Although little work has been done to validate the Jacobson and Truax (1991) cutoff score formulas as a method of providing adequate demarcations of meaningful patient change, some validity data have been published. Beckstead et al. (2003) examined the OQ® cutoff scores for clinical significance by comparing concordance rates with cutoff scores based on other measures of psychotherapy outcome. The OQ® and the SCL-90-R (Derogatis, 1983), the SAS-SR, SAS-OR (Weissman, Prusoff, Thompson, Harding, & Myers, 1978), the IIP-S (Hansen, Umphress, & Lambert, 1998) and the QOLI (Frisch, 1988) were administered to participants in pre-and post-treatment assessments. It was found that at pretest, the mean concordance rate for classifying patients as functional or dysfunctional was 75%; at post-test, it was 77.5%, with one-third to just less than one-half (43%) of the clients being classified perfectly across all six measures at pre- and post-testing. At pre-test, at least three out of the five comparative measures agreed 85% of the time with the OQ® classification as clinical or non-clinical. At post-test, the percentage was 82.2%. Finally, regarding clinically significant change, 64.6% of the time, at least three out of five measurements agreed with the OQ® classification as meeting or not meeting criteria for clinically significant change. The results suggested similarity between the OQ® and the other measures in the study, which offers preliminary support for the use of the OQ® alone (instead of a battery of measures) to classify clients as functional or dysfunctional and to detect clinically significant change.

Lunnen and Ogles (1998) also reported a study that simultaneously used the OQ® and other measures of outcome for the purpose of validating clinical significance cutoffs. The purpose of their study was to explore the practical meaning of cutoff scores and criteria for the Reliable Change Index. These authors compared the perceived level of change as subjectively reported from three distinct perspectives (patient, therapist and significant other). They also compared reports of the therapeutic alliance and satisfaction across outcome groups. The results of this study suggested that those patients who were classified as improved (20-point positive change on the OQ® Total Score, based on sample cutoff), also were rated as most improved on therapist and client ratings of perceived change. They also tended to have higher alliance scores. Surprisingly, perhaps, satisfaction scores did not, for the most part, distinguish between improvers, no-changers and deteriorators.

Although more work needs to be done to validate the current cutoff scores, they appear to have important practical value, and to be a central aspect of effectively using the OQ®-45.

**INTERPRETATION OF INITIAL SCORES**

To use the OQ® clinically, the clinician should consider three elements: the participants' answers to certain critical items, the total score (TOT) and the subscale scores. Interpretive graphs are included for the total and subscale scores (see Appendix C).

**Item Evaluation**

The clinician should first consider patient ratings on certain critical items. Item 8 is a screening item for potential suicide that should be investigated further if the
participant gives any rating higher that 0 (never). Items 11, 26 and 32 refer to substance abuse items, and should also be investigated further if ratings other than 0 (never) are given. Item 44 screens for violence at work; any rating other than 0 (never) should be investigated for the possibility of current and/or future work conflicts that lead to violent acts against fellow employees.

**Total Score (TOT)**

A high total score indicates that the patient admits to a large number of symptoms of distress (mainly anxiety, depression, somatic problems and stress) as well as interpersonal difficulties in social roles (e.g. work problems), and in their quality of life. In general, lower scores suggest that the patient is no more disturbed than the general population.

An effective way to use the OQ® in clinical settings is to compare a patient’s score with different normative samples. Ideally, normative data from inpatients, outpatients, community samples and asymptomatic individuals would be available. At this time, only cutoff scores comparing patient and non-patient samples are available for the OQ®. The cutoff score is presented in Appendix C. Cutoff scores for the total score and subscale scores were derived using the procedures suggested by Jacobson and Truax (1991). As can be seen in the Total Score graph, the cutoff for entering the community population has been set at 63. When a patient’s score falls at or below 63, it is more likely that they are part of the community sample than the patient sample. In addition, when a patient’s score changes by more than 14 points in either direction from pre-test, this change is said to be reliable. Changes of 14 points or more suggest movement by the patient that reliably (p < .05) exceeds the measurement error of the OQ®.

Extremely low scores (<20) from those who are entering treatment is an uncommon occurrence; such scores indicate that the person is admitting to little disturbance. It is possible that they have a problem that is so specific and limited that it causes them little difficulty and therefore if is reflected accurately by their score on the OQ®-45. It is more likely that they are not being open about their concerns. Low test scores in treatment samples are not uncommon in people who take the test under duress, such as involuntarily committed patients and substance-abusing patients referred in by employers or spouses.

**Subscale Scores**

To identify specific problem areas, subscale scores can be consulted. The OQ® reports three subscale scores: Symptom Distress, Interpersonal Relations and Social Role. It is not possible for a patient to have a high Total Score without also having high subscale scores. On the other hand, a low Total Score does no mean that the patient does no have problems in one or more subscale domains.

**Symptom Distress (SD)**

Research suggests that the most common disorders are anxiety disorders, affective disorders, adjustment disorders and stress-related illnesses. The Symptom Distress subscale is composed of items that have been found to reflect the symptoms of these disorders. A high score indicates that patients are bothered by these symptoms and low scores indicate either absence or denial of symptoms. Symptom Distress scores correlate
highly with measures of depression, such as the Beck Depression Inventory. They also correlate highly with measures of anxiety, such as the State Trait Anxiety Inventory (see section on psychometric properties). The cutoff for this subscale was derived by the same method used for the total score cutoff. The graph is presented in Appendix D. As noted, the cutoff for symptom distress is 36. When a participant’s score falls below this point, they are scoring like people in the non-patient sample. Reliable change is considered to occur after a patient’s score has changed 10 points.

**Interpersonal Relationship (IR)**

Research suggests that most patients experience difficulty in interpersonal relationships in addition to the subjective discomfort reflected in the Symptom Distress subscale. Interpersonal Relationship subscale items assess such complaints as loneliness, conflict with others and marriage and family difficulties. High scores suggest concerns in those areas, and low scores suggest both the absence of interpersonal problems, as well as satisfaction with the quality of intimate relationships. The cutoff for Interpersonal Relationships (IR) is presented in Appendix E. Scores below the cutoff of 15 suggest that the patient is experiencing a level of satisfaction in relationships that is equivalent to normal functioning. Reliable change is considered to occur after a patient’s score has changed 8 points.

**Social Role Performance (SR)**

Dysfunction may extend beyond a person’s subjective sense of discomfort and beyond their closest relationships into the behaviors that are commonly expected to be manifested by adults in our society. The Social Role subscale measures the extent to which difficulties fulfilling workplace, student or home duties are present. Conflicts at work, overwork, distress and inefficiency in these roles are assessed. High scores indicate difficulty in social roles, while low scores indicate adequate social role performance. Additional attention should be given to low scores to determine whether they result from social role satisfaction or from participant unemployment (e.g. the participant arbitrarily marking the items 0 for never or not applicable). The cutoff score for SR is 12. The graph for this subscale is located in Appendix F. Reliable change is considered to occur after a patient’s score has changed 7 points on this subscale.

**POTENTIAL USES OF THE OUTCOME QUESTIONNAIRE®**

**Use of the OQ® for Treatment Planning**

The OQ® can be used in treatment planning, if it is employed with other patient data. For example, Human Affairs International (HAI), a large multi-state managed care company, used the OQ®-45 total score at the inception of treatment to assist clinicians in initial level of care decisions. Because their system is proprietary, specific details cannot be offered, but generalities of procedures can be explained. HAI’s system used the OQ®-45 intake score to sort clients into categories of high (85 and above), medium (64-84) or low (63 or below). Other patient information, such as history of psychological treatment (e.g. no history of psychological treatment, recent inpatient care), motivation for treatment and diagnosis, were combined through algorithms to produce computer-generated suggestions for clinicians and care managers for treatment planning or referral.