge the help of Dr. Robert Finley in understanding alliance issues, Richard Ebling, LCSW for pragmatic suggestions during the development, Lonny Stanford, M.S., for his analysis of the items in the SRS, and Dr. Scott Miller for suggestions on the revised version. The SRS is also referred to as the SRF (Session Rating Form) and both terms apply to the same instrument. It is useful to note that Dr. Miller has developed his own alliance measure, the Session Evaluation Questionnaire, or SEQ.

The original version of the SRS appeared in my book, Psychotherapy in the age of accountability, published 1995 by Norton Professional Books. Please consult it for more information on the original development of the SRS.

Research on Alliance

Generally the patient's own rating of the alliance is a better predictor of how the therapy will end than the therapist's ratings. Most research looks at the patient's experience at the third session. Since many of the rating methods are quite long and complicated, it is understandable that researchers would tend to measure alliance once, such as at the third session. Our view has been that progress and alliance should be measured at every session. I developed the SRS to give a quick assessment of alliance that could be used every session.

Bordin (1979) conceptualized three components to the alliance: the bond between the client and the therapist, and degree to which the client and the therapist agrees on goals to be pursued, and the agreement on the types of tasks that are appropriate. When I developed the SRS, I focused on bond with the first four items, and used items 5 and 6 to track agreement on goals and tasks.

Orlinsky and Howard demonstrated that in a majority of studies (60%), the alliance measures predict the eventual outcome in treating depressed clients. When we combine this information with the reviews by Lambert and colleagues (Lambert, Shapiro & Bergin, 1986) we begin to see that the skill of creating a good therapeutic alliance is most vital to create positive outcomes. As my colleagues and I have noted elsewhere (Miller, Duncan, Hubble & Johnson, 2000), we often see therapists who are technically skilled but unable to help; conversely we encounter therapists who are earnest but unskilled who have very strong therapeutic effects. Lambert's reviews suggest just that effect: around 15% of the therapeutic effect is due to technical skills, but 30% or more is the result of a positive alliance. Others suggest that number may be as high as 50% of the therapeutic effect.

Using the SRS

Why do we ask our patients to fill out the Session Rating Scale (SRS)? There are a number of advantages. Of course, there are always dangers and reasons to not use it. We have found the advantages outweigh the disadvantages.

First, global or common factors in psychotherapy actually seem to contribute more to the total outcome than do specific factors. David Burns once said that the best clinician in his clinic was not highly skilled in cognitive-behavioral therapy, but she had tremendous talent at connecting with patients. The SRS gives you a tool to see how you are doing at common factors.

Second, a particular client may take exception to a part of the session yet not say anything about it. Even though you may be a very skilled therapist, you may inadvertently step on toes. The SRS gives you a way to check for that, and offers an opportunity to fix it. Therapists have high confidence in their ability to detect such reactions, but our experience is that confidence is misplaced. Third, the SRS invites our clients into a partnership, emphasizing that their own perceptions are valued and important. Because we ask, they know we care. The process
of measuring and tracking alliance actually helps us improve our alliance. After all, we have long known that what we measure we tend to get more of.

**Dangers of using the Session Rating Form**

We have not found any particular dangers, but some clinicians have suggested some, and a respect for their opinions requires we mention those here.

- Some forms of psychotherapy depend on mobilizing anxiety or confronting the client. In those cases, the alliance may be strained for some time. Since we view anxiety caused by therapist confrontation as an impediment to therapeutic progress, that does not apply to our own work, but it certainly can apply to some forms.

- Some therapists object to the content of the first four items, those measuring the emotional connection between the therapist and the client. There is often an objection to item 2, "My therapist liked me." We will get objections to this item because some therapists feel a preference to keep some emotional distance.

- An occasional objection is that using this type of form makes the therapist rely on the scale rather than using his / her intuition or connection with the patient. The notion seems to be that alliance is a mysterious or ineffable process and measuring it will harm or destroy it. Obviously, we think alliance is measurable.

- Therapists sometimes wonder whether the client will object to the form, and they are hesitant to try it out of caution that such objections may complicate therapy. One client in several hundred will refuse to fill out the form, and if a therapist is easily traumatized then a general antagonism toward such rating scales will remain.

- Therapists who have patients fill out the SRS on the first session may be dismayed to see that the patient rates the session in the low range. This may be offensive to therapists who naturally feel that they have done their best. In reality, low scores on the first session may mean a lot of things, including low self-esteem on the part of the patient. Thus when asked to rate whether the therapist seems to like the patient, the patient may respond with a >1 rating, and when asked may say, "I don't think anybody likes me." Thus the alert therapist may use low ratings to further therapy; the defensive therapist may abandon the instrument.

**Administration**

The way you use the SRS is very straightforward. At the end of the session, hand the SRS to the client. Ask: "Would you help me be more helpful to you? Please fill out this form. Be very frank and honest, so I can get the best picture of our session. Leave the form with the receptionist, and make your appointment for our next visit."

The client fills out the form and leaves. You should look at the forms at the end of the day, before you put away the day’s files. Slip the SRS into the file, and make some mention of it in the next session. Ask the patient to elaborate on how you could do better. By mentioning results, you show the client that you are involved and interested.

An exception to this procedure is if there is a 0 on any item, and possibly if there is a 1. In this case, perhaps it would be wise to call right away and see if the client needs something different than what you offered.

**Rationale**

The SRS was designed to be very simple and easy. It is transparent. None of the items is reverse scored. None is subtle. If a client does not want to share this information, or wants to offer a false picture, it is easy to do that.

At the same time, because it is simple, it only takes a moment to assess. You can see at a glance where the strengths and the weaknesses of a session were. So when you first get the SRS back, just scan it. Look for your high points. What did you do right? What would the client say you did right?

Look at the low scores. If the next session is better on those low scores, what do you suspect you will do differently?

Would you be willing to discuss the SRS with the client in the next session? What do you suspect you might learn if you took a bit of time to discuss these factors in the next session?

**Subscales**

There are four rationally derived subscales. What I mean by *rationally derived* is that they seem to go together from my point of view. The studies we have done so far suggests that the whole score is more important than individual scales. But I like to look at the subscales, and I will explain here how to do that.
First, look at the total score. You should be in the neighborhood of 27 or greater. In supervision with students, we found that scores in the area of 26, 25, or less were indicators of some problems in the session. Adolescents often give lower scores than adults; seriously depressed clients will also give lower scores. Common factor items are items one through four. They measure the factors that seem to go with the necessary conditions for change. If you convey acceptance, liking, understanding, and are seen as honest and sincere, you will generally have a better outcome. Do you have any scores of 2 or 1 or even 0 on these four? What would happen in the next session for the client to rate you as clearly higher?

This is perhaps the most productive area of the SRS. We often find depressed clients rating this area low and when questioned, they reply they cannot believe that anyone could like them! Of course, this leads to some useful dialog and offers a therapeutic focus.

Agreement items are items 5 and 6. High scores on these items seem to say to the counselor that “You respect me, I feel valued and safe with you, I am willing to open up further with you.” Clinicians who are quite expert at framing client concerns as problems that the clinician can address generally get high ratings here. For example, if you see David Burns, he will frame whatever problem you have as an issue of changing self-talk. And he will do that so skillfully that you find yourself feeling that he genuinely agrees with your own ideas and thoughts. Again, 2 or less suggests some thoughtfulness about the next session.

Smoothness / depth are addressed in items 7 and 8. Some clients prefer depth and will accept a rough session, some require smoothness and will accept a shallow session. Client feedback is vital in these two items. I have asked patients about a >2 score on Depth of the Session, and they reply in essence that while I am a shallow therapist, I am getting things done, so they are happy with that!

Our studies find these two items have the lowest correlation with outcome, but that may be idiosyncratic with our approach. You should do your own studies on the instrument and please share what you learn. Email me at DrJ@DrLynnJohnson.com

Agreement on treatment / pace of the session

Since items 7 and 8 had low correlations with outcome, Dr. Scott Miller and I have created two substitute items for the second version. Item Seven is Agreement on treatment and is based on Dr. Miller's research of the power of client-directed therapy. Item Eight is Pace of the session. Again, we are seeking studies in other clinics and settings and welcome validation studies.

Global items of hope: The last two items asks for ratings on how helpful the session was and how hopeful the client feels now. Clinically I find these two items to be the most helpful. I have occasionally gotten good ratings on the first four items but low on helpfulness or hope and find that this is a real danger signal.

Critical items: Any time you see a 0, 1, or 2, you should investigate that rating. If you see either one or zero, I suggest you call right away. My view is that the client is always right, even if the client is wrong. So you do not have to take what the client says personally, but you should take it seriously. You may have done a technically excellent job of the session, and the client may give a low rating based on some idiosyncratic misunderstanding. Nevertheless, the client is right, and as you move quickly and confidently to resolve the problem, you will see gratifying progress.

Signs of progress: You should see an improvement in the SRS by the third session. It is not unusual to see low scores at first and higher ones thereafter. If not, there may be problems you must address.

Psychometric properties of the SRS

The SRS was examined with 39 patients in a brief psychotherapy clinic in the western United States(Stanford, 1999). Twenty-six patients were seen by a Ph.D. psychologist, and 13 were seen by a graduate student intern. Analyzing the data set involved the estimation of reliability for the SR. Cronbach's alpha reliability coefficients were utilized to determine the SR's internal consistency. Inter-item correlations were calculated to provide evidence for the existence of subscales for the SR.

Item analysis of the SR provided a Cronbach's alpha reliability coefficient of .89. The first six items measuring therapeutic alliance also returned a high alpha of .86, while items 7, 9, and 10, measuring session impact, provided an alpha of .75. The analysis of data continued based on these acceptable reliability statistics of the SR. Inter-item correlations ranged from .43 to .73 for the first six items of the SR purported to measure therapeutic alliance. Depth of session was considered as a factor separate from session impact. This consideration
was promoted by observations that some depth of session scores remained low while other session impact subscale items were being rated much higher. Inter-item correlational analysis seems to support using depth of session as a factor separate from session impact. Depth of session had a moderately significant correlation with the other items (items 7, 9, and 10) of the SR purporting to measure session impact (item 8: r = .36, p < .01). These other items measuring session impact had slightly higher correlations (item 7: r = .41, item 9: r = .60, item 10: r = .59, p < .01). Inter-item correlations also revealed less association for depth of session with other SR items, when compared with other correlations.

**Comment on the research**

It may well be that my patients rate me low in depth but high in positive impact because of the here-and-now focus of my psychotherapy (Johnson, 1995). I don't ask questions that clients would view as "deep" but still get good results. If your work is focused on “deep” issues, then you should probably use the original version.

To the contrary, if you are more behavioral, solution-focused, or cognitive in your approach, I suggest the revised version is more appropriate for you.

**SRS in Supervision**

Students are naturally fearful and insecure. They are new to the skills and they are unsure about their abilities. So they will be hesitant to use and discuss the SRS. If I set an example by letting students observe my work through the mirror, by using the SRS myself and discussing imperfect scores with the student, they soon realize this is an excellent way to improve their learning about their own abilities.

Help the student to focus on the highest ratings, not the lowest. Attend to what the student does right in the session. Often when the student does *more of what works* the ratings will come up very nicely.

With low ratings, discuss small steps forward. If the client thought you had been slightly more in agreement on goals or tasks, what do you suspect you will do to achieve that? What would help you do just a bit better in conveying liking or trustworthiness?

As an appendix to this manual, I have included a handout on alliance that I have used in brief therapy workshops. You may reproduce it for supervising students.

**Combining SRS with outcome measures**

Often outcomes are assessed by expert ratings, such as the Hamilton with depressed patients. A rater looks at progress notes or views videos of sessions. Such a measure is useless for clinical work. Or sometimes Managed Care asks clinicians to rate the progress of the patient. Such ratings are scientifically useless. There are two types of outcome measures that are practical for clinical work. Both use patient ratings, not therapist ratings. *Objective rating tools*

First, use a simple, objective outcome measure. I recommend the OQ-45. I have used it for several years, find it reliable and valid enough for individual assessment. You can obtain the OQ-45 by calling 1-888-647-2673, or by E-mail at apcs@erols.com. This is a very inexpensive instrument; a solo clinician can obtain the OQ-45 license for approximately $75 (in 2015). It is truly an astonishing bargain and the OQ-45 has been used in published research, both by me and by many other clinicians and researchers.

But any outcome measure of 20-50 items should be helpful. I also recommend the Beck Depression Inventory, or the CES-D. The CES-D is in public domain, anyone can use it. The Beck and the CES-D are very similar and have the same significance scores, namely that for a person to be recovered from depression, the score should be ≤10. There are also some find anxiety checklists of around 20 items that can be useful.

The Brief Symptom Rating Scale is also well researched and has good reliability and validity and comes in versions of 45 and 50 items.

You may have realized that each of these instruments only take about 5 minutes to fill out. That is important. It is feasible to give any one of these after every single session. And they are easy to score. The OQ-45 can be scored by hand in about 3 minutes or less, and there are software packages to score it in less time. The Beck and the CES-D are simple sums of the item values, so it takes about a minute. You can graph the results, and I suggest that generally they be shared with your client. In fact, Dr. Scott Miller in Chicago has been encouraging his patients to score the OQ-45 themselves, before they come into the session. They are taking an active role in
assessing their own progress. Easy to take. Easy to score. This means these items are practical. Yes, a measure should be valid and reliable, but it must also be practical. With these measures, you can get a clinical useful, valid outcome on each and every session. So give the outcome measure at the beginning of the session, the SRS at the end, and you will have a rich pool of clinically helpful information to aid your treatment of your client.

Goal attainment scaling

I mentioned two types of measures. The other measure is the Goal Attainment Scaling, the GAS process. We simply ask the client to rate their problems on a 1-10 scale, and anchor the ratings we get behaviorally. That means we note what it means in terms of behavior when the client is at a 1, 3, or 5. We set a reasonable goal, and rate that as 10. Then at the beginning of each session, you should ask the client to rate how they have progressed in the past week in reaching their goal.

I have attached a copy of my Session Rating Scale (and a later, revised version) and also a copy of a Goal Attainment Rating scale I use. I have spoken with medical directors of several managed care organizations (and I consulted with Aetna Insurance for eight years) and keeping data such as I am suggesting here will help you enormously in coping with managed care.

Coping is not the real reason. The real reason to do this is that we all want to be the very best clinician we can be. We went into this profession to help others, and we want to do it in the most time sensitive and effective ways we can. I hope this process will help you. I know it has helped me.

I have attached the alliance handouts. After that attachment, I have attached the original and the revised versions of the SRS, and I have also attached my Goal Attainment Scaling form, a simple outcome measure that you can use to track treatment response. Finally, I have attached the CES-D, a depression rating scale for adults, and the CES-D for children. The copyright on these is owned by NIMH and I have received permission to reprint them. They are well accepted in research and are good clinical instruments. I am not saying you must use them but rather they are the type of instrument that is helpful to use.

NOTE: You can print out all of the forms. Just go to that page in the file and select that page alone to print. I give you permission to print and use any and all of these forms.

I welcome correspondence on the SRS and associated issues. Please feel free to contact me.

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February, 2000

References


1. **Attend to and match nonverbal behavior** (social psychologists claim 70% of meaning is derived from nonverbal aspects of communication). Experiment with matching some of the following:
   - Posture and movements: not mirroring but similar. Research suggests that when two people are in a positive relationship, when one moves, the other will make a similar move within 3 - 5 seconds.
   - Breathing rates: high in chest vs. diaphragmatic, rapid or slow. You can first match and then lead the client toward a more relaxed breathing pattern.
   - Paraverbal behavior: Verbal, auditory, kinesthetic predicates: If you tend to match the kind of language your client uses, there may be an improved alliance.
     - Rate, tone, latency of reply: Does the client speak quickly or slowly? Try to generally match the tone of voice and rate of speech. Latency of reply means how long it takes a patient to reply when you ask a question. Some patients will respond immediately, others take a while. Match that.

2. **Attend to customer status**: Ask the two questions: Do you have a problem?, and Are you willing to work hard to solve it? The next page is the Customer Status Assessment and you should study that carefully.
   - Goal for a Customer: put this client to work. Send them home with a task assignment.
   - Goal for a Shopper: give information, suggest books or articles or handouts. This client wants to make a decision and needs insights.
   - Goal for a complainant: help this client discover how to cope with the problem even better.
     - Goal for a visitor: to encourage return visit. Confrontation avoided. Use paradoxical acceptance and discourage change. Look for the hidden customer in the visitor: substitute the official goal for one which the visitor might find appealing. The visitor is the most difficult patient for most counselors.

3. **Listening skills**, empathy, congruence, genuineness; allow patient to express emotions. Patients who feel they have expressed their deeper feelings will be more open generally to making some changes.

4. **Give appropriate compliments**: move from criticism (expected by patient) to validation (surprising patient). Surprisingly enough, some therapists have a superstition that giving compliments will make clients dependent on them. If you believe this, you should test that belief and find if you agree with me, that the opposite is true.

5. **Utilize the system**: Family therapy, Network therapy (friends, coworkers, roommates). Some people feel more comfortable if you involve others. Check out whether this is true of your client.

6. **Positive reframing**: Pace the client (agree) and then add a new way of looking at the problem ("I can't help but notice..."). Empathy plus reframing seems to be quite freeing for many of my clients.

7. **Appropriate self-disclosure**: appropriate "housekeeping chores" and structuring the sessions. Discuss roles and responsibilities in treatment. Offer treatment contract. Use measures of empathy (SRS, Burns, WAI). If you offer some checklist of alliance after each session, that in itself may tend to help the patient feel more included and attended to.

   Use the session rating scale included with this handout as an instrument to refine quality.

8. **Deal quickly, gently, clearly with patient dissatisfaction or complaints**. Fix it now, not later. If a patient is unhappy, agree with that patient, don't interpret their unhappiness as "resistance" or show the patient how they are mistaken. Both research and clinical experience suggests that a respectful agreement is far more effective and powerful than trying to explain away the client's experience. No matter how technically skillful you are at interpreting dissatisfaction as transference, process studies show that the client will perceive it as defensive on your part, and will much more often terminate early and before successful therapy has happened.
People have different levels of “readiness to change.” If you are proposing a change, you will be more effective if you understand how people's readiness to change may affect your ability to effectively carry out the change. Here are four categories of readiness to change:

<table>
<thead>
<tr>
<th>Category of Customer Status</th>
<th>Is there a problem?</th>
<th>Are you willing to work hard to solve that problem?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer:</td>
<td>Yes, I have a problem.</td>
<td>I am willing to work hard.</td>
</tr>
<tr>
<td>Shopper:</td>
<td>Yes, I do and I need information about how I might solve it.</td>
<td>I might be willing, but not at this particular moment. Let me think on it.</td>
</tr>
<tr>
<td>Complainant:</td>
<td>Yes, there is a problem. It is not mine, though. I am not ready yet to change, I am waiting for a change from someone else.</td>
<td>No, I am not ready to work because it is someone else’s responsibility. I may feel depressed, disappointed, or even angry, but not ready to work.</td>
</tr>
<tr>
<td>Visitor or guest:</td>
<td>No, things are fine, thanks. <em>Sometimes:</em> I resent being here.</td>
<td>I see no need to work hard. I haven't considered a need for change.</td>
</tr>
</tbody>
</table>

**USING THE CUSTOMER STATUS TOOL**

If you follow these suggestions, you will help people move toward a Customer status.

<table>
<thead>
<tr>
<th>Customer status</th>
<th>You, the change agent, should:</th>
<th>You should probably avoid:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer (I have a problem and I am willing to work hard to solve it.)</td>
<td>Give challenges, ask for changes, make new behavior happen. Focus on the future and emphasize what works already. Do more of what works.</td>
<td>Focusing on the past or talking about things that can't be changed if the customer is ready to work and wants a challenge.</td>
</tr>
<tr>
<td>Shopper (There is a problem and I will be solving it at some point, but not today.)</td>
<td>Give information about people who have made the change; congratulate or compliment the shopper on being aware of the problem. Ask what would help the shopper make a decision. Some shoppers benefit from understanding and analyzing the past. Pro-con analysis of costs of changing can help. Exceptions &amp; coping talk may help.</td>
<td>Avoid pushing for an early decision; allow some time for the shopper to accumulate information and weigh options. Don't assign homework or change of behavior work; you can assign data collection though. What is different about times you expect the problem to happen and it doesn't happen? Instead, what does happen?</td>
</tr>
<tr>
<td>Complainant (There is a problem but I don't think I can solve it because it is someone else's responsibility.)</td>
<td><em>Listen patiently!</em> Give sincere compliments, focus attention on exceptions when the problem doesn't occur or on how the complainant <em>copes</em> with the problem. Focus on how to cope even better.</td>
<td>Avoid focusing attention on the problem; focus on the coping instead. Never give suggestions about how to solve the problem.</td>
</tr>
<tr>
<td>Visitor or guest (Problem? What problem? And as far as working hard, I have other things I need to do, thank you very much.)</td>
<td><em>Listen curiously!</em> Give sincere compliments, engage in pleasant conversation, listen to the visitor's story, tell your story. Your goal is to keep the visitor in the relationship, get him or her to return. Look for a &quot;hidden customer&quot; or hidden desire for a change. Perhaps it is only to get out of trouble, but that is enough to get started. Sometimes things have to get worse before they get better.</td>
<td>Avoid pushing for any commitment or change. Give information about others and how they change but don't expect any response just give examples. Stories are always entertaining and usually a visitor will listen.</td>
</tr>
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</table>

*These categories are about the relationship between you and the other person, they don't describe the other person. For example you may be a shopper at one store, a customer at another. These rules help the other person become a customer with you!"
Therapy is a cooperative relationship. Please rate today's session. Be honest and frank, to be the most helpful to your counselor. Read each set of descriptions. Circle the number that best describes your reaction, from 0 to 4. Use the rating system below:

<table>
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<th>AGREED WITH THIS SIDE</th>
<th>NEUTRAL</th>
<th>AGREED WITH THIS SIDE.</th>
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<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
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</table>

(Under each set of statements, circle the number that best describes your feelings about today's session)

1. ACCEPTANCE
I felt accepted. I felt criticized or judged.

2. LIKING, POSITIVE REGARD
My therapist liked me. The therapist pretended to like me or seemed to not like me.

3. UNDERSTANDING
My counselor understood me and my feelings. My counselor didn't understand me or my feelings.

4. HONESTY AND SINCERITY
My therapist was honest and sincere. My therapist was not sincere, was pretending.

5. AGREEMENT ON GOALS
We worked on my goals; my goals were important. We worked on my counselor's goals; My goals didn't seem important.

6. AGREEMENT ON TASKS
I approved of the things we did in the session or what I was asked to do as a homework assignment. I didn't like what we did in today's session or what I was asked to do as a homework assignment.

7. SMOOTHNESS OF THE SESSION
The session was smooth; I felt comfortable. The session was rough; I felt uncomfortable.

8. DEPTH OF THE SESSION
The session was deep. We got to the heart of things. The session was shallow. We stayed on the surface.

9. HELPFULNESS, USEFULNESS
I found the session helpful. The session was not helpful.

10. HOPE
I felt hopeful after the session. I felt hopeless after the session.

One more thing: What could help the next session go better? Please continue on the back if necessary.
Therapy is a cooperative relationship. Please rate today's session. Be honest and frank, to be the most helpful to your counselor. Read each set of descriptions. Circle the number that best describes your reaction, from 0 to 4. Use the rating system below:

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(Under each set of statements, circle the number that best describes your feelings about today's session)

1. ACCEPTANCE
I felt accepted.  
4  3  2  1  0
I felt criticized or judged.

2. LIKING, POSITIVE REGARD
My therapist liked me.  
4  3  2  1  0
The therapist pretended to like me or seemed to not like me.

3. UNDERSTANDING
My counselor understood me and my feelings.  
4  3  2  1  0
My counselor didn't understand me or my feelings.

4. HONESTY AND SINCERITY
My therapist was honest and sincere.  
4  3  2  1  0
My therapist was not sincere, was pretending.

5. AGREEMENT ON GOALS
We worked on my goals; my goals were important.  
4  3  2  1  0
We worked on my counselor's goals; My goals didn't seem important.

6. AGREEMENT ON TASKS
I approved of the things we did in the session or what I was asked to do as a homework assignment  
4  3  2  1  0
I didn't like what we did in today's session or what I was asked to do as a homework assignment

7. AGREEMENT ON TREATMENT
The treatment I received was right for me  
4  3  2  1  0
There was something wrong with the treatment I received

8. PACE OF THE SESSION
The session moved along at the right pace  
4  3  2  1  0
The session moved too fast or too slowly

9. HELPFULNESS, USEFULNESS
I found the session helpful  
4  3  2  1  0
The session was not helpful

10. HOPE
I felt hopeful after the session  
4  3  2  1  0
I felt hopeless after the session.

One more thing: What could help the next session go better? Please continue on the back if necessary.
GOAL ATTAINMENT SCALING FORM

Name ____________________________ Therapist:

Main complaint:

-Goal description: Focus on 1 - 3 goals the patient wants to achieve from counseling. Turn the problems into goals & define the goals behaviorally. How would others know the goals had been achieved? The A, B, C indicates at least three goals.

A----A  1:

B----B  2:

C--C  3:

Goal attainment scaling anchors: Describe the worst patient has ever been (and when or how recently), current functioning, and what would characterize an adequate or satisfactory treatment outcome. Make these "video" descriptions; what would you see and hear on a video that describes the situation.

Worst ever:

current:

therapy goal:

Goal attainment graph

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Date/ Ses #
This inventory asks you to describe how you have felt over the past week. For each set of answers, circle the number next to the description that best describes you. During the past week:

1. I was bothered by things that usually don't bother me.
   0 Rarely or none of the time (less than 1 day).
   1 Some or a little of the time (1 - 2 days).
   2 Occasionally or a moderate amount of the time (3 - 4 days).
   3 Most of the time (5 - 7 days).

2. I did not feel like eating; my appetite was poor.
   0 Rarely or none of the time (less than 1 day).
   1 Some or a little of the time (1 - 2 days).
   2 Occasionally or a moderate amount of the time (3 - 4 days).
   3 Most of the time (5 - 7 days).

3. I felt I could not shake off the blues even with help from my family and friends.
   0 Rarely or none of the time (less than 1 day).
   1 Some or a little of the time (1 - 2 days).
   2 Occasionally or a moderate amount of the time (3 - 4 days).
   3 Most of the time (5 - 7 days).

4. I felt I was just as good as other people.
   3 Most of the time (5 - 7 days).
   2 Occasionally or a moderate amount of the time (3 - 4 days).
   1 Some or a little of the time (1 - 2 days).
   0 Rarely or none of the time (less than 1 day).

5. I had trouble keeping my mind on what I was doing.
   0 Rarely or none of the time (less than 1 day).
   1 Some or a little of the time (1 - 2 days).
   2 Occasionally or a moderate amount of the time (3 - 4 days).
   3 Most of the time (5 - 7 days).

6. I felt depressed.
   0 Rarely or none of the time (less than 1 day).
   1 Some or a little of the time (1 - 2 days).
   2 Occasionally or a moderate amount of the time (3 - 4 days).
   3 Most of the time (5 - 7 days).

7. I felt that everything I did was an effort.
   0 Rarely or none of the time (less than 1 day).
   1 Some or a little of the time (1 - 2 days).
   2 Occasionally or a moderate amount of the time (3 - 4 days).
   3 Most of the time (5 - 7 days).

8. I felt hopeful about the future.
   3 Rarely or none of the time (less than 1 day).
   2 Some or a little of the time (1 - 2 days).
   1 Occasionally or a moderate amount of the time (3 - 4 days).
   0 Most of the time (5 - 7 days).

9. I thought my life had been a failure.
   0 Rarely or none of the time (less than 1 day).
   1 Some or a little of the time (1 - 2 days).
   2 Occasionally or a moderate amount of the time (3 - 4 days).
   3 Most of the time (5 - 7 days).

10. I felt fearful.
    0 Rarely or none of the time (less than 1 day).
    1 Some or a little of the time (1 - 2 days).
    2 Occasionally or a moderate amount of the time (3 - 4 days).
    3 Most of the time (5 - 7 days).

11. I had crying spells.
    0 Rarely or none of the time (less than 1 day).
    1 Some or a little of the time (1 - 2 days).
    2 Occasionally or a moderate amount of the time (3 - 4 days).
    3 Most of the time (5 - 7 days).

12. I was happy.
    3 Rarely or none of the time (less than 1 day).
    2 Some or a little of the time (1 - 2 days).
    1 Occasionally or a moderate amount of the time (3 - 4 days).
    0 Most of the time (5 - 7 days).

13. I talked less than usual.
    0 Rarely or none of the time (less than 1 day).
    1 Some or a little of the time (1 - 2 days).
    2 Occasionally or a moderate amount of the time (3 - 4 days).
    3 Most of the time (5 - 7 days).

    3 Rarely or none of the time (less than 1 day).
    2 Some or a little of the time (1 - 2 days).
    1 Occasionally or a moderate amount of the time (3 - 4 days).
    0 Most of the time (5 - 7 days).

15. People were unfriendly.
    0 Rarely or none of the time (less than 1 day).
    1 Some or a little of the time (1 - 2 days).
    2 Occasionally or a moderate amount of the time (3 - 4 days).
    3 Most of the time (5 - 7 days).

16. I enjoyed life.
    3 Rarely or none of the time (less than 1 day).
    2 Some or a little of the time (1 - 2 days).
    1 Occasionally or a moderate amount of the time (3 - 4 days).
    0 Most of the time (5 - 7 days).

17. I had crying spells.
    0 Rarely or none of the time (less than 1 day).
    1 Some or a little of the time (1 - 2 days).
    2 Occasionally or a moderate amount of the time (3 - 4 days).
    3 Most of the time (5 - 7 days).

18. I felt sad.
    0 Rarely or none of the time (less than 1 day).
    1 Some or a little of the time (1 - 2 days).
    2 Occasionally or a moderate amount of the time (3 - 4 days).
    3 Most of the time (5 - 7 days).

19. I felt that people dislike me.
    0 Rarely or none of the time (less than 1 day).
    1 Some or a little of the time (1 - 2 days).
    2 Occasionally or a moderate amount of the time (3 - 4 days).
    3 Most of the time (5 - 7 days).

20. I could not get "going."
    0 Rarely or none of the time (less than 1 day).
    1 Some or a little of the time (1 - 2 days).
    2 Occasionally or a moderate amount of the time (3 - 4 days).
    3 Most of the time (5 - 7 days).
CES-D Children's Rating Scale

Name

Date_________________ Session #

Sometimes it is hard for kids to find words to describe how they feel. Here's something that gives you different ways to say how you feel. There are four choices for each sentence. Read each sentence and pick out the choice that best describes how you have been feeling or acting for the past week. Make a mark (like an X) by the answer which best describes your feelings. There are no right or wrong answers.

During the past week:
1. I was bothered by things that don't usually bother me.
   Not at all__ A little__ Some__ A lot
2. I did not feel like eating; I wasn't very hungry.
   Not at all__ A little__ Some__ A lot
3. I wasn't able to feel happy, even when my family or friends tried to help me feel better.
   Not at all__ A little__ Some__ A lot
4. I felt that I was not as good as other kids.
   Not at all__ A little__ Some__ A lot
5. I felt like I couldn't pay attention to what I was doing.
   Not at all__ A little__ Some__ A lot
6. I felt down.
   Not at all__ A little__ Some__ A lot
7. I felt like I was too tired to do things.
   Not at all__ A little__ Some__ A lot
8. I felt like something bad was going to happen.
   Not at all__ A little__ Some__ A lot
9. I felt like things I did before didn't work out.
   Not at all__ A little__ Some__ A lot
10. I felt scared.
    Not at all__ A little__ Some__ A lot
11. I didn't sleep as well as I usually sleep.
    Not at all__ A little__ Some__ A lot
12. I was unhappy.
    Not at all__ A little__ Some__ A lot
13. I was more quiet than usual.
    Not at all__ A little__ Some__ A lot
14. I felt lonely, like I didn't have any friends.
    Not at all__ A little__ Some__ A lot
15. I felt like kids I know were not friendly, or that they didn't want to be with me.
    Not at all__ A little__ Some__ A lot
16. I didn't have a good time.
    Not at all__ A little__ Some__ A lot
17. I felt like crying.
    Not at all__ A little__ Some__ A lot
18. I felt sad.
    Not at all__ A little__ Some__ A lot
19. I felt people didn't like me.
    Not at all__ A little__ Some__ A lot
20. It was hard to get started doing things.
    Not at all__ A little__ Some__ A lot

Thank you for taking your time to fill out this rating scale.

If there is anything at all you would like us to know, write it below.

If you noticed anything this week that you felt good about, please write it below.
Center for Epidemiological Studies Instruments

The CES-D & the CES-D Child Version copyrights are held by the NIMH; they have graciously agreed to let me duplicate and distribute the instruments. That is to say, they are copyrighted by the U.S. federal government, which automatically makes them Public Domain instruments.

**CES-D adult version:** Note that some of the items are reverse scored, so that the first answer is weighted A₃₀ instead of ₀. Sum the scores.

*Interpretation of scores:*

₀ - ₉: Probably not depressed.

₁₀ - ₁₇: Mildly depressed

₁₈ - ₂₆: Moderately depressed

₂₇ - ₆₀ Severely depressed.

**Scoring and interpretation for the CES-D Children's Rating Scale**

This instrument is suitable for children up to the mental age of 12. Please bear in mind this is not a substitute for a professional evaluation, but it is a help at understanding the level of depression a child may have. Note that none of the items are reverse scored so there may be a problem with response set, meaning the child just checks the same answer on every item. If all the items have a check mark in the same place, investigate a response set problem.

Sum the score of the test with the following:

Not at all = ₀

A little = ₁

Some = ₂

A lot = ₃

*Interpretation of scores:*

₀ - ₉: Probably not depressed.

₁₀ - ₁₇: Mildly depressed

₁₈ - ₂₆: Moderately depressed

₂₇ - ₆₀ Severely depressed.

Originally the cutoff for 'probably not depressed' was ₁₇ but this is too high and creates false negatives. The lower number of less than ₁₀ may create more false positives, but this instrument should be used as a screening device, not a final answer. Use clinical judgement.

On the next page are Scott Miller's instruments. They are easy to use, and track clinical functioning and the alliance. The lines are 10 centimeters long, and you can convert a slash (/) mark into a ₀ – ₁₀ scale, and perhaps use the goal attainment scaling handout or a similar graph to track clinical rating and alliance over time. Note: I did change his versions, and offer that to you. I like my language better, but I am not saying it is better. You can take your choice. The important thing is to track and measure.

His version is at [http://www.scottdmiller.com/performance-metrics/](http://www.scottdmiller.com/performance-metrics/) and you can download a personal version for free. If you want to use it in an agency or group, you should buy a license, since that is the right thing to do. Scott is not at a university, so his fees have to support the research and development. Certainly you want to do the right thing.
Outcome Rating Scale (ORS)

Name ________________________ Age (Yrs):____ ID# _________________________
Sex: M / F 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. Make a slash “/” mark to rate how you feel over the last week.

Overall:
(General sense of well-being)

Feeling Low >------------------------------------------------------------------------< Feeling very good

Individually:
(Personal well-being)

I am not doing well. >------------------------------------------------------------------------< I am doing very well

Interpersonally:
(Family, close relationships)

Distant or strained >------------------------------------------------------------------------< Close, warm, loving

Productivity:
(Work, School, Housework, Tasks and Chores)

Doing poorly >------------------------------------------------------------------------< Doing very well

Institute for the Study of Therapeutic Change
_________________________________________
www.talkingcure.com

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Session Rating Scale (SRS V. 3.1)
(Modified by Lynn Johnson, 2014)

Name _________________________ Age (Yrs): ____ ID# ______________________
Sex: M / F Session # ____ Date: ______________________

Please rate today’s session by placing a slash mark “/” on the line nearest to the description that best fits your experience. Be honest and frank.

Relationship:
I did not feel heard, understood, and respected I felt heard, understood, and respected
>--------------------------------------------------------------------------<

Goals and Topics:
We did not work on or talk about We worked on and talked about
what I wanted to work on and talk about what I wanted to work on and talk about
>--------------------------------------------------------------------------<

Approach or Method:
The therapist’s approach is not a good fit for me. The therapist’s approach is a good fit for me
>--------------------------------------------------------------------------<

Overall:
There was something missing in the session today Overall, today’s session was right for me
>--------------------------------------------------------------------------<

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