

TEACHING ACCOUNTABILITY: USING CLIENT FEEDBACK TO TRAIN EFFECTIVE FAMILY THERAPISTS

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The AAMFT Task Force on Core Competencies (Nelson et al., 2007) proposed that marriage and family therapy (MFT) educators teach and provide evidence of trainee competence beyond coursework and accrued clinical hours. This article describes the integration of a systematic client feedback protocol into an MFT-accredited program's curricula to address the call for outcome-based learning. Outcome management (OM) provides a framework for teaching and assessing trainee effectiveness. Continuous incorporation of client feedback embodies collaborative, strengths-based, integrative, and diversity-centered program values. Students learn a system for being accountable to clients, the profession, and service communities.

Within the past decade, calls have been made for the provision of “safe, effective, patient-centered, timely, efficient, and equitable” health care for all persons (Committee on Quality of Health Care in America, 2001, pp. 7–8). This call has extended to mental health services (President's New Freedom Commission on Mental Health, 2003). Moreover, consumers have demanded evidence of treatment effectiveness. In response, mental and behavioral health organizations have taken steps to define effective, safe care (e.g., see APA Presidential Task Force on Evidence-Based Practice; Hoge et al., 2005; Nelson et al., 2007). Despite varying definitions of best practice, mental health disciplines appear united in the ethics of providing evidence of effectiveness. Indeed, a current focus on outcome, the *sine qua non* of effectiveness evidence, prompted Leigh et al. (2007) to call this the “era of accountability” (p. 463).

The AAMFT Task Force on Core Competencies responded to the demand for accountability by first defining six domains of knowledge and skills required for entry-level independent practice as a marriage and family therapist (Nelson et al., 2007).¹ These domains encompass all aspects of care and presumably define competent practice as a couple and family therapist. The Task Force invited further discussion regarding how best to teach and assess competence and suggested that training models shift from an input-oriented to outcome-based education. This entails less reliance on coursework and accrual of clinical hours as proof that trainees can provide effective care (Nelson et al., 2007). Instead, trainees would be required to demonstrate that their educational experiences have translated into core skills.

That training of clinical practitioners should include teaching demonstrable skills seems obvious. However, some have questioned whether therapist skill development leads to better client outcomes. According to Lambert and Hawkins (2001), the degree to which skills generalize to practice is inconclusive. For example, students may succeed in learning a particular skill set, yet have difficulty transporting that into the therapy room. Moreover, there is evidence that therapist mastery of specific interventions may actually interfere with client and therapist engagement, resulting in suboptimal outcomes (Beutler et al., 2004; Lambert & Ogles, 2004).

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Furthermore, means of evaluating knowledge may be readily available, while methods assessing skills present greater challenges (Leigh et al., 2007). Lichtenberg et al. (2007) claimed that traditional paper and pencil testing lacks ecological validity in evaluating practice skills. These considerations present practical and conceptual challenges in evaluating competence.

One response to addressing these difficulties is the incorporation of information derived directly from the trainee's clinical practice. Psychology educators have asserted that assessment methods that do not involve direct observation of the person in actual situations, do not include feedback from clients, and do not assess clinical outcomes cannot adequately evaluate a trainee's ability to help clients (Leigh et al., 2007; Lichtenberg et al., 2007). Kaslow, Celano, and Stanton (2005) described a competencies-based approach in family psychology as one emphasizing "the ability to apply knowledge and skills in the real world and [one that] uses performance outcome as criteria for evaluating learners and training programs" (p. 338). The APA's Task Force on the Assessment of Competence has endorsed assessments that evaluate the trainee's intervention with clients (Kaslow et al., 2007). Similarly, the Annapolis Coalition recommended the use of multiple data sources for assessment, including client surveys (Hoge et al., 2005).

Family therapy educators have proposed the use of evaluative tools in supervision as one framework for assessing competence (Nelson et al., 2007). Supervision has long been a mainstay of quality assurance in therapist training (Falender et al., 2004) and particularly for MFTs (Liddle, Breunlin, & Schwartz, 1988; Nichols, Nichols, & Hardy, 1990; Todd & Storm, 1997; White & Russell, 1995). Supervision ultimately should serve client welfare (e.g., Avis & Sprenkle, 1990; Holloway & Carroll, 1996; Worthen & Lambert, 2007). However, decades of research have produced very little regarding its actual impact on outcome (Ellis & Ladany, 1997; Freitas, 2002; Lambert & Hawkins, 2001; Lambert & Ogles, 1997; Storm, Todd, Sprenkle, & Morgan, 2001). One recent study, addressing methodological concerns of earlier studies, found that supervision exerted a moderate effect on outcome, accounting for approximately 16% of the outcome variance beyond that accounted for by the client's initial severity and therapist attributes (Callahan, Almstrom, Swift, Borja, & Heath, 2009). Nevertheless, with so few studies, it is still reasonable to state, as Storm et al. did, that "it would not be overstating the case to assert that the field's belief in the importance of supervision rests mostly on faith" (p. 227).

Similarly, therapists in training are most often supervised without any objective information about clients' responses to the therapy (Sapyta, Reimer, & Bickman, 2005). As "supportive consultation," supervision may be considered satisfactory by both supervisor and supervisee, yet remain disconnected to whether or not clients improve (Worthen & Lambert, 2007, p. 4). In other words, supervision as a benefit for therapist development is separated from client benefit. This disconnect has prompted recommendations for routinely incorporating client outcome information into the supervision process (Lambert & Hawkins, 2001; Worthen & Lambert, 2007). This would require trainees to systematically track and discuss progress of their cases in supervision. Supervisors can then provide targeted oversight in addressing cases not proceeding satisfactorily while supervisees learn the value of flexible, informed clinical practice.

To date, agreed-upon guidelines for assisting couple and family therapy educators to train a competent, accountable workforce have not been devised. Realignment of educational curricula in MFT training programs with identified competencies is likely to take a decade (Nelson et al., 2007). Moreover, the field has yet to offer guidance regarding the integration of practice-based research into all aspects of clinical training, including supervision. Furthermore, the cogent critiques of training methods that do not include client outcomes appear underrepresented in MFT literature and practice. This article discusses one MFT-accredited program's efforts to integrate a systematic client feedback protocol into its training, supervision, and educational curricula in an effort to develop procedures consistent with the transition to outcome-based learning recommended by the AAMFT and address the call for accountability in delivering measurably effective treatment. We begin by describing the evolution of an OM system at our family therapy program at the University of Rhode Island and its integration into coursework, clinical training, and supervision. We report students' views of their experiences with this method and conclude with discussion and future directions for the field.

CLIENT FEEDBACK AND OUTCOME

A relatively new research paradigm offers a potential training model to bridge research and practice and teach trainees the ethical and practical value of being accountable to their clients. Howard, Moras, Brill, Martinovich, and Lutz (1996) advocated for the systematic evaluation of client response to treatment during the course of therapy and recommended such information be used to “determine the appropriateness of the current treatment . . . the need for further treatment . . . [and] prompt a clinical consultation for patients who [were] not progressing at expected rates” (p. 1063). The development of new statistical techniques has allowed researchers and clinicians to generate trajectories of change using session-by-session data and to compare client progress with similar clients utilizing large databases of client change scores. These comparisons generate probabilistic predictions about the client’s posttreatment outcome (see Lambert, 2010). Computerized predictions provide a basis for identifying clients who are not responding as expected and a chance for clinicians to respond accordingly. Computerized predictions, in fact, have proven superior to therapists. Hannan et al. (2005), comparing therapist predictions of client deterioration to actuarial methods, found that therapists identified only one of the 40 clients who deteriorated, even though they were aware of the study’s purpose and informed that the base rate was likely to be 8%. In contrast, the actuarial method correctly predicted 36 of the 40.

Investigations into client feedback methods have revealed consistently positive findings. In a meta-analysis of five major randomized trials, Lambert (2010) reported that as many as 45% of feedback groups, supplemented with clinical support tools (alliance measures, motivation assessment, and discussion of client support systems) reached reliable improvement and clinically significant change (Jacobson & Truax, 1991) compared with 22% of treatment as usual (TAU) at-risk cases. Miller, Duncan, Brown, Sorrell, and Chalk (2006) used continuous feedback and brief outcome instruments to explore the impact of feedback in a large, culturally diverse sample ($n = 6,424$) utilizing telephonic employee assistance services. The use of outcome feedback doubled the effect size (ES) from 0.37 to 0.79 and significantly increased retention.

Couple and family feedback research lags behind individual studies, perhaps in part because of the complexity of obtaining frequent measurements from multiple persons in a given couple or family unit. A small recent study of feedback in wraparound services for youth and families (Ogles et al., 2006) found that provision of feedback at four intervals using the 48-item Ohio Scales (Ogles, Melendez, Davis, & Lunnen, 2001) did not contribute to improved youth outcomes or family functioning in comparison with a no-feedback group. Sparks and Duncan (2010) suggest that lack of separation between feedback and no-feedback conditions in this study can be explained by the collection of feedback at only four intervals during the course of treatment. Moreover, Lambert (2010) cautions that lack of continuous monitoring limits findings as effects of dropout or premature termination are unknown. Reese et al. (2009), using briefer instruments, found that MFT and counseling trainees ($N = 28$) assigned to the continuous feedback condition and who shared feedback with their supervisors were approximately twice as effective as those in the no-feedback condition over the course of an academic year. Trainees in both feedback and no-feedback groups increased their sense of self-efficacy over the year, but only feedback trainees’ self-efficacy correlated with client outcome. A strong effect of feedback also was found in a recent couples study (Anker, Duncan, & Sparks, 2009), the largest clinical trial with couples to date. Couples ($N = 205$) at a community-based family counseling clinic were randomly assigned to either TAU or feedback. Feedback couples demonstrated significantly greater improvement at termination than those in the TAU condition and achieved over four times the rate of clinically significant change. This superiority carried over at follow-up—divorce and separation rates for feedback couples were 46.2% less than for couples who received therapy as usual 6 months after termination. In sum, there are, to date, eight trials supporting the use of client feedback to monitor treatment and improve outcomes.

OUTCOME MANAGEMENT ADOPTION

Our adoption of a client feedback system, or OM (Duncan, Miller, & Sparks, 2004),² grew out of a consensus regarding the value of OM as a research-informed method for training therapists to work effectively with families and couples. Outcome management refers to the

systematic collection of client feedback regarding progress and the alliance during treatment to facilitate management of the therapy toward the best possible outcome. We believed that clients had largely been overlooked as teachers for those in training. Instituting a formal client feedback system could bring clients to the front of the class, so to speak, to impart valuable lessons in how to be of assistance to those seeking change in therapy.

Research is clear regarding the significance of therapist variability in relation to outcome. Some therapists clearly are better than others in helping clients reach optimal benefit (Beutler et al., 2004; Wampold & Brown, 2005). Depending on the study, therapist effects range from 6% to 9% of the overall variance of change, or about 6–9 times more than that of model differences. Differences in therapist ability are often apparent early in the training process. However, there is evidence that therapists performing poorly can improve when they routinely integrate client feedback into their work. For example, Anker et al. (2009) found that 9 of 10 therapists improved their outcomes with feedback. Moreover, less-effective therapists benefited more from feedback than the most effective therapists. Feedback, therefore, seems to act as a leveler. In another study, the number of below-average counselors dropped by 80% after feedback was implemented (Bohanske & Franczak, 2010). A feedback system, then, would give us a field-tested method for helping trainees with poorer outcomes improve.

In light of current research, we also speculated that OM could serve as a vehicle for improving the effectiveness of our clinic services. Dropouts are a significant problem in the delivery of mental health services, averaging at least 47% (Wierzbicki & Pekarik, 1993). Moreover, there is evidence that training clinics have more premature terminations and fewer successful outcomes than other outpatient settings (Callahan et al., 2009). Training clinics often provide services to financially disadvantaged clients, making the mandate for the provision of quality care of particular concern. Our family therapy clinic serves a predominantly low-income outpatient population. Approximately 90% of clients meet federal poverty guidelines. Providing the best care possible for the population we serve is particularly critical.

In addition to enhanced service to clients and improved training, implementing an OM system would provide students with opportunities to engage in practice-based research. MFT research and practice historically have been disconnected, if not viewed as in opposition (Hodgson, Johnson, Ketring, Wampler, & Lamson, 2005). Ironically, the immediate practice environments characteristic of most MFT programs are prime locales for the integration of research and clinical work. Without protocols for evaluative research, clinics operate “in the dark,” and students absorb the message that continuous assessment of services is not important. We could not think of a more powerful way to instill in students a sense of the ethics and utility of a client-service system loop than through the requirement that they systematically elicit and be informed by client feedback. Further, OM would supplement our ongoing research and client satisfaction protocols. As data are collected at each session, pre- and posttherapy data are available for each client, even those who drop out or do not respond to follow-up.

Outcome management additionally appeared to be an opportunity for us to put into practice assumptions that underpin our program. Our students are expected to collaborate with their colleagues as well as their clients. Further, they are taught to support clients’ unique strengths and resources. We felt that teaching students to routinely ask for and respond to client feedback would embody core values related to collaboration and a strengths focus. Additionally, our program is integrative, exposing students to many different theories and models. We encourage students to utilize those approaches that resonate for them. We speculated that routine client feedback could provide a safety net to ensure that a favored approach was, in fact, working and prompt a shift to a different one when it was not. In this way, OM would serve as a centerpiece for student integration of diverse treatment models.

We further considered that OM would give life to our program’s commitment to diversity; students could put into practice what they were learning about diversity in the classroom. Government reports have concluded that nondominant groups often face treatments that fail to consider their unique contexts and are, therefore, ineffective (Sue & Zane, 2006). Furthermore, training in cultural competency, particularly in a stand-alone course, may inadvertently marginalize diversity and reinforce blindness to privilege disparities between White, heterosexual, middle-class mental health professionals and their diverse clientele (Levant & Silverstein, 2006).

With client voices guiding clinical work, trainees could learn from and better assist persons whose social and cultural locations differed from their own. The outcome assessment measures chosen consist of content-free dimensions, requiring therapists to invite clients to clarify their views regarding their unique journeys of change. We hoped that a process of respectful inquiry, embodied in this collaborative feedback system, would help students step outside their own worlds and understand more fully those of their clients.

As educators in an accredited MFT training program, we were interested in how to move from an input-oriented to outcome-based education model (see Nelson et al., 2007). With this in mind, we considered how OM might help us assess learning outcomes not measured by test scores or standard numbers of accrued clinical hours. In the broadest sense, we grasped the obvious link between utilization of an OM system and the important objective of training students to effectively help clients. More specifically, we began to recognize that OM could provide a means for teaching and evaluating particular MFT core competencies.

Based on a preliminary mapping of OM onto a core competencies framework, we identified numerous areas of congruence. For example, within the primary domain “Admission to Treatment,” OM directly addresses the following executive functions:

- Establish and maintain appropriate and productive therapeutic alliances with the clients.
- Solicit and use client feedback throughout the therapeutic process.

Pertaining to “Clinical Assessment and Diagnosis,” OM procedures support the following:

- Assess each client’s engagement in the change process.
- Identify clients’ strengths, resilience, and resources.
- Assess the therapist–client agreement of therapeutic goals and diagnosis.

Similarly, specific therapist activities listed for “Treatment Planning and Case Management” are consistent with OM procedures:

- Integrate client feedback, assessment, contextual information, and diagnosis with treatment goals and plan.
- Evaluate progress of sessions toward treatment goals.
- Recognize when treatment goals and plan require modification.

OM is especially pertinent to the domain “Therapeutic Interventions”:

- Match treatment modalities and techniques to clients’ needs, goals, and values.
- Modify interventions that are not working to better fit treatment goals.
- Evaluate ability to deliver interventions effectively.
- Evaluate treatment outcomes as treatment progresses.
- Evaluate clients’ reactions or responses to interventions.
- Evaluate clients’ outcomes for the need to continue, refer, or terminate therapy.

The overlap between OM and MFT core competencies that emerged after our analysis convinced us that use of the system could provide a bridge between traditional learning assessment and more objective and meaningful evaluations of student outcomes.

Finally, OM had additional appeal for our program based on broader contextual elements in the University and community environments. The University of Rhode Island, in which our program is located, had moved to an outcome-based model of learning evaluation. Including measurable outcomes generated by client report would be one way of providing evidence of student progress. Larger systems of care serving children and families in our state with whom our students interact in internships were similarly moving toward developing models that would measurably identify treatment success or failure. We believed that it was important that our program be accountable to the University and that students appreciate the context of systems of care in which they are likely to spend a good portion of their professional careers.

OUTCOME MANAGEMENT PROTOCOL

Despite its fit with our program, the road to implementation of an OM system has required a shift in all aspects of how our students learn and how we teach. Our first step was

choosing the measures students would use in session with clients. We selected the Outcome Rating Scale (ORS; Miller, Duncan, Brown, Sparks, & Claud, 2003) and Child Outcome Rating Scale (CORS; Duncan, Sparks, Miller, Bohanske, & Claud, 2006) as outcome measures, and the Session Rating Scale (SRS; Duncan et al., 2003) and Child Session Rating Scale (CSRS) as alliance measures.³ The ORS and SRS are validated for use with adults and adolescents aged 13–17 and the CORS for children between the ages of 6 and 12. The instruments collapse multiple items into a few broad domains, minimizing disruption of the session when administered. This is especially important because OM protocols recommend tracking client progress and alliance at each meeting. At our clinic, children, their caretakers, and extended family are often seen together in session. Feasibility, therefore, is critical. The brevity and face validity of the instruments facilitate administration within this context. In addition, the measures selected had been translated into many languages. Many areas of our small state are ethnically diverse. We wanted to be sure that all our clients could participate comfortably.

Most importantly, the measures met our standards of practicality for everyday clinical use without sacrificing validity and reliability. Miller et al. (2003) reported that the internal consistency of the ORS was 0.93 and test–retest reliability was 0.66. The ORS has demonstrated adequate concurrent validity through correlates with the Outcome Questionnaire 45.2 (Lambert et al., 1996; $r = .74$; Campbell & Hemsley, 2009; $r = .59$; Miller et al., 2003). The ORS and CORS have displayed strong evidence of reliability for adolescent and 6–12 age groups, with coefficient alpha estimates of 0.93 and 0.84, respectively (Duncan et al., 2006). The CORS/ORS and Youth Outcome Questionnaire 30 (YOQ; Burlingame et al., 2001) caretaker scores have shown correlations of 0.61; the ORS and YOQ completed by adolescents resulted in a 0.53 correlation. These correlations provide evidence of the concurrent validity of the CORS/ORS as brief alternatives for assessing global individual well-being similar to that measured by the full-scale YOQ.

Our decision to measure the therapeutic alliance was based on consistent findings of the association between the alliance and outcome across treatment modalities (Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000). Accurate assessment of the alliance, especially early in treatment, alerts therapists to potential ruptures and permits corrective efforts to be undertaken when necessary. We selected client–report alliance measures based on evidence of superior predictive capacity of this source over therapist or observational ratings (Horvath & Bedi, 2002). The SRS offered a short, reliable, and valid client–report form for alliance measurement. Initial research has shown that the SRS generates reliable, valid scores. Duncan et al. (2003) found that the SRS had a coefficient alpha of 0.88 and a correlation coefficient of 0.48 with the Helping Alliance Questionnaire–II (HAQ-II; Luborsky et al., 1996) and 0.63 with the Working Alliance Inventory (Campbell & Hemsley, 2009). Test–retest reliabilities averaged 0.74 across the first six sessions with the SRS compared to 0.69 for the HAQ-II. The SRS has been used to measure the alliance in couple therapy (Anker et al., 2009) and family therapy (Reese et al., 2009), and the alliance as measured by the SRS has correlated with outcome in couple therapy (Anker, Owen, Duncan, & Sparks, 2010).

The ORS is a visual analog scale consisting of four lines, three representing major life domains—subjective distress, interpersonal relationships, social role functioning—and a fourth, overall. Clients rate their status by placing a mark on each line, with marks to the left representing greater distress and to the right, less distress. The ORS score provides an anchor for understanding and discussing the client’s current situation and allows a comparison point for later sessions. Further, it involves the client in a joint effort to observe progress toward goals. Unlike traditional assessment, the mark on the ORS is most relevant when the client bestows meaning on it in dialogue with a helping collaborator.

The SRS, like the ORS, is a paper-pencil measure using four visual analog scales. The SRS measures the client’s perceptions of a meeting with a helper on a continuum of three dimensions of the alliance as defined by Bordin (1979): the relationship; goals and topics; and approach or method. The fourth line elicits the client’s perception of the meeting in total. Clinicians ask clients to provide feedback at the end of each point of service, leaving enough time for discussion of their responses. The SRS allows all to react immediately to the client’s view of the alliance. The SRS is most helpful in the early identification of alliance problems, allowing changes to be made before clients disengage.

The CORS is similar in format to the ORS but contains child-friendly language and graphics to aid the child's understanding. To our knowledge, it is the only valid and reliable measure that allows persons under the age of 13 to provide formal feedback to helpers about their views of therapy progress. Similarly, the CSRS offers a visual component as well as language oriented toward children to assess a child's perception of the alliance. Parents or caretakers also use these measures to give their perspective of their child's progress.

Our OM protocol requires data collection from the first session and at every session thereafter. This requirement is based on substantial evidence that change in psychotherapy occurs early (Baldwin, Berkeljon, Atkins, Olsen, & Neilsen, 2009; Howard et al., 1996). Clients score the ORS or CORS in the reception area prior to being seen or in the room at the beginning of each session. Alliance measures are filled out at the end-of-session break. The data are entered into a computer software program (either in the room on a laptop or after the session) that automatically calculates and graphically depicts a trajectory of change. Composite graphs show multiple trajectories on a page to display how different members of a family or couple are changing in relation to each other. These composite graphs capture a systemic snapshot of change. Graphs are routinely shared and discussed with clients. Therapists are trained to enter these conversations with a respectful curiosity. Clients teach trainees their interpretations of what the scores mean in relation to their lived experience.

INTEGRATION AND LEARNING PERSPECTIVES

Students are exposed to research supporting client-directed, outcome-informed practice in two primary theory courses through reading, lecture, and discussion. Training includes the rationale for continuous assessment, in particular, findings that client subjective experience of early change and the alliance are reliable predictors of ultimate treatment outcome (Haas, Hill, Lambert, & Morrell, 2002; Martin, Garske, & Davis, 2000). However, we felt that actual clinical practice was the best way for students to fully appreciate what they were learning in the classroom. OM is now integrated continuously into student training experiences. From pre-practicum through on-site clinical practice and, in some instances, off-site internships, students learn to routinely collect client-generated data to inform treatment decisions.

As a way of bringing to life some of our experiences integrating an OM protocol into our curriculum, the first author solicited examples from coauthors that illustrate its use in therapist training. The first author's own supervisory experience with a practicum student was the source of an additional example. Finally, students were invited to contribute their perspectives. The collected illustrations represent self-selected instances that each of us believed captured some particularly compelling aspect of early OM adoption and would be instructive of how an OM system serves as a training tool.

To construct the first example, the pre-practicum instructor reviewed a videotape of one role-play of a first-semester therapist's use of the SRS. This provided her a chance to reflect on differences in therapist learning since adopting OM. In the practicum example, the supervisor selected a session that described use of the ORS to note and celebrate progress with a young girl. An additional example from the same family at a different session describes the therapist's use of the SRS to identify and repair an alliance rupture. Both practicum sessions were observed by the supervisor and team behind a one-way mirror, recorded, and transcribed. Key dialogue was selected that offered a snapshot of how OM assisted the supervisor and therapist to focus on change and secure the therapist's connection with the client. The final example was derived from a videotaped supervision session. In this example, the supervisor discussed one client's tracking graph to expand the therapist's view, create a more optimistic frame, and generate strategies consistent with client feedback.

Finally, students were invited to be part of an informal gathering in which two supervisors asked several open-ended questions designed to elicit student perspectives about using systematic client feedback in learning how to conduct couple and family therapy. This discussion was recorded and transcribed. The supervisors selected segments of the conversation they believed were particularly illustrative of students' views.

Pre-practicum

In pre-practicum, first-semester students role-play therapist and family members in simulated sessions, with a supervisor and team behind the one-way mirror. The following story illustrates the evolution of the use of OM as a training tool in this early learning experience:

In teaching pre-practicum over the years, I (D. B.) have noticed that students generally have a rough time having to remember so many things while dealing with the anxiety of being observed [behind a one-way mirror] by their team and supervisor. There would be awkward pauses, and students would visibly falter getting sessions underway. As a result, I would call into the room with numerous reminders. Unfortunately, these only seemed to increase everyone's discomfort. Since teaching OM in pre-practicum, I've noticed a marked change. For example, one student, in her first attempt as therapist, incorporated everyone's ideas of the family's story by asking role-played family members to help her understand the meaning of their ORS scores. She then commented on family strengths and resources, as reflected in their scores. This process allowed her to confidently structure the session and collaboratively engage her "clients." One of the most beneficial moments occurred at the end of the session when the trainee reviewed each person's alliance ratings. Contrary to our initial expectations, one of the adults in the role-played family gave the therapist mid-range SRS scores. The therapist, without hesitation, asked what she could do differently to make it a better experience at the next meeting. A lively post-session discussion followed in which the "client" commented on how she easily could have "voted with her feet" instead of sharing her concerns via the SRS. This experience was a powerful demonstration of the need to elicit and respond to clients' assessments instead of our own speculations.

Practicum

Once trainees move into actual practice, OM allows students a ready-made structure. More significantly, students learn from their clients whether or not they are being effective before clients drop out. This gives the therapist-in-training a second chance, even if errors have been made. The following is an example of a student's use of OM with a client family to track change and flexibly tailor her involvement:

The Johnson family presented for therapy due to the parents' recent separation. The family was made up of father, mother, son (Sam, age 14), and daughter (Sarah, age 10). The mother had left the household and was living with her parents. Sam had aligned with his father and was refusing to see or speak to his mother. The stated family goal was to improve the home environment. By the fourth session, Sarah had moved from well below the clinical cutoff (the dividing line on the CORS that distinguishes distressed and non-distressed children) to above the cutoff. Noting this, the therapist engaged her in a discussion of what this meant—for herself and for the family.

Therapist: Okay, this looks good. This looks much better than last time I saw you. What's changed? What's happening?

Sarah: Um, well I like school. Um, 'cause the people I have as teachers and I have, like, boys that, like go really crazy and they are obnoxious, but um, not all the time so. . .

Therapist: Not all the time, okay.

Sarah: Um, me, I'm doing good, and um my friend is still on the bus. Um, school's good.

Therapist: Good. I noticed this marks a lot higher (points to Family dimension). What's happening that made that mark so much higher?

Sarah: Well, I mean, it's not like it's perfect, but . . .

Therapist: No, I can see that, but it's pretty good, right? 'Cause perfect would be like all the way over here (points to the end of the continuum).

Father and daughter nod and laugh.

Therapist: What's making it pretty good?

Sarah explained that her older brother still argues with her but things are a little calmer and not as depressing. Further, she said it's more relaxing at home, and that her brother finally wants to talk to his mother on the phone—he is happier now and it makes the family environment calmer.

In this instance, the therapist used CORS feedback to identify change pertinent to the goal of therapy. A similar strategy was used with this same family to track the alliance.

In a first mother and son meeting, the son's alliance score at the end of the session dropped significantly from his previous high ratings. The therapist commented on this change. At the suggestion of her supervisor, she decided to begin the next session with further clarification to repair any alliance rupture that might still remain.

Therapist: So after the last time we met, in thinking about that session, what could've been more helpful to you last time? What could've gone better for you?

Sam: You mean last session?

Therapist: Yeah.

Sam: Um I don't know.

Therapist: Because I really rely on your feedback to know how to best help the both of you, to know how best to work with you.

Sam: Well, last session wasn't the best I ever had but, so . . .

Therapist: What would make it you know, a little better? What would be one thing that would make the next session a little better, like this session a little better than last session?

Sam: Uh, well I don't know I guess just, I don't know I kinda felt like I was, everything I say I kinda felt like everyone else was against me, like you didn't, you know, just in general.

Therapist: You know I felt that way a little bit too. You know, and in one perspective, in one view I was trying to give you both a different perspective (to the mother: I was trying to help you look at it from Sam's point of view and have Sam look at it from your point of view). But I felt like that a little bit too. And I don't want you to feel that way. Okay? I'm supposed to be right in the middle working on things for both of you. So that's how we need to make these sessions work. And I need to pay better attention to that because if you felt that way then I missed the mark somewhere. You know, so I don't want you to feel that you can't speak your mind freely in thinking that I'm going to give you another view or try to change the way you feel because I'm not going to do that. Okay? Thank you for sharing that with me, that really helps me.

At the end of this session, Sam's SRS score rebounded and remained high in following sessions.

The above examples illustrate how students learn to respectfully, yet persistently, request and respond to client feedback. That is, they create a "feedback culture" (Duncan et al., 2004, p. 97). The sincerity of this effort translates into clients coming to trust not only their therapist's desire to learn their views, but also the significance of their own perspectives to treatment success.

Supervision

Live supervision (supervisor behind a one-way mirror) has been a prime training venue for OM. The supervisor has immediate access to the therapist's facility with the instruments and can provide remedial instruction as needed. More importantly, information from the instruments gives the supervisor timely information regarding the progress of therapy. In this way, the supervisor can suggest targeted directions for the in-session interview or post-session

homework. It has been our experience that live supervision using an OM protocol has resulted in more productive supervisory focus and ultimately more efficient and successful sessions.

Supervisees in our program are required to bring raw data from the measures into every supervisory meeting. Supervisors use information from the measures to structure the supervisory conversation, including requests for specific video data. In other words, there are no discussion of cases that are not informed by clients' own assessments of their progress and connection to their therapist. This has been a shift for faculty supervisors accustomed to relying on video observation and therapists' assessments. We have noticed that supervisees have shifted their supervision focus in a similar fashion. Supervisees often spontaneously offer their views of client experiences based on the information obtained from the forms and their conversations with clients triggered from the use of the forms. Supervisee stories are frequently colored by a curiosity about how clients are experiencing therapy. In other words, supervisee and client stories are now more intimately connected in a continuous information feedback loop.

Bringing clients' voices into the supervisory conversation has assisted supervisors and trainees to make data-informed decisions regarding treatment planning (Duncan & Sparks, 2010). Specifically, all now have concrete, graphic information that identifies at-risk cases. The OM software program flags cases that are not proceeding according to the expected trajectory and prompts the therapist to discuss the situation in supervision and to have a conversation with clients about ways to make more progress. OM supervision has helped to generate conversations about different approaches that may better fit a given client's preferences and expectations.

In addition, the systematic incorporation of client-generated data into every supervision meeting has provided a tool for identifying and capitalizing on change. Prior to OM supervision, knowing when clients are changing has been somewhat an educated guess. Now, trajectories provide a visual estimation of meaningful change that can assist therapists, clients, and supervisors in demarcating change and planning for termination. The following relates how formal client feedback via graphed client outcome scores aided a supervisor and supervisee to recognize change and plan for termination:

I (J. S.) began supervising a team of second-year students in the fall semester. At our first supervision meeting prior to the evening's practicum, one student discussed her client who was scheduled for that night. The client was a young man (aged 25) who had begun therapy to gain better control of his life, particularly in the areas of organization and keeping a job. He had, as the therapist described it, a drinking and substance use problem. According to the therapist's report, the young man experienced a repetitive pattern of holding a job for several months, then bingeing, resulting in loss of the job.

The therapist reported that her client, over the course of 3 months of treatment, continued to drink and use other substances. However, there had been considerable success in implementing new strategies for making sure this behavior did not interfere with his current job which he had held for the longest time of any job in the past 5 years. I requested to see a chart of his ORS and SRS scores. In reviewing the graph, I noticed and discussed with the therapist and team that the client appeared connected to the therapist as evidenced by moderately high SRS scores. I also noted that he had achieved reliable change early in treatment and had maintained change, with fluctuations typical of everyday life circumstances. Figure 1 indicates the client's early change and change maintenance during the course of treatment.

The client exceeded the expected treatment response⁴ (ETR) (dashed line) and the clinical cutoff (solid line) by the third visit. In spite of the graph's evidence of client change, the therapist insisted that she felt "stuck." In her view, the client was at risk of relapse due to his substance use and possible loss of his current job, even though he had reported success toward his goals in their last session. I suggested that the meeting scheduled for that evening review the client's goals, using his graph as a backdrop for this conversation. If new data indicated that he was maintaining positive change, it would be appropriate to discuss termination. I reframed being stuck as being stuck in seeing change. Nevertheless, these speculations needed to be confirmed in dialogue

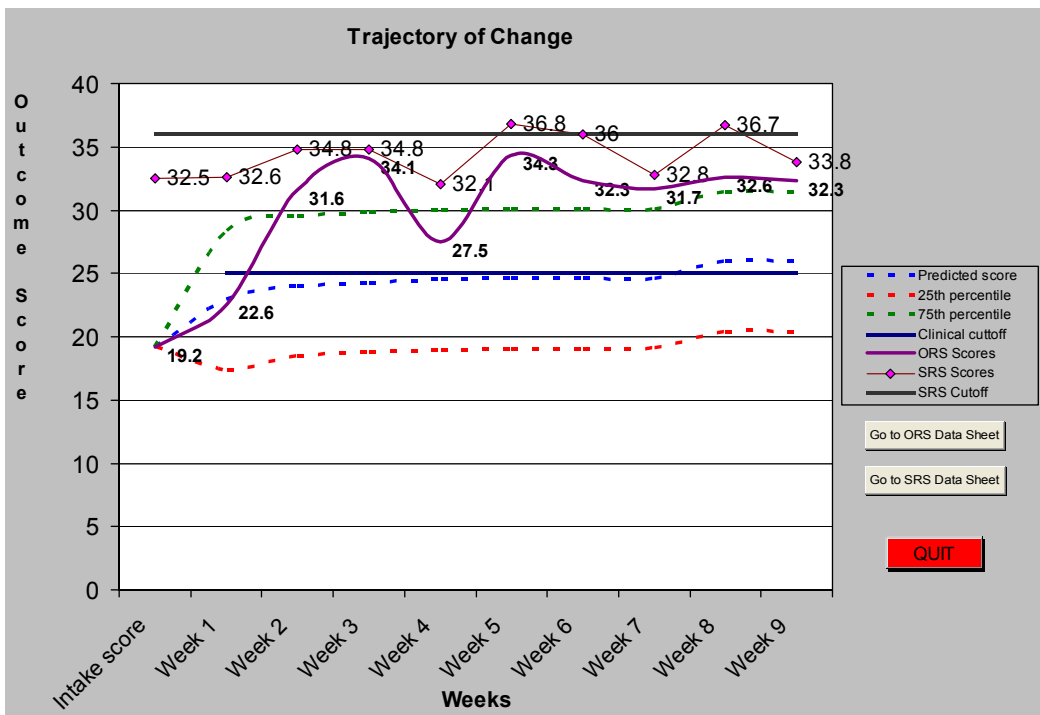


Figure 1. Client trajectory of change graph.

with the client. The opportunity for a further discussion of goals did not happen; the client did not show for that evening's appointment. He called several days later stating that he had forgotten about the meeting but was very happy with his progress and would no longer need our services. He thanked the therapist for her work. In the team's follow-up discussion, some believed that the client may have relapsed and had dropped out of therapy for that reason. While there was no way to disconfirm this suspicion, there was also no data to support it. In fact, data from his graph as well as his own assertion at completing his objectives pointed toward a different conclusion—that he, in fact, had a successful outcome. I highlighted to the students that our training embeds theoretical discourses that sometimes steer us away from hearing clients. In this case, the discourse of substance abuse, despite all it has to offer in illuminating this serious problem, may have played a role in the therapist and previous supervisor failing to see the client's progress. Even so, it was clear that the therapist had responded to this client's goals, as indicated by the positive alliance and progress reflected in his feedback data and confirmed in his verbal reports.

In our supervisory learning curve, greater attention to this client's change, as reflected in his feedback, may have facilitated an earlier, better planned termination. However, OM offered concrete evidence and a learning opportunity for students to better understand the nature of his journey of change. At the same time, it gave the supervisor a tool for privileging the client's unique lived experience over theory.

Student Perspectives

Just as we teach our students to seek and value feedback from clients, we were interested in feedback from students. While we were excited about OM, it was possible that students did not feel that the system was helpful for their learning and practice. Using a focus group format, we invited students to discuss their experiences using OM. Although we encouraged them to be as open as possible about pros and cons from their perspectives, differences in power between students and focus group facilitators (J. S. and T. K.) may have influenced student responses.

However, the consistency among comments, both in the formal focus group and in other contact settings, gives credence to students' observations. The following are some of the themes that emerged from the focus group, with exemplars:

- Gives a conceptual and practical framework to establish early comfort and confidence

I think for the first time I was a little relieved because I wasn't sure how to approach working with a client right away. It was a good way to start a conversation with somebody.

- Provides practical guidance for structuring the session

It definitely makes it easier to start . . . it just allows that opening to know where to go right from the beginning of a session and not to miss certain areas.

- Provides a format for clients to guide treatment

[To client] as far as last time when we talked after the session you had said [we] hadn't quite been on goals so I wanted to start out this next session talking about some of the goals that you had.

- Provides an incentive for expanding beyond one's comfort zone and for learning new skills

I got a low score. . . . I asked why, what can make this a little bit better and he's like well, you can be a bit more direct. . . . I was like ok, you want me to be more direct, I'm gonna take it and run with it.. That's hard for me, like ok you know we are getting a little bit off topic. So that was a way for me to say that and be comfortable with it because he had told me to do it.

- Helps to minimize guesswork regarding whether progress is being made or a case may be at risk

I think I was more anxious than nervous because I wanted to know even if it was bad. I still wanted to know because if it's bad then you can ask how you can fix it. But if you never know, then you never know.

- Provides a format for learning about children's views

I think it's great to use these forms with kids. Especially because it's really hard to get into their emotional level . . . they can actually mark where they are and let you know why and give examples. . . . Without using the forms, it's real hard to identify for a kid where he or she is right now.

Many of our students' comments were similar to those expressed by trainee participants in Reese et al. (2009). In that study, novice therapists in the feedback condition were pleased to see how they were doing with their clients—they felt that client feedback gave them more structure and a good place to start in difficult cases.

DISCUSSION AND FUTURE DIRECTIONS

In the current era of accountability, the call to devise outcome-based protocols for training competent, effective family and couple practitioners is timely. To date, MFT training has not sufficiently incorporated robust findings regarding the efficacy of routine utilization of client feedback. Adopting an OM system into our training curricula has enhanced our ability to teach and assess trainee effectiveness. Moreover, we have realized a merging of practice and program philosophy, an energizing of students and faculty around an innovative method, enhanced research opportunities, and greater accountability to clients and the University. Data collected over the past 3 years indicate that students are achieving outcomes that exceed what would be expected. According to our storage and interpretation software, clients

receiving family and couple therapy ($n = 159$) from first- and second-year students trained and regularly entering data ($n = 18$) reached target benchmark 69% of the time. This is remarkable given research indicating that as few as 32.7% of clients served by university counseling centers either improve or recover (Hansen, Lambert, & Forman, 2002). The average length of stay for clients for the sample of trained therapists was 2.7 months, with an average number of sessions just over 7. While a statistical comparison of these findings with outcomes prior to OM implementation is in process, anecdotal evidence suggests that clients are dropping out less frequently and fewer cases are extending beyond 4 months when no measurable change has occurred.

As educators, we are able to respond more effectively to immediate in-session and session-to-session clinical process. Additionally, we are better able to identify student learning needs and collaborate with them in developing specific learning objectives. Knowing that feedback has a positive impact on poorer-performing therapists has provided a hopeful learning context for all students, particularly those experiencing difficulty engaging clients. Teaching and learning now take place within a climate of optimism. It was always our aim to say that we train effective couple and family therapists. We are now confident that we have a method for accomplishing this goal. Furthermore, students leaving us have evidence, and the confidence that goes with it, of their own ability to help others. We cannot take full credit for this achievement. In a very real sense, clients have become our best trainers.

Steps remain for fuller integration of OM into our program. First, we need to better train students to attend to computer-generated alerts and respond immediately by seeking supervision. Second, faculty needs greater facility with the software capabilities for monitoring student progress to offer timely and targeted assistance for each student. Third, the use of OM as an evaluative tool requires further articulation. Currently, we are developing a training structure that will serve as a guide for assessing student progress in becoming a competent and effective couple and family therapist. We are interested in the trainee's ability to conceptually grasp the implications of the empirical case for feedback, utilize the OM feedback system, and respond to assessment of their effectiveness with each client and their accumulated caseload data over time. Essentially, we believe that students who value learning from client feedback and integrate it into their ongoing practice, with the assistance of faculty and supervisors, will improve their outcomes. Similarly, data from OM can provide objective indices of particular core competencies. We envision the continuous collection of student practice outcomes across training venues, including off-site internships.

We believe strongly that student caseload ratings of outcome and alliance *not* be sources of grading or promotion. In our opinion, this would have the unfortunate consequence of shifting student, and perhaps client, attention away from the true purpose of gathering client data (client welfare and student learning) toward a competitive reward and punishment process. Instead, grading should reflect students' engagement in the process and willingness to learn from clients. Based on available research, we have confidence that students who want to improve will improve using client feedback. We have witnessed some students struggle early, but rapidly make measurable progress because of a persistent willingness to learn from their clients. While there may be some initial trepidation students have in holding up the mirror of feedback and taking a hard look, our mantra is "There is no negative feedback, only negative responses to it."

Finally, we have yet to fully exploit the research possibilities now available by virtue of systematic data collection and storage. As data accumulate, we will be in a position to provide objective evidence of service efficiency, overall site ES, average lengths of stay, and other important practice data that will help us not only train students better but also improve service to the community. We currently are developing a project that will more formally evaluate, using quantitative and qualitative analyses, the impact of adoption of OM on our student learning outcomes and service delivery. This project will include perspectives of key stakeholders—clients, students, faculty, and members of the University and larger communities concerned with the evaluation of learning and practice outcomes.

Based on the research to date and our own experience, we agree with Michael Lambert that, yes, it is time for clinicians to routinely monitor outcome (Lambert, 2010). As Worthen

and Lambert (2007) suggest, trainees and their supervisors can utilize ongoing outcome assessment to focus learning and skill development. The gap between student development and client outcome can be bridged. In sum, feedback monitoring provides a viable means for addressing the requirements that clinical programs develop and implement research-based training methods and provide quality care to all clients. Students, learning from clients, learn to be accountable from their very first training experiences and throughout their professional careers as marriage and family therapists.

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NOTES

¹The terms *marriage and family therapy* and *couple and family therapy* will be used interchangeably, with an understanding that marriage and family therapy may not convey the same inclusiveness of same-sex and unmarried couples as couple and family therapy.

²The systematic use of client feedback has been called patient-focused research (Howard et al., 1996), client-directed, outcome-informed work (Duncan et al., 2004), and Partners for Change Outcome Management System (PCOMS; Anker et al., 2009). We have chosen the term *OM* as it fits our aim to describe the use of systematic feedback in managing both client and student learning outcomes.

³Measures can be downloaded from <http://www.heartandsoulofchange.com>.

⁴The expected treatment response (ETR) refers to the computerized trajectory generated by the software based on the client's initial intake ORS score. The ETR includes a benchmark score that is the maximum score at the 50th percentile trajectory based on all other client trajectories with the same intake score in the database. Reaching the benchmark score is one indicator of successful treatment.