

Client Feedback Data in Supervision: Effects on Supervision and Outcome

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Monitoring psychotherapy treatment outcome has become a recommended activity for training and practice. Despite the apparent success of continuous outcome assessment (or “client feedback”) in improving client outcome, little research exists concerning its utility in supervision. The purpose of the study presented here was to determine if the use of client feedback data during supervision would influence the supervisory process and treatment outcome. Trainees ($n = 44$) administered the Partners for Change Outcome Management System (PCOMS) to clients and were assigned to a continuous feedback supervisory condition or a no-feedback supervisory condition. Results indicated that trainees who used client feedback data during supervision reported greater satisfaction with supervision than did trainees who did not discuss client feedback with their supervisor. However, supervisory alliance score differences were not statistically significant. Results also indicated that client outcomes were similar across supervisory conditions. Implications of the findings, as well as limitations and future studies, are addressed.

Keywords: psychotherapy supervision, client progress and outcome, trainee satisfaction with supervision, supervisory working alliance

Continuous outcome assessment, or client feedback, entails the use of outcome measure(s) throughout therapy to monitor treatment progress, as opposed to the usual prepost therapy format (Lambert, 2001). Client feedback can assist the therapist in the recognition of clients who are not progressing in treatment as expected. By becoming aware of clients’ perceptions regarding treatment outcome, the opportunity is then made available to immediately address the lack of progress with the client (Duncan, 2010). Research has demonstrated that the use of client feedback is effective in the reduction of premature termination and im-

proved treatment outcomes (e.g., Brown & Jones, 2005; Lambert & Shimokawa, 2011; Reese, Norsworthy, & Rowlands, 2009). Lambert and Shimokawa (2011) conducted a meta-analysis with six feedback randomized clinical trial studies (feedback vs. treatment as usual) and found effect sizes (ES) ranging from $r = .25$ to $r = .33$, indicating medium ES. In the psychotherapy literature, these are, indeed, impressive findings.

Significant findings such as these have resulted in the American Psychological Association’s (APA) Division 29 Task Force on Empirically Supported Relationships to encourage clinicians “. . . to routinely monitor patients’ responses to the therapy relationship and ongoing treatment. Such monitoring leads to increased opportunities to repair alliance ruptures, to improve the relationship, and to avoid premature termination” (Ackerman et al., 2001, p. 496). Further, the American Psychological Association Presidential Task Force on Evidence-Based Practice (2006) and the American Psychological Association Commission on Accreditation (2011) have recommended that practice and training should include monitoring treatment outcome.

Despite the promising research findings and the calls to monitor client outcome, little research exists concerning its utility in training and clinical supervision. The use of client outcome data in supervision has been proposed to be a useful process for providing additional information about client progress and as a means to bring the client’s perspective more directly into the supervisory process (Lambert & Hawkins, 2001; Sparks, Kisler, Adams, & Blumen, 2011; Worthen & Lambert, 2007). Further, Worthen and Lambert (2007) reason that the use of client feedback data in supervision may foster the provision of specific supervisory feedback, particularly because such feedback may be perceived to be “value neutral” because the information was derived from the

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client. This shift may allow for feedback from the supervisor to seem more collaborative rather than evaluative. If true, then it may follow that the use of client feedback in supervision might contribute to the supervisee's perception that the supervisor is working with him or her to address the lack of progress with a client.

Reese et al. (2009) evaluated whether the effectiveness of outcome assessment would extend to trainees if the clients' feedback were made available to supervisors for use in the supervision session. Trainees ($n = 28$) were assigned to a continuous feedback condition (client feedback was used with clients and the results were discussed with the supervisor) or a no-feedback condition (client feedback was not used with clients). Trainees in both conditions demonstrated statistically significant improvement of client outcomes (client sample, $n = 110$), but those in the feedback condition exhibited greater improvement. However, they did not find that the supervisory alliance or satisfaction with supervision was different across conditions. One could argue that clients improved and the inclusion of client feedback did not disrupt or alter the supervisory process. Two limitations of this study were the small sample size and the specific effects of discussing client feedback data in supervision were not isolated because trainees in the control condition did not use client feedback with their case-loads.

Satisfaction With Supervision and Supervisory Alliance

Two constructs that have received considerable attention in the supervision literature and that have been identified as potentially integral ways to evaluate "successful" supervision include supervisee satisfaction with supervision (Ellis & Ladany, 1997) and the supervisory working alliance (Efstation, Patton, & Kardash, 1990; Lehrman-Waterman & Ladany, 2001). Satisfaction with supervision has been evaluated in numerous studies (e.g., Fernando & Hulse-Killacky, 2005; Son & Ellis, 2013). In fact, Bernard and Goodyear (2009) noted that satisfaction is perhaps even being "overused" (p. 301) as an outcome of supervision given that a supervisee's level of satisfaction may not reflect the quality and rigor of training received. We agree, but we also believe that when considered along with other outcome and process variables, the supervisee's perspective of supervision globally is still worthwhile. Evaluating supervisee's satisfaction with and perception of the quality of supervision serves as a direct way to assess the supervisee's view of the supervision process and his or her supervisor. Research has found that satisfaction is related to other process variables including supervisee nondisclosure (Ladany, Hill, Corbett, & Nutt, 1996) and supervisor feedback (Lehrman-Waterman & Ladany, 2001).

The supervisory relationship has consistently been found to be an important variable to consider in providing effective supervision. For example, Ellis (1991) found that counseling trainees rated the relationship with their supervisor as the single most important component of a positive supervisory experience. Although there are exceptions, the supervisory alliance has been found to be related to satisfaction with supervision (Reese et al., 2009; Son & Ellis, 2013), counseling self-efficacy (Efstation et al., 1990), supervisory feedback (Lehrman-Waterman & Ladany, 2001), and even client outcome (Patton & Kivlighan, 1997).

Purpose of Study

Monitoring treatment outcome is recommended for practice and training. Specific to training, although the use of client feedback data has been proposed to improve the supervision process, little research exists that examines this particular claim. The purpose of the current study was to address this gap by evaluating the utility of client feedback data in supervision with known correlates of effective supervision. This study aimed to extend the Reese et al. (2009) study with two notable differences: use of a larger sample size and an attempt to isolate the specific effects of feedback in supervision. Specifically, the study compared the supervisory alliance and satisfaction with supervision of trainees in a feedback condition (i.e., used their client feedback data in supervision) to trainees in a supervision-as-usual condition (i.e., client feedback data were not used in supervision). We also included a secondary research question to evaluate if there were treatment outcome differences between supervisory conditions. We consider these to be exploratory questions given that the Reese et al. (2009) study did not find that the use of client feedback data in supervision increased satisfaction or supervisory alliance, but others have still advocated for the benefits of client feedback in supervision (Stoltenberg & McNeill, 2012; Worthen & Lambert, 2007). Moreover, we were uncertain if using the data from client feedback in supervision would provide incremental efficacy with client treatment outcome compared with what has been found in previous client feedback studies.

The Partners for Change Outcome Management System (PCOMS; Duncan, 2011) was selected from other feedback systems because of its research support and for comparison to the Reese et al. (2009) study. PCOMS consists of two brief, four-item measures that use a visual analog scale: the Outcome Rating Scale (ORS; Miller & Duncan, 2000; described in the *Measures* section) and the Session Rating Scale (SRS; Miller, Duncan, & Johnson, 2000). The ORS is completed at the beginning of a session and the SRS at the end of each session. Scores are plotted on a graph, and therapist and client discuss the scores. The SRS is based on the working alliance model (Bordin, 1979) and evaluates the client's perception of the therapeutic bond, the goals of treatment, and the approach or tasks in therapy to accomplish the goals. The fourth item asks if the session was helpful overall.

Method

Participants

Trainees. A total of 44 graduate-level trainees participated in the study. All were enrolled in a master's level clinical/counseling psychology program ($n = 15$) or marriage and family program ($n = 15$) at a medium, private, southwestern university or in a counseling psychology doctoral program ($n = 14$) at a large, public, southeastern university. The sample was composed of 18 men (40.9%) and 26 women (59.1%). Most of the sample identified as Caucasian (78.6%), 14.3% identified as African American, and 7.1% identified as Asian. The mean age was 26.38 years ($SD = 4.16$), with ages ranging from 20 to 31 years. Master's trainees were enrolled in either their first or second semester of practicum, and doctoral students were enrolled in their third or fourth semester of practicum. Treatment paradigms varied, includ-

ing cognitive-behavioral, empowerment feminist therapy, psychodynamic, family systems, and solution-focused therapy approaches.

Supervisors. Eighteen supervisors ($N = 18$; men = 8, women = 10) provided supervision to the trainees during the study. All of the supervisors were either licensed psychologists or marriage and family therapists and all had doctoral degrees. Supervisors had a range of 1–6 supervisees (mode = 1).

Clients. A total of 138 clients attended therapy at a training clinic or university counseling center. The sample was composed of 79 women (57.2%) and 59 men (42.8%). Most of the sample identified as Caucasian (74.4%), 18.3% identified as Hispanic/Latino, 2.8% as African American, 1.1% as Asian American, and 3.5% as other. The average age of clients was 25.6 years ($SD = 8.67$), with ages ranging from 18 to 30 years. Although specific diagnoses were not accessible given the variety of sites at which trainees provided services, clients generally presented with concerns similar to those that would typically be seen at community mental health and university counseling centers. Trainees worked with clients who presented with mood and anxiety disorders, grief, relationship and marital problems, and various other Axis I and Axis II disorders.

Measures

ORS. The ORS (Miller & Duncan, 2000) is a four-item visual analog self-report outcome measure that is to be administered to the client at the beginning of each session to assess client progress in therapy. This can occur electronically or using a paper-based format; the paper-based format was used in the current study. The client is asked to make a hash mark on a 10-cm visual analog scale that reflects his or her level of difficulty over the past week on four domains. Three of the domains of client functioning, which were derived from the Outcome Questionnaire-45 (OQ-45; Lambert et al., 1996), include “Individually” (personal well-being), “Socially” (work, school, friendships), and “Interpersonally” (family, close relationships). An “Overall” (general sense of well-being) item is also included. Marks toward the left indicate the client is experiencing more difficulty in the particular area and marks on the right indicate fewer difficulties. The distance from the left end of the visual analog scale to the mark made by the client is then measured to the nearest millimeter. The recorded distance for each of the four domains is totaled (0–40) and recorded on a graph to chart progress.

The established cutoff score for the ORS is 25, which is equivalent to the 77th percentile. Any score falling below this cutoff indicates the client has responded to the items in a manner that is similar to other individuals seeking therapy, and a score higher than 25 is characteristic of a nonclinical population (Miller & Duncan, 2000; Duncan, 2011).

Miller, Duncan, Brown, Sparks, and Claud (2003) found the ORS to generate reliable scores for individuals receiving therapy in a community mental health center. For all administrations ($n = 336$), the coefficient α was .93. Coefficient α s for the ORS within training clinics have ranged from .82 (Reese et al., 2009) to .84 (Reese et al., 2009). Miller et al. (2003) also examined the validity of the ORS by comparing scores on the OQ-45 with ORS scores among a group of clinical participants and a group of nonclinical participants. The total scores on the ORS had a moderate correla-

tion of .59 with the OQ-45 total scores, providing evidence for construct validity. Cronbach’s α for the first session of the current sample was .90.

Supervisory Satisfaction Questionnaire. The Supervisory Satisfaction Questionnaire (SSQ; Ladany et al., 1996) is an eight-item scale used to measure one’s satisfaction with supervision. Participants respond using a four-point Likert-type scale with options ranging from 1 (*low*) to 4 (*high*). Items included, “How would you rate the quality of supervision you have received?” and “In an overall, general sense, how satisfied are you with the supervision you have received?” Possible scores range from 8 to 32, with higher scores indicating greater satisfaction. Ladany et al. (1996) found that the SSQ generated scores with high internal consistency (Cronbach’s $\alpha = .96$) and reported that satisfaction with supervision was positively related to trainee disclosure during the supervision process. For the current sample, Cronbach’s α was .92.

Supervisory Working Alliance Inventory–Trainee Version. The Supervisory Working Alliance Inventory–Trainee Version (SWAI-T; Efstation et al., 1990) is a 19-item questionnaire used to assess the supervisee’s perspective of the supervisory relationship. The measure is made up of two subscales, Rapport and Client Focus, which contain items such as “I feel comfortable with my supervisor” and “My supervisor helps me work within a specific treatment plan with my clients,” respectively. Trainees respond to each item using a seven-point Likert-type scale with options ranging from 1 (*almost never*) to 7 (*almost always*). Efstation et al. (1990) found internal consistency coefficients for the Rapport and Client Focus subscales to be 0.90 and 0.77, respectively. A confirmatory factor analysis conducted by Efstation et al. (1990) revealed evidence for validity via a two-factor structure; the Rapport subscale accounted for 30% of the variance, and the Client Focus subscale accounted for 8%. Several researchers have elected to combine the two subscales because of high interfactor correlations (Patton & Kivlighan, 1997). In keeping with this approach, a composite scale compiled of items from the two subscales was used. Cronbach’s α for the composite scale for the current sample was .96.

Procedures

All trainees and supervisors received 1 h of training provided by one of the coauthors using the PCOMS manual (Duncan, 2011). The manual provides cut scores and a simple rubric to assist clinical decision-making for monitoring treatment outcome and alliance progress. Supervisors and trainees were also provided with a briefer manual that highlighted the administration, scoring, and use in session. Supervisors and trainees were then randomly assigned to either the Feedback Supervision (FBS) condition ($n = 9$ supervisors, 23 trainees) or the Supervision-As-Usual (SAU) condition ($n = 9$ supervisors, 21 trainees) for one academic semester (16 weeks). All trainees in both conditions used the ORS with all clients in individual therapy at the beginning of every session to assess progress in treatment and the SRS at the end of every session to monitor the therapeutic alliance as prescribed in the PCOMS manual.

Supervisors in the FBS condition reviewed the ORS/SRS results for each client with their supervisees during weekly individual supervision meetings, and supervisors in the SAU condition pro-

vided weekly individual supervision as usual without review of the data from the measures. Supervisors in the FBS condition were provided with a brief protocol to guide their use and discussion of the measures during supervision. The measures were introduced as a means by which to help the supervisor work with the supervisee in better understanding how each client is progressing in treatment. Supervisees were informed that the ORS and SRS would be viewed as “dashboard indicators” of the clients’ progress and would not be used as an evaluative tool of the therapists’ skills. FBS supervisors and supervisees were informed that the sole purpose for using the measures was to provide specific feedback regarding the therapy process to help improve client outcomes. Supervisees were asked to bring the ORS, SRS, and graph for each client to each supervision meeting. The supervisor was then to consider whether or not the client was (a) progressing as expected, (b) above the clinical cutoff, (c) not improving as expected (i.e., no reliable change by the third of six sessions), or (d) deteriorating.

When a client was identified as not improving as expected or deteriorating, more focus was placed on these clients in supervision. If a client was identified as doing well or progressing, the supervisee was asked to identify specific components that could potentially be contributing to the client’s success. The supervisor was to encourage the supervisee to focus on the client’s contribution and the therapist’s contribution to the positive progress. Fidelity was evaluated at the therapist and supervisor level. This was done in two ways. First, weekly data entry was used to make sure the trainees enrolled were turning in copies of the ORS/SRS completed by their clients. Encouragement through e-mails was also provided to elicit cooperation. Second, at the conclusion of the academic semester a measure was provided that asked trainees to answer whether the ORS/SRS scores were discussed in supervision (“every week,” “most weeks,” “occasionally,” “rarely,” or “never”). We did this anticipating there would be times supervisors in the FBS condition would forget and times when trainees/supervisees discussed the outcome measures in the SAU condition. This was in fact the case with approximately 18% of participants in the SAU endorsing that the ORS/SRS scores were discussed in supervision “occasionally.” Moreover, roughly 64% in the FBS condition reported using the feedback protocol at least most weeks (the rest endorsed “occasionally”). However, it appears that there was a level of adherence to the supervision protocol given the large differences reported between supervision conditions.

Trainees in both conditions also completed the SSQ and the SWAI-T at the end of the academic semester to measure satisfaction and the supervisory working alliance. An open-response follow-up questionnaire was also given to supervisors and supervisees to obtain their feedback and attitudes regarding use of the measures in therapy and supervision. Data were collected for a 2-year period. Trainees in the study participated for one semester (16 weeks) and were using client feedback in a practicum training experience for the first time.

Results

Preliminary Analyses

Because of the hierarchical nature of the data for our primary research questions, in which trainees were nested within supervisors, analyses were first conducted to determine whether multi-

level modeling (MLM) was appropriate. Following the steps outlined by Peugh (2010), we first analyzed whether statistically significant variations existed in supervisee scores on the SSQ and on the SWAI across supervisors. SSQ and SWAI scores were expected to vary across supervisees within a supervisor because of individual differences in the trainees. However, to assess for variance across supervisors, SSQ and SWAI-T scores were averaged for trainees within each supervisor to produce a mean SSQ and a mean SWAI-T score (Paccagnella, 2006). If statistically significant variations in either the mean SSQ or mean SWAI-T scores were found, then MLM would be warranted to separately estimate the SSQ variance and the SWAI-T variance that occurs across supervisees and across supervisors. To assess for significant differences, design effect statistics were calculated. Results of these analyses indicated that supervisee reports of satisfaction with supervision and the supervisory working alliance did not differ significantly across supervisors. Because no statistically significant variations existed across supervisors, MLM was not warranted.

Supervisee Satisfaction and the Supervisory Working Alliance

SSQ and SWAI-T total score means and standard deviations for the FBS and SAU conditions can be found in Table 1. A multivariate analysis of variance (MANOVA) was conducted to evaluate the differences between the treatment and control conditions. The analysis revealed no overall main effect on the supervisory alliance or the supervisee’s satisfaction when using client feedback data during supervision, Wilk’s $\lambda = .88, F(2, 38) = 2.46, p > .05$, partial $\eta^2 = 0.12$. However, the ES for the multivariate analysis (0.12) revealed a medium ES across the measures, which is large enough to warrant conducting a between-subject analysis of treatment condition to evaluate univariate differences (Cohen, 1988).

The univariate tests for between-subject effects revealed that trainees who utilized feedback during the supervision process had statistically significant higher scores on the SSQ than did those who did not utilize feedback during supervision, $F(1, 39) = 5.04, p = .03, \eta^2 = 0.11$. However, the mean difference for scores on the SWAI-T was not found to be statistically significant, $F(1, 39) = 3.49, p = .07$, partial $\eta^2 = 0.08$, but a medium ES was found.

Table 1
Supervisory Working Alliance Inventory and Satisfaction With Supervision Means and Standard Deviations for FBS and SAU Conditions

Condition	<i>n</i>	<i>M</i>	<i>SD</i>
SWAI-T			
FBS	21	115.14	13.30
SAU	20	104.14	23.28
SSQ			
FBS	21	29.86	3.09
SAU	20	26.85	5.26

Treatment Outcome by Supervisory Feedback Condition

Inclusion in the analysis of treatment outcome required a client to have attended at least two sessions. Clients in the FBS condition attended a mean of 5.51 sessions ($SD = 3.21$), and those in the SAU condition averaged 4.77 sessions ($SD = 2.44$). Trainees in both conditions saw an average of 4.43 clients ($SD = 3.73$), ranging from 1 to 16, and provided a total of 1,007 sessions ($M = 5.33$; $SD = 2.91$). Clients in the FBS condition improved an average of 6.98 points from pretest to posttest on the ORS (21.59 to 28.57) compared with 7.17 points (22.99 to 30.16) in the SAU condition. This difference was not significant, $F(1, 165) = .02$, $p > .05$. ES ($d = M_{\text{post}} - M_{\text{pre}}/SD_{\text{pooled}}$) were also observed to be roughly equivalent across conditions, $d = 0.84$ (FBS) and $d = 0.87$ (SAU).

Discussion

Few studies have investigated how the use of continuous client feedback data in supervision may influence the supervisory process. The purpose of the present study was to examine the potential benefits of using the data from client feedback measures in supervision on two known correlates of effective supervision from the supervisee's perspective. We evaluated whether the use of client-reported outcome and alliance data during supervision would lead to differences in supervisee satisfaction with supervision, the supervisory working alliance, and client treatment outcome. Results indicated that trainees who used client feedback data during the supervision process reported statistically significant higher mean levels of satisfaction with supervision than did individuals in the SAU condition. However, there were no significant differences between supervisory conditions on trainee ratings of the supervisory alliance and client treatment outcome. This was a bit surprising given the relationship often found between the supervisory alliance and satisfaction (Reese et al., 2009; Son & Ellis, 2013). However, the medium ES (partial $\eta^2 = 0.08$) suggests that the sample may have been underpowered. A post hoc power analysis confirmed this ($1 - \beta = .53$). When taking the ES into consideration, it could be argued that the inclusion of client feedback data may have been beneficial to the supervisory alliance. Future research is certainly warranted to help clarify this further given the importance of the supervisory alliance to the supervisory process (Ellis, 1991) and perhaps client outcome (Patton & Kivlighan, 1997).

As reasoned by Worthen and Lambert (2007), the use of continuous client outcome data during the supervision process may help to provide the trainee with the specific feedback he or she desires and finds helpful. Because supervisors are sometimes hesitant to provide this feedback for fear it will damage the supervisory alliance, the use of client outcome data may allow for feedback that is perceived as more "value neutral" but meets the needs of the client and supervisee. The shift in obtaining specific feedback from the client as opposed to only the supervisor may allow for the feedback to seem more collaborative rather than evaluative, thus improving the supervisee's satisfaction with supervision.

The results obtained in this study differ from those of Reese et al. (2009), who found no difference in trainee satisfaction with supervision between the feedback and no-feedback conditions. The

difference in study findings is possibly due to the smaller sample size in the Reese et al. (2009) study (28 trainees and 9 supervisors), but perhaps it is for other reasons. For example, some of the students in the SAU condition anecdotally commented that it was frustrating to have the client feedback data but not be able to use the data during the supervision sessions. In the Reese et al. (2009) study, trainees in the SAU condition did not monitor outcome or alliance with their clients. The trainees did not have the additional information to share in supervision.

Although not a primary research question, we compared client treatment outcomes between the supervisory conditions. This was an exploratory research question because there is little research (Bambling, King, Raue, Schweitzer, & Lambert, 2006) to suggest that a different approach in supervision would lead to causal differences in client outcome. In fact, the supervision literature is still grappling with the fundamental question of whether supervision even affects client outcome (Watkins, 2011). However, the ES of trainees in both conditions were comparable to the ES ($d = 0.92$) for trainees who used client feedback in the Reese et al. (2009) study.

Subjectively, on the open-ended item that asked them to share their experience of using client feedback data during supervision, trainees generally reported a positive experience with using client feedback and that the process helped them to better understand and meet the individual needs of clients. Several trainees also noted that the process helped them to better organize and consolidate which clients they needed to discuss. This may have promoted the possibility for more specific feedback (Lehrman-Waterman & Ladany, 2001), which resulted in increased satisfaction with supervision. Lastly, when asked if client feedback should be a required process in clinical training, all but two endorsed that it should be required.

Limitations

There were three major limitations of the current study. First, the sample was limited in size and in diversity. The sample size limited the capacity to find differences between the supervisory conditions—we only had enough power to detect medium ES. The use of a larger sample size would have perhaps led to larger differences between the two supervisory conditions on the supervisory measures. At the same time, we did find significant differences in supervisee satisfaction. Obtaining a sample that required supervisor, supervisee, and client participation in three different graduate programs proved to be quite challenging. This is perhaps the primary reason why so few controlled supervision studies exist that include client outcome and supervisory process data (Watkins, 2011).

A second limitation is the issue of protocol fidelity. Because three levels of participants were used (supervisors, supervisees, and clients), it was difficult to ensure that all followed the provided protocol. We attempted to address this by asking supervisees if their supervisors used the client feedback protocol in supervision, and if so, how often. Supervisees in the FBS condition reported that their supervisors used client feedback data more frequently than those in the SAU condition, but there was not 100% compliance in either condition. In fact, approximately 36% of the respondents in the FBS condition said they discussed the measures only occasionally. This certainly may have led to a weakening of the

intervention and to an underestimation of the effects in the FBS condition. This is tempered by a follow-up analysis with the 64% compliant subgroup that did not yield a change in the results. Anecdotally, supervisees reported more positive attitudes regarding use of the ORS and SRS during therapy and supervision than did supervisors. We suspect that the difficulty with adherence was primarily due to the supervisors; most of the supervisors had several years of experience and likely had difficulty altering established supervisory approaches. Although a formal assessment of fidelity was not conducted at the supervisory level, multiple supervisors anecdotally noted that they simply forgot.

A third limitation is that we evaluated only one semester of data with students who had never used client feedback with their clients. We are uncertain how trainee experience influenced the results. Perhaps after a semester, supervisors and supervisees would have been more comfortable with the client feedback process and would have been able to implement it more efficiently or effectively. Furthermore, trainees who were found to have struggled with clients in the first semester may have had the groundwork laid to consolidate supervisory feedback and demonstrate significant clinical improvement in subsequent semesters (Duncan, 2010). Conversely, Reese et al. (2009) found that client outcome ES improved in the second semester of using client feedback. Better client outcomes coupled with the likelihood that supervisees would be more confident after a semester of practicum experience (Kozina, Grabovari, De Stefano, & Drapeu, 2010) may have led supervisees and supervisors to have relied on the measures in supervision less. In short, this limitation affects the generalizability of the study's findings and may be a reason the results differed from the Reese et al. (2009) study.

Future Study

The findings of the present study point to a couple of potentially beneficial research possibilities that should be considered. First, further examination of the role that various supervisory processes play in relation to client and supervisory outcomes is needed. In the current study, differences in supervisory outcome did not reflect differences in client outcome. Specifically, although those in the FBS condition were more satisfied with their supervision, this did not reflect better treatment outcomes. Effective supervision has typically been based on supervisory process outcomes (e.g., satisfaction, supervisory alliance, counselor self-efficacy); however, how these variables relate to what happens in the therapy room with clients is not well understood.

Specific to client feedback, more studies are needed given the current study findings. If client feedback data are used in supervision, then perhaps there are more effective ways in which to use the feedback data than what were evaluated in the current study. We evaluated what could be considered a "triage" approach to using client feedback data to help focus supervision, but there may be better ways in which to incorporate client data. The intervention we used was rather minimal. Moreover, being "forced" to talk first about clients struggling the most may not be the most effective means for some supervisees, especially beginning supervisees who are trying to become comfortable in the therapist role (Stoltenberg, 2005). For example, using the client outcome/alliance data from a more process-oriented paradigm that is focused on building a collaborative supervisory relationship may yield different out-

comes with beginning therapists. If client feedback does indeed facilitate supervisory feedback to be perceived as more "value neutral" (Worthen & Lambert, 2007) because the supervisor's critique is based on information provided by the client, then supervisors may be perceived as more supportive and collaborative.

Conclusions and Implications

The primary purpose of clinical supervision is to ensure that the needs of the supervisee and the client are effectively met. The use of continuous client feedback data in supervision would appear to be beneficial in helping to meet both of these goals. The results of the present study using client-based outcome and therapeutic alliance data with a sample of master's and doctoral-level trainees demonstrated that the use of client feedback in supervision led to an increase in satisfaction with supervision. At this point, we can only speculate why that may be. Supervisees indicated that it helped them to organize what they wanted to discuss in supervision and helped to consolidate their understanding of how they were doing with their clients and, more broadly, their clinical training. They generally liked using client feedback with their clients and in supervision. The current results are encouraging, but this study is merely a starting point. More research on client feedback in training is needed as is more general research on how supervision processes are related to client outcome. As it has been documented elsewhere (e.g., Stoltenberg & McNeill, 2012; Watkins, 2011), there is a paucity of research that connects clinical supervision with client outcome. More studies need to be conducted that evaluate the process of if and, if so, how supervision influences and contributes to better client outcomes. Without an established connection, research that evaluates only supervisory process variables is superfluous.

The American Psychological Association Commission on Accreditation (2011) now requires that the monitoring of treatment outcomes be a part of the training process in APA-approved doctoral programs; having a better understanding of how this process influences trainee development is critical to clinical supervision and training. The problem, as already lamented, is the difficulty with collecting sufficient data with limited numbers of trainees and then having client outcome data. The use of client feedback systems in training programs offers a great opportunity for programs to share data across graduate programs. A nice model for this is the national standardized outcome data consortiums for university and college counseling centers, such as the Center for Collegiate Mental Health housed at Penn State University's counseling center (<http://cmh.squarespace.com/>).

Psychology needs to improve its training and supervision research. The current study is an example of the opportunity that monitoring client outcome of trainees offers for supervision and training research. We attempted to build on previous research (Reese et al., 2009) by isolating the effects of client feedback data discussed in supervision. The results indicated that the use of client feedback data in supervision did not lead to better client outcomes, but doing so increased supervision satisfaction. Given that the ES in the current study were similar to the ES of trainees in the Reese et al. (2009) study, the results suggest that client feedback is a useful process for clinical training. Future research needs to un-

pack this process further to better understand the potential and limits of client feedback in training.

References

- Ackerman, S., Smith, B., Beutler, L. E., Gelso, C. J., Goldfried, M. R., Hill, C., . . . Ranier, J. (2001). Empirically supported therapy relationships: Conclusions and recommendations of the Division 29 Task Force. *Psychotherapy: Theory, Research, Practice, Training*, 38, 495–497. doi:10.1037/0033-3204.38.4.495
- American Psychological Association Commission on Accreditation. (2011). *Commission on Accreditation Implementing Regulations*. Retrieved from <http://www.apa.org/Ed/accreditation/about/policies/implementing-guidelines.pdf>
- American Psychological Association Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, 61, 271–285. doi:10.1037/0003-066X.61.4.271
- Bambling, M., King, R., Raue, P., Schweitzer, R., & Lambert, W. (2006). Clinical supervision: Its influence on client-rated working alliance and client symptom reduction in the brief treatment of major depression. *Psychotherapy Research*, 16, 317–331. doi:10.1080/10503300500268524
- Bernard, J. M., & Goodyear, R. K. (2009). *Fundamentals of clinical supervision* (4th ed.). Boston, MA: Allyn & Bacon.
- Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, 16, 252–260. doi:10.1037/h0085885
- Brown, G. S., & Jones, D. R. (2005). Implementation of a feedback system in a managed care environment: What are patients teaching us? *Journal of Clinical Psychology*, 61, 187–198. doi:10.1002/jclp.20110
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.
- Duncan, B. L. (2010). *On becoming a better therapist*. Washington, DC: American Psychological Association. doi:10.1037/12080-000
- Duncan, B. L. (2011). *The Partners for Change Outcome Management System (PCOMS): Administration, scoring, interpreting update for the Outcome and Session Ratings Scale*. Jensen Beach, FL: Author.
- Efstation, J. F., Patton, M. J., & Kardash, C. M. (1990). Measuring the working alliance in counselor supervision. *Journal of Counseling Psychology*, 37, 322–329. doi:10.1037/0022-0167.37.3.322
- Ellis, M. V. (1991). Critical incidents in clinical supervision and in supervisory supervision: Assessing supervisory issues. *Journal of Counseling Psychology*, 38, 342–349. doi:10.1037/0022-0167.38.3.342
- Ellis, M. V., & Ladany, N. (1997). Inferences concerning supervisees and clients in clinical supervision: An integrative review. In C. E. Watkins (Ed.), *Handbook of psychotherapy supervision* (pp. 447–507). New York, NY: Wiley.
- Fernando, D. M., & Hulse-Killacky, D. (2005). The relationship of supervisory styles to satisfaction with supervision and the perceived self-efficacy of masters's level counseling students. *Counselor Education and Supervision*, 44, 293–304. doi:10.1002/j.1556-6978.2005.tb01757.x
- Kozina, K., Grabovari, N., De Stefano, J., & Drapeu, M. (2010). Measuring changes in counselor self-efficacy: Further validation and implications for training and supervision. *The Clinical Supervisor*, 29, 117–127. doi:10.1080/07325223.2010.517483
- Ladany, N., Hill, C. E., Corbett, M. M., & Nutt, E. A. (1996). Nature, extent, and importance of what psychotherapy trainees do not disclose to their supervisors. *Journal of Counseling Psychology*, 43, 10–24. doi:10.1037/0022-0167.43.1.10
- Lambert, M. J. (2001). Psychotherapy outcome and quality improvement: Introduction to the special section on patient-focused research. *Journal of Consulting and Clinical Psychology*, 69, 147–149. doi:10.1037/0022-006X.69.2.147
- Lambert, M. J., Hansen, N. B., Umphress, V., Lunnen, K., Okiishi, J., Burlingame, G. M., & Reisinger, C. W. (1996). *Administration and scoring manual for the OQ 45.2*. Stevenson, MD: American Professional Credentialing Services.
- Lambert, M. J., & Hawkins, E. J. (2001). Using information about patient progress in supervision: Are outcomes enhanced? *Australian Psychologist*, 36, 131–138. doi:10.1080/00050060108259645
- Lambert, M. J., & Shimokawa, K. (2011). Collecting client feedback. *Psychotherapy*, 48, 72–79. doi:10.1037/a0022238
- Lehrman-Waterman, D., & Ladany, N. (2001). Development and validation of the Evaluation Process Within Supervision Inventory. *Journal of Counseling Psychology*, 48, 168–177. doi:10.1037/0022-0167.48.2.168
- Miller, S. D., & Duncan, B. L. (2000). *The Outcome Rating Scale*. Chicago, IL: Author.
- Miller, S. D., Duncan, B. L., Brown, J., Sparks, J. A., & Claud, D. A. (2003). The Outcome Rating Scale: A preliminary study of the reliability, validity, and feasibility of a brief, visual, analog measure. *Journal of Brief Therapy*, 2, 91–100.
- Miller, S. D., Duncan, B. L., & Johnson, L. D. (2000). *The Session Rating Scale 3.0*. Chicago, IL: Author.
- Paccagnella, O. (2006). Centering or not centering in multilevel models? The role of the group mean and the assessment group effects. *Evaluation Review*, 30, 66–85. doi:10.1177/0193841X05275649
- Patton, M. J., & Kivlighan, D. M. (1997). Relevance of supervisory alliance to the counseling alliance and to treatment adherence in counselor training. *Journal of Counseling Psychology*, 44, 108–115. doi:10.1037/0022-0167.44.1.108
- Peugh, J. L. (2010). A practical guide to multilevel modeling. *Journal of School Psychology*, 48, 85–112. doi:10.1016/j.jsp.2009.09.002
- Reese, R. J., Norsworthy, L. A., & Rowlands, S. (2009). Does a continuous feedback system improve psychotherapy outcome? *Psychotherapy: Theory, Research, Practice, Training*, 46, 418–431. doi:10.1037/a0017901
- Reese, R. J., Usher, E. L., Bowman, D. C., Norsworthy, L. A., Halstead, J. L., Rowlands, S. R., & Chisolm, R. R. (2009). Using client feedback in psychotherapy training: An analysis of its influence on supervision and counselor self-efficacy. *Training and Education in Professional Psychology*, 3, 157–168. doi:10.1037/a0015673
- Son, E., & Ellis, M. V. (2013). A cross-cultural comparison of clinical supervision in South Korea and the United States. *Psychotherapy*, 50, 189–205. doi:10.1037/a0033115
- Sparks, J. A., Kisler, T. A., Adams, J. F., & Blumen, D. G. (2011). Teaching accountability: Using client feedback to train effective family therapists. *Journal of Marital and Family Therapy*, 37, 452–467. doi:10.1111/j.1752-0606.2011.00224.x
- Stoltenberg, C. D. (2005). Enhancing professional competence through developmental approaches to supervision. *American Psychologist*, 60, 857–864. doi:10.1037/0003-066X.60.8.85
- Stoltenberg, C. D., & McNeill, B. W. (2012). Supervision: Research, models, and competence. In N. A. Fouad & L. M. Subich (Eds.), *ZAPA handbook of counseling psychology* (5th ed., Vol. 1, pp. 295–327). Washington, DC: American Psychological Association.
- Watkins, C. (2011). Does psychotherapy supervision contribute to patient outcomes? Considering thirty years of research. *The Clinical Supervisor*, 30, 235–256. doi:10.1080/07325223.2011.619417
- Worthen, V. E., & Lambert, M. J. (2007). Outcome-oriented supervision: Advantages of adding systematic client tracking to supportive consultations. *Counseling and Psychotherapy Research*, 7, 48–53. doi:10.1080/14733140601140873

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