PSYCHLOPS, or Psychological Outcome Profiles, has been designed as a mental health outcome measure. Originally intended as a before and after measure, to be used for determining outcomes following therapy, it has now developed into a repeated measures instrument used to track progress throughout a course of therapy. PSYCHLOPS aims to refocus outcome measurement away from professionally determined domains and towards a patient-centred definition of outcomes. This emphasis on the patient perspective is intended to capture items of greatest personal significance rather than imposing an external frame of reference to interpret psychological distress.

The development of PSYCHLOPS started in 1999 with the search by primary care therapists for an outcome instrument that captured aspects of recovery which appeared to be missed by conventional instruments. They reported patients who, during the course of therapy, appeared to have resolved many of the issues for which they were originally referred and yet outcome measurement had failed to capture this recovery. In response, an idiographic instrument was designed which contained questions asking patients to describe their problems in their own words using free-text response boxes. Idiographic instruments are well described in the literature (Donnelly & Carswell, 2002) but are generally used in secondary care and require assistance to complete either from the therapist or by someone trained in the specific requirements of the instrument. In contrast, PSYCHLOPS was developed with the intention of being the first, easy-to-use, self-administered idiographic measure. The end product was a one-page questionnaire.

Two principles guided the development of PSYCHLOPS. User-involvement was a key feature in its development and was provided by the UK patient organisation, Depression Alliance. Since the instrument was intended to be patient-centred, it also had to be patient-friendly. The wording was scrutinised by the Plain English Campaign and, after various revisions, the instrument was awarded the ‘Crystal Mark’ in recognition of the clarity of its language. An attractive design was also a feature of the patient-friendly approach to development and a simple format was devised with coloured banding used to highlight each question and colour differences to distinguish each version.

PSYCHLOPS was piloted then launched in 2004 as a pre-therapy and post-therapy mental health outcome instrument. Following validation studies, the instrument went through several stages of refinement to both wording and scoring, and a new during-therapy version was introduced in 2010 (Version 5). The intention of this version was that, after a period of change derived from therapy, items of greatest personal significance would be re-assessed.
through the iterative process of validation, it should be the definitive version of PSYCHLOPS, remaining unchanged for a minimum of five years. Stability over a longer period was intended to promote international collaborations and longer term studies.

The measure is designed for use in the context of primary care psychotherapy. Validation studies have excluded those with literacy problems, although therapist assisted completion would be possible in this situation. In 2011, a children’s version of PSYCHLOPS was launched: PSYCHLOPS Kids. This is a shortened version of PSYCHLOPS and uses emoticon faces rather than tickboxes to elicit scores. With the development of ‘PSYCHLOPS Kids,’ the instrument is suitable for anyone from the age of five years and upwards.

PSYCHLOPS is not intended for use as a diagnostic instrument and can therefore be used with patients experiencing a wide variety of mental health problems without being confined to those fulfilling single disease-based diagnostic criteria. This broad spectrum of distress is typical of the sort of mental health problems encountered in primary care. PSYCHLOPS has been developed in English but is also available in French, Spanish, Dutch, Polish and Arabic.

**Domains Assessed**
Three domains are included in PSYCHLOPS: Problems (2 questions); Function (1 question); Wellbeing (1 question). The underlying Problem-Function-Wellbeing domains are derived from a pan-theoretical model which describes an empirical sequence of causality; psychological problems which then trigger deficits in functional capacity which in turn triggers diminished wellbeing. In parallel with its applicability to a broad range of mental health problems, the measure is applicable to a breadth of talking therapies and may be used before, during and after any type of psychological intervention.

**Use and Procedures**
The Problem and Function domains of PSYCHLOPS elicit freetext responses which are then scored by the therapist on an ordinal 6-point scale (ranging from a score of zero to five). If the patient only reports one Problem, rather than two, then the score is pro-rated (doubled) such that the maximum possible score for the Problem domain remains at ten. The Wellbeing domain is a nomothetic measure (omitting a freetext component), again scored zero to five. Thus the score range, derived from the sum of each domain, is from zero to 20.

In the pre-therapy version of PSYCHLOPS, patients are asked to describe their main Problem (in a freetext box) and to score it. In subsequent during-therapy and post-therapy versions, the therapist transcribes the freetext description of the original Problem, and the patient is asked to re-score the original Problem (the original score is not disclosed). The same process is followed for the other freetext questions: the second Problem and Function. The Wellbeing score is simply scored on the scale numbered zero to five, each time the instrument is administered.

PSYCHLOPS is self-administered and self-completed with the proviso that the therapist transcribes the freetext sections from the pre-therapy version to all subsequent during-therapy versions and the post-therapy version. PSYCHLOPS is an outcome measure, designed to measure change, and the score reflects its purpose. The actual change is simply the during-therapy or post-therapy total score subtracted from the pre-therapy score. Interpreting this change requires calculation of the Effect Size for a sample. The Effect Size is calculated by dividing the change score by the standard deviation of the pre-therapy score. By using this method, change is ‘standardised’ and the greater the pre-therapy score variability, the greater the pre-therapy standard deviation and the less the overall Effect Size. Effect Size values greater than 0.8 are generally considered large in health service research (Kazis et al., 1989). In common with all idiographic instruments, there is no population norm since the baseline score is a measure of items which differ between each person and is not strictly comparable between individuals.

All data are stored with the therapist and instrument completion is based on hard copies of the questionnaire, not on-line copies. There is no on-line version. Data collection is not centralised. The simplicity of score calculation means that a score can be calculated immediately upon completion of the instrument. Progress, or otherwise, can be charted on a zero to twenty scale. Ideally, this score would be available at the start of each talking therapy session.

There is a charge for use of PSYCHLOPS. Specimen copies may be viewed on the website. Actual copies are available on CD-ROM and cost £40 (£CA65) for individual therapists, £100 (£CA160) for small organizations and £250 (£CA400) for larger health service organizations (employing over 100 people). There is no annual fee and there is no limit to usage.
Assessment and Treatment Planning
Therapists have described the usefulness of pre-therapy freetext information reported in the Problem and Function domains of PSYCHLOPS (Ashworth et al., 2005a). This information can be triangulated with referral information to the therapist from other health professionals such as general practitioners, and provides a focus for therapy from the outset, acting as a tool to instigate therapeutic work. The during-therapy versions elicit information on new problems arising during the course of therapy, adding to the information available to the therapist. Although research evidence on the importance of this information is not yet available, it would seem intuitive to suggest that new issues described by patients on PSYCHLOPS would need to be addressed by therapists during the talking therapy process. There are no population norm data for PSYCHLOPS, in common with all idio graphic instruments (Lacasse et al., 1999; Donnelly & Carswell, 2002).

Technical Support
Background information about PSYCHLOPS is available from the website: www.psychlops.org.uk. The website provides links to background literature, validation studies, the scoring system, latest developments and an email address for further information. Upon purchase, an information pack is mailed out, providing further in-depth information on instrument usage.

Psychometric Properties
Internal reliability has been tested by calculating Cronbach’s alpha for the three domain scores in PSYCHLOPS. Three studies have so far reported internal reliability data based on alpha scores: 0.79 pre-therapy and 0.87 post therapy (Ashworth et al., 2005b); 0.75 pre-therapy and 0.83 post therapy (Ashworth et al., 2008); and 0.81 pre-therapy, 0.85 during therapy and 0.88 post therapy (Czachowski et al., 2011). One study has reported test-retest reliability, based on a survey of students in higher education. The test-retest intraclass correlation coefficient was 0.70 (Evans et al., 2010). Sensitivity to change has been reported as Effect Size in three studies: 1.53 (95% CI 1.30 to 1.76) (Ashworth et al., 2005b); 1.61 (95% CI 1.41, 1.80) (Ashworth et al., 2008); 3.1 (95% CI 2.7, 3.4) (Czachowski et al., 2011)

The first two studies were conducted in the setting of psychotherapy offered within the context of primary care in the UK. The latter study was conducted in a Polish setting and the brevity of the psychotherapy programme (three sessions of CBT conducted by GPs with a special interest in CBT) may have contributed to the high observed Effect Size.

Convergent validity of the measure has been reported in two studies: comparison with CORE-OM (Clinical Outcomes in Routine Evaluation – Outcome Measure) revealed a Spearman’s rho of 0.61, pre- and post therapy data combined (Ashworth et al., 2005b); comparison with HADS (Hospital Anxiety Depression Scale) showed a rho of 0.47 pre-therapy and 0.63 post-therapy (Ashworth et al., 2008).

Patient/Client/Clinician Feedback
Based on the findings of a qualitative study of the views of therapists (Ashworth et al., 2005a), PSYCHLOPS was perceived as complementing the information derived from conventional quantitative instruments, with its qualitative information being of particular interest to therapists, contributing to the therapist-patient interaction. Therapists reported that it was a ‘therapist friendly’ instrument and likely to increase acceptance and uptake of outcome measures.

Institutional Implementation
PSYCHLOPS is a generic instrument, designed within the context of primary care but not aligned to any one primary care discipline nor psychotherapy discipline. Its findings are of relevance to all primary care health professionals involved in the care of patients with mental health problems. The UK Department of Health (DH) has produced a list of DH ‘approved’ mental health outcome measures which was published in an ‘Outcomes Compendium’ in 2009. PSYCHLOPS is included in the list of approved measures: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093316

PSYCHLOPS is also included in the international Quality of Life Instruments database: www.proqolid.org.
PSYCHLOPS combines both quantitative and qualitative information. On-going studies will report on both qualitative analysis of patient reported data and more detailed quantitative analyses in a variety of international contexts.

If you would like to know more about PSYCHLOPS or would like to purchase a copy, please go to the website: www.psychlops.org.uk or contact the PSYCHLOPS research manager, Marilyn Peters: marilyn.peters@kcl.ac.uk

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