

Using Client Feedback in Psychotherapy Training: An Analysis of its Influence on Supervision and Counselor Self-Efficacy

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Tracking client outcome and the therapeutic relationship across treatment (i.e., client feedback) has become a recommended practice for clinicians. This study investigated whether the utility of this practice would extend to trainees if the data gained from clients was provided to their supervisor for use within supervision. Trainees ($N = 28$) were assigned to a continuous feedback condition or no-feedback condition for 1 academic year. Results indicated that trainees in both conditions demonstrated better client outcomes at the end of their practicum training than at the beginning, but those in the feedback condition improved more. However, those in the feedback condition did not rate the supervisory alliance or satisfaction with the supervision process differently. The relationship between counselor self-efficacy and outcome was stronger for trainees in the feedback condition than for those in the no-feedback condition, perhaps indicating that feedback may facilitate a more accurate assessment of one's skills. Implications of how counseling self-efficacy, the supervisory alliance, and satisfaction with supervision are related to effective supervision are addressed.

Keywords: psychotherapy supervision, counselor trainee, counseling effectiveness, client progress and outcome, counselor self-efficacy

Supervised practice is typically perceived as the sine qua non of excellent graduate psychotherapy training, particularly when it comes to helping students develop their therapy skills. Although the developmental needs of trainees (we use *supervisee* and *trainee* interchangeably) influence the specific tasks and goals of training (Stoltenberg, 2005), the general purpose of psychotherapy supervision is to ensure ethical and competent treatment (i.e., meet the needs of the client) and to promote skill and professional development (i.e., meet the needs of the trainee). Much of the supervision research to date has focused on the latter, but there is a paucity of research that has focused on the benefits of psychotherapy supervision for clients (Lambert & Hawkins, 2001).

The lack of supervision research in this area is certainly not the result of failing to recognize its importance. For example, Ellis and Ladany (1997) stated that client outcome is the “acid test” of effective supervision (p. 485). Other reviews of the supervision literature have also consistently noted the lack of supervision-related studies that address client outcome (Good-year & Bernard, 1998). Freitas (2002) conducted a review of the literature on the influence of supervision on client outcome and found only 10 studies, all of which were conducted before 1998. The studies he reviewed focused on client outcome but were otherwise disparate in nature. For example, 1 study found that client-focused supervision led to a better outcome than an administrative approach (Iberg, 1991); another found that su-

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pervisee attraction to the supervisor improved client outcome (Dodenhoff, 1981). The lack of a larger, cohesive focus in this area is surprising given the centrality of supervision to psychotherapy training.

Client Feedback in Psychotherapy

One advance in the psychotherapy outcome literature has been the development of continuous outcome assessment to track client progress in psychotherapy. Continuous outcome assessment, or client feedback, refers to using a psychotherapy outcome measure every session rather than in a typical pre-post outcome format (Lambert, 2001). The premise of using such an approach is that it helps identify clients who are not progressing as expected in treatment and affords the opportunity to proactively address their lack of improvement. A number of research studies have indicated that continuous outcome assessment leads to fewer premature terminations and improved outcomes for clients who are at risk for terminating treatment early (e.g., Brown & Jones, 2005; Whipple et al., 2003). These findings prompted the American Psychological Association's Division 29 (Psychotherapy) Task Force on Empirically Supported Relationships to advise practitioners "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).

Using Client Feedback Data in Supervision: Possible Advantages

Lambert and Hawkins (2001) have discussed the potential advantages of using client outcome data for counselor training and supervision. They have suggested that supervisees could use client outcome data to inform treatment and to discuss progress with their clients. The client outcome data could also be used by the supervisor and supervisee to help inform supervision. Lambert and Hawkins noted that tracking outcome data can provide feedback to supervisees regarding their performance, provide both supervisor and supervisee with more information that may facilitate training, provide beginning therapists with information about where to begin with clients, and also help ensure that clients are not harmed by therapy. Beginning therapists want to know whether they are being helpful to clients; using outcome data provides a specific means for broaching this question. It is conceivable that a trainee could complete his or her training without really having an answer to this question beyond some general notion.

Another possible advantage of using client outcome data in supervision is that it may help make more efficient use of supervision time. Client outcome data provide a quick "dashboard indicator" for a supervisee's client load and may help quickly identify clients who require more attention during supervision. Accurate assessment of a supervisee and his or her caseload can be challenging, and time consuming, when dealing with multiple supervisees with large caseloads. Not only can using outcome data provide key information for assisting supervisees who are struggling with a client, it can also highlight and reinforce the growth of supervisees with clients who are faring well in therapy. Outcome data can also assist in granting supervisors more direct access to their trainees' performance. For example, in many practi-

cum training settings, supervisees are placed in environments that do not allow audio or video recording. In such cases, supervisors are left to rely on a trainee's perspective. Moreover, research has consistently shown that therapists, regardless of experience, have difficulty judging whether their clients are deteriorating in treatment (Grove, Zald, Lebow, Snitz, & Nelson, 2000).

From a supervisory process perspective, client feedback may also help the supervisor provide feedback to supervisees. Effective supervision is generally assumed to require that the supervisor provide a balance of both positive and challenging feedback (Falender & Shafranske, 2004). However, most supervisors withhold feedback, particularly feedback regarding performance (Hoffman, Hill, Holmes, & Freitas, 2005), and if feedback is provided, it is often general and positive (Friedlander, Siegel, & Brenock, 1989).

Purpose of Study

Although the use of client feedback data has been proffered to be of value in the supervisory process, there is no research to support this contention. The purpose of this study was to investigate the use of continuous client outcome data in psychotherapy supervision. The study was also designed to help redress the lack of research on the influence of psychotherapy supervision on client outcome, as well as to assess how using such data in supervision might influence known correlates of effective supervision (i.e., the supervisory alliance and satisfaction with supervision) and counselor self-efficacy. In the following sections, we review the literature in these areas and provide hypotheses for the study.

Supervisory Alliance and Satisfaction With Supervision

The supervisory relationship is an important variable to consider in relation to the use of client feedback data in supervision. Previous research has found that specific and clear supervisory feedback can contribute to an improved supervisory alliance and increased satisfaction with supervision (Lehrman-Waterman & Ladany, 2001). In fact, Ellis (1991) found that trainees rated the supervisory relationship as the most important component of a positive supervisory experience. Although the supervisory alliance is perceived to be integral to the supervisory process, those who have measured its relationship to counselor affect and development have reported mixed results. For example, Ladany, Ellis, and Friedlander (1999) found that the supervisory alliance was unrelated to counselor self-efficacy. Yet others have found that a strong supervisory working alliance was positively related to counseling self-efficacy (Efstation, Patton, & Kardash, 1990). Despite this ambiguity, a strong supervisory alliance has been found to be related to a positive therapeutic alliance (Patton & Kivlighan, 1997). Clearly, more evidence is needed to assess the potential benefits of the supervisory alliance.

Counseling researchers have also sought to examine the degree of satisfaction counselors in training feel with the supervision they receive. Evaluating trainees' level of satisfaction is a straightforward way to measure their perception of their supervisor and the supervisory process. Satisfaction with supervision has been an integral outcome variable in many studies evaluating the supervisory process (Ellis & Ladany, 1997). However, some have suggested that supervisory satisfaction should be considered not as an

outcome variable but as a process variable that may influence therapy outcomes (Fernando & Hulse-Killacky, 2005). Either way, continuing to evaluate the relationship between perceptions of supervision (i.e., both the supervisory alliance and satisfaction with supervision) and client outcome is certainly warranted. We expected that trainees who received continuous assessment feedback would rate the supervisory alliance and satisfaction with supervision more favorably than would trainees in a no-feedback condition. This is because we believe continuous assessment measures would likely facilitate the supervisor's ability to provide more specific and clear feedback to trainees regarding their performance with clients; previous research has linked specific and clear feedback to favorable ratings of supervision (Lehrman-Waterman & Ladany, 2001).

Feedback and Counseling Self-Efficacy

From a social-cognitive theoretical perspective, feedback does seem to matter. For example, Bandura (1997) theorized that evaluative judgments from others can have a profound effect on an individual's self-efficacy beliefs. Indeed, supervisory feedback has been found to influence counseling self-efficacy for trainees (Daniels & Larson, 2001). Bandura also argued that compared with the task-specific judgments of others, general feedback rarely has any lasting effect on self-efficacy and that the potency of social persuasions depends on the interpretation a trainee makes of a host of factors. "Persuasive efficacy appraisals have to be weighted in terms of who the persuaders are, their credibility, and how knowledgeable they are about the nature of the activities" (Bandura, 1997, p. 104).

Using client feedback as the focal mechanism in supervision has been suggested as a means by which the supervisory process can remain more objective (Worthen & Lambert, 2007). Bandura (1997) would concur that "deferral to supposedly objective indicators of capability can boost persuaders' influence on people's beliefs in their efficacy" (p. 104). Instead of imposing their own subjective standards, supervisors and trainees can refer to client feedback as a starting point for a discussion of the training counselor's efficacy. For this reason, using client feedback in the supervisory process could prove to be a potent source of counselor self-efficacy, particularly for trainees who lack an experiential basis for judging their capabilities.

Bandura (1997) has long contended that self-efficacy beliefs are strong predictors of subsequent behavior. We were only able to identify one study that investigated the relationship between trainee counseling self-efficacy and outcome with actual clients, however, the results of which were far from definitive (Heppner, Multon, Gysbers, Ellis, & Zook, 1998). In general, counseling self-efficacy did not correlate with most of the outcome variables. However, confidence to build a relationship with a client was related to clients being more motivated to address their career goals. Heppner et al. (1998) noted that the relationship between self-efficacy and client outcome was not linear, that simply possessing more counseling self-efficacy did not yield better outcomes. Given the few findings in this area, we followed Bandura's theorizing and expected that counselors' self-efficacy beliefs would be predictive of their clients' judgments of whether their therapy was indeed effective.

Client Feedback Systems

The Outcome Questionnaire 45 (OQ45; Lambert et al., 1996) is the most researched instrument used for client feedback (e.g., Lambert et al., 2001; Whipple et al., 2003). The OQ45 is completed by the client right before every session and provides feedback to the therapist on the client's progress. The thrust of the instrument's use is to identify clients who are not progressing and who are projected, on the basis of normative data, to terminate prematurely or not to benefit from treatment. The feedback from the client allows the therapist to intervene by changing the course of treatment, assessing the reason(s) for the lack of progress such as a poor therapeutic alliance (see Lambert, 2001, for a full description), or both. In their meta-analysis, Lambert et al. (2003) concluded that clients who were identified as at risk for terminating prematurely or having a poor treatment outcomes attended more sessions and had better treatment outcomes when using continuous assessment; client feedback conditions demonstrated a mean medium effect size of .39 when compared with no-feedback conditions.

Concerned with the feasibility of asking that clients complete 45 items before every session, Miller and Duncan (2000) developed a briefer outcome measure, which they called the Outcome Rating Scale (ORS). Consistent with the recommendations from the Division 29 task force to monitor the therapeutic alliance, the four-item Session Rating Scale (SRS; Miller, Duncan, & Johnson, 2000) was also developed for use after every session to monitor the therapeutic relationship. The use of these two measures in conjunction is referred to as the Partners for Change Outcome Management System (PCOMS; Miller & Duncan, 2004). Although many factors influence clients' compliance in completing outcome measures, initial research has indicated that using shorter measures may be especially influential. For example, Miller, Duncan, Brown, Sparks, and Claud (2003) reported that compliance rates in a training clinic for the ORS and SRS measures were 86%, as compared with 25% for the OQ45.

Although based on Lambert et al.'s (1996) system of continuous assessment, PCOMS has two other major differences than just brevity. First, PCOMS assesses both client outcome and the therapeutic relationship; the OQ45 only assesses client outcome. Second, PCOMS is prescribed to benefit all clients, not just clients who are not progressing as expected.

Research findings have shown PCOMS to be related to a host of positive therapeutic outcomes. Similar to the OQ45 research, studies using the ORS and SRS have reported fewer premature terminations and increased effectiveness. For example, in a study of 6,424 clients who received services through an employee assistance program, researchers found that effect sizes increased from .37 to .79 when PCOMS was implemented (Miller, Duncan, Brown, Sorrell, & Chalk, 2006). Investigating how such a measure might affect the supervision process could potentially provide an excellent resource to those interested in the effective training of psychotherapists.

With these findings in mind, we undertook the study with three major hypotheses. First, we expected that supervisees in a feedback condition (using a continuous assessment feedback measure with clients and in psychotherapy supervision) would demonstrate greater client outcomes (as measured by the ORS) than would supervisees in the no-feedback condition over the course of an

academic year. Second, we expected that supervisees in a feedback condition would rate the supervisory alliance and their satisfaction with supervision more favorably than would their counterparts in a no-feedback condition. We also conjectured that the supervisory alliance and satisfaction with supervision would be related to client outcome. Third, we hypothesized that supervisees in the feedback condition would report higher counseling self-efficacy than would those in the no-feedback condition, but in keeping with the tenets of social-cognitive theory, we expected the relationship between counselor self-efficacy and client outcome to be similar for supervisees in both conditions.

Method

Participants

Twenty-eight trainees (10 men and 18 women; 79% White, 10.5% African American, 10.5% Asian American; mean age = 25.14, $SD = 3.49$) participated in the study during their 2nd year of training in a master's-level marriage and family ($n = 19$) or clinical-counseling psychology ($n = 9$) program at a medium-sized, private southwestern university. Participants' theoretical orientations included cognitive-behavioral, solution-focused, and variations on a general systems perspective.

Supervisors ($N = 9$) who participated in the study were either full-time faculty or adjunct faculty within each program (marriage and family = 6, clinical-counseling psychology = 2, both = 1; 5 men and 4 women; 100% White; doctorate in counseling-clinical psychology = 3, doctorate in marriage and family therapy = 3; master's in marriage and family therapy = 3). Client participants ($N = 110$) attended individual therapy at either the graduate program's marriage and family training clinic that serves the community ($n = 95$; 25 men and 68 women, and 2 who did not indicate gender; 79.5% White, 15.7% Hispanic-Latino, 3.6% African American, 1.2% Asian American; age range = 15-69 years, $M = 34.05$, $SD = 11.70$) or the university's counseling center ($n = 15$; 5 men and 10 women; 86.6% White, 6.7% Asian American, 6.7% international; age range = 18-24, $M = 19.54$, $SD = 2.15$). Clients presented with problems similar to those that would be seen at a typical community mental health center or university counseling center, including mood and anxiety disorders, relationship or marital problems, grief, and a variety of other Axis I and Axis II disorders.

Measures

ORS (Miller & Duncan, 2000). The ORS is a four-item measure designed to assess client progress in treatment. Three items are taken from the three subscales of the OQ45 and address social (work, school, and friendships), interpersonal (family and close relationships), and individual (personal well-being) domains. The fourth item asks the client to evaluate his or her general sense of well-being. Each item is rated using a visual analog scale. Clients make a hash mark on each of the four analog scales that are 10 cm in length, with scores on the left side of the scale indicating lower functioning and scores on the right indicating higher functioning. A ruler is then used to measure the distance from the left end of the scale to the client's hash mark. The measures for the four items are then summed to provide a total score, ranging from 0 to 40.

A clinical cut score of 25 was determined (77th percentile) on the basis of a sample of 34,790 participants, indicating that those scoring higher than 25 are more consistent with a nonclinical population and less likely to benefit from psychotherapy (Miller & Duncan, 2004). Miller et al. (2003) also found that the ORS discriminates well among clients and nonclients. Their research indicated that the ORS generates reliable scores among individuals who receive therapy in a community mental health center ($\alpha = .93$). Test-retest reliability from the first to second therapy session was .60. The correlation coefficient of .59 between the ORS and OQ45 also provided evidence of construct validity. Later evidence also demonstrated that clients made gains across therapy (Miller et al., 2006). Lambert et al. (1996) stated that evidence for construct validity on outcome measures can be established by showing that scores later in treatment differ from those obtained at the beginning of treatment. In this study, we obtained coefficient alphas of .82 and .90 for the first two sessions of the current study, respectively.

SRS (Miller et al., 2000). The SRS consists of four items that are also measured via a visual analog scale. Based on Bordin's (1979) pantheoretical definition of the therapeutic alliance and an inclusion of the client's theory of change, the scale assesses the therapeutic relationship ("I felt heard, understood, and respected"), goals and topics covered in therapy ("We worked on or talked about what I wanted to work on or talk about"), the approach used in therapy ("The therapist's approach is a good fit for me"), and the overall rating of the session ("Overall, today's session was right for me"). Clients make a hash mark on each of the four analog scales as described earlier. Marks on the left of the scale indicate less satisfaction for each item, and marks on the right indicate higher satisfaction. Once again, a ruler is used to measure the distance from the left end of the scale to the hash mark. The individual items are then recorded and totaled, ranging from 0 to 40. Problem(s) with the therapeutic alliance are indicated by either a clinical cut-score of 36 or a rating below 9 on any one item.

Miller and Duncan (2004) found that increases on the SRS during the course of treatment were statistically significantly associated with better outcome. When compared with clients who did not use the SRS, clients who used the SRS were three more times likely to attend a next session and experienced more change during treatment. The cut-score of 36 was derived from a sample of 15,000 clients, of whom only 24% scored below 36 and were "at a statistically greater risk for dropping out of or experiencing a negative or null outcome from treatment" (p. 14).

Initial research has indicated that the SRS generates reliable and valid scores. In their sample of 337 community mental agency clients, Duncan et al. (2003) found that the SRS had a coefficient alpha of .88 and possessed a correlation coefficient of .48 with the Helping Alliance Questionnaire-II (Luborsky et al., 1996). Test-retest reliabilities averaged .74 across the first six sessions with the SRS as compared with .69 for the Helping Alliance Questionnaire-II. For this study, coefficient alphas for the first two sessions were .97 and .92, respectively.

Supervision Outcomes Survey (SOS; Worthen & Isakson, 2003). The SOS is a 20-item measure designed to assess the supervisee's satisfaction with the supervisory process. Items are measured using a 7-point Likert-type scale ranging from 1 (*not at all*) to 7 (*greatest degree possible*). Sample items include "My supervisor helps me develop by providing both challenge and support," "Supervision

helps me see my mistakes as learning experiences,” and “Overall I feel satisfied with my supervision.” Scores for the items are totaled for a composite score ranging from 20 to 140. Worthen and Isakson (2003) found evidence for construct validity in that SOS scores increased across the supervisory process in a manner similar to the supervisee and trainee versions of the Supervisory Working Alliance Inventory (trainee version: SWAI-T; Efstation, Patton, & Kardash, 1990). For the current sample, internal consistency was evaluated for the first administration (middle of the first semester) and last administration (end of the second semester); coefficient alphas were .92 and .98, respectively.

SWAI-T. The SWAI-T consists of 19 items designed to measure supervisees’ perceptions of the supervisory relationship. The measure consists of two subscales, Rapport (13 items; e.g., “I feel comfortable with my supervisor”) and Client Focus (6 items; e.g., “My supervisor helps me work within a specific treatment plan with my clients”), that are rated on a 7-point Likert-type scale ranging from 1 (*almost never*) to 7 (*almost always*). Efstation et al. (1990) reported evidence for validity via a confirmatory factor analysis that revealed a two-factor structure. The Rapport subscale accounted for 30% of the variance, whereas the Client Focus scale accounted for 8%. Both factors were found to be statistically significantly correlated with the Supervisory Styles Inventory and had low correlations with a supervisor version of the same measure. The authors also reported internal consistency estimates for the items in each subscale of .90 and .77, respectively. Despite these findings, other researchers have opted to combine the items from the two subscales because of high interfactor correlations (Patton & Kivlighan, 1997). In keeping with this approach, we elected to use a composite scale made up of items from the two subscales. Coefficient alphas for the current sample were .87 (middle of first semester) and .97 (end of second semester).

Counseling Self-Estimate Inventory (COSE; Larson et al., 1992). The COSE is a 37-item, 6-point Likert-type scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). The COSE is designed to measure a counselor’s self-efficacy across five counseling areas: microskills, counseling process, dealing with difficult client behaviors, cultural competence, and (awareness of one’s own) values. In their initial validation study, Larson et al. (1992) reported that five factors accounted for 36% of the variance with eigenvalues all above 1.0. Additional support for construct validity was found via convergent validity (moderate correlation with a measure of self-concept) and discriminant validity (weak correlations with measures of personality and social desirability). Internal consistency estimates ranged from .88 (microskills) to .62 (values) and demonstrated an overall alpha of .93 (Larson et al., 1992). For the current study, scores at the initial administration generated a coefficient alpha of .91 for the total score, with the subscale alphas ranging from .86 (microskills) to .62 (values).

Procedure

The study took place over the course of 1 academic year consisting of two 16-week semesters. Assignment to the feedback or no-feedback condition for supervisors and trainees was different for each program. For the marriage and family program, supervisors and trainees were randomly assigned to the client feedback condition ($n = 4$ supervisors and 9 trainees) or to the no-feedback condition ($n = 3$ supervisors and 10 trainees). Random assignment

was not possible for the 9 trainees in the clinical–counseling psychology program; however, the 2 supervisors were randomly assigned. Two trainees from this program were eligible to be in the feedback condition because they were placed at a site that permitted the use of outcome measures. The other 7 trainees were at practicum sites where the use of outcome measures was not appropriate or permitted (e.g., acute care facility for adults or adolescents). Therefore, they were placed in the no-feedback group.

Trainees in the marriage and family program conducted all of their practicum training in the marriage and family clinic, whereas trainees in the clinical–counseling program completed practicum training in a variety of clinical settings (e.g., university counseling center, career and academic development center, acute care facility for adults and adolescents, and neuropsychology clinic). Because of the inability to randomly assign the clinical–counseling graduate students, their data were not included in the first research question that addresses comparing outcomes in the feedback and no-feedback conditions. However, their outcome data were included for the second and third research questions because those questions are focused on how the use of the PCOMS data influenced the supervisory process and counseling self-efficacy.

In this study, the trainees provided all of the counseling sessions individually. Clients were randomly assigned to trainees in each condition. Trainees in the feedback condition used PCOMS with their clients and the resulting data in supervision. That is, each trainee in the feedback condition administered, scored, graphed, and then discussed the ORS scores at the beginning of each session with the client and then repeated the process with the SRS at the end of each session. The feedback was discussed directly with the client. Consistent with the PCOMS protocol, trainees in the feedback condition used the following four categories to help track client progress and frame how to proceed with clients (see Miller & Duncan, 2004, for a complete description):

No change: For a client who has not shown reliable change (a gain of 5 points) after three sessions, therapists are directed to address the therapeutic alliance and the course of treatment. If the client has not demonstrated reliable improvement after six sessions, the manual suggests consultation, supervision, or staffing.

Deteriorating: Clients in this category are considered to be at risk for terminating prematurely or having a poor outcome. Therapists are directed to discuss possible reasons for the drop in score, review the SRS items with the client to assess the therapeutic alliance, or consider changing the treatment approach, frequency, mode, or even therapist if no improvement is noted after three sessions.

Reliable change: Treatment is progressing as expected. Therapists are advised to reinforce changes and to continue treatment until progress begins to plateau, whereupon a therapist should consider reducing the frequency of sessions.

Clinically significant change: The client is likely no longer struggling with issues that led to therapy. Therapists are advised to consolidate changes, anticipate potential setbacks, and consider reducing the frequency of sessions.

Trainees in the no-feedback condition at the marriage and family clinic administered the ORS at the beginning of each session (to track outcome) but did not observe, score, or discuss the results with clients. The measures were placed in a centralized collection area and were scored by a coinvestigator. To reduce the potential for demand characteristics (i.e., concern that people would not answer honestly for fear of hurting the trainee's feelings or grade), trainees in both groups were instructed to encourage clients to complete the measures honestly and to tell clients that their scores would not be tied to the trainee's grade or evaluation. Trainees in the no-feedback condition in the clinical-counseling program did not have clients complete the measures and provided services in a business-as-usual format.

All supervisees received weekly individual and group supervision (trainees were not separated by treatment condition for group supervision). Individual supervision typically consisted of providing updates on a supervisee's caseload and viewing selected video and audio recordings of a session for discussion. More focus was placed on the supervisee's goals and strengths or weaknesses in the individual supervision format. Group supervision typically relied on a case presentation format with supervisees designated to present on clients with a selected video or audio recording segment to facilitate the presentation. Time was also provided to discuss pressing trainee concerns regarding clients and other trainee needs.

The client feedback group used PCOMS in both individual and group supervision to facilitate the aforementioned supervision formats. For the feedback group in individual supervision, supervisors and supervisees reviewed each client's scores together using the PCOMS categories to denote whether a client was progressing as expected and, if not, identified strategies for how to proceed. In general, the data were used to help direct which clients needed more attention in supervision. Supervisors used the client feedback data to organize the supervisory sessions in a triage fashion, prioritizing those clients demonstrating less progress (i.e., deteriorating or no change) or having lower scores. Clients identified as progressing as expected (i.e., reliable change or clinically significant change) or having higher scores were discussed later within the supervisory session to identify or reinforce the trainee's areas of strength. In group supervision, the PCOMS data were used similarly, but trainees in the feedback condition (rather than both supervisor and trainee) selected which client(s) needed the most attention. Both ORS and SRS scores were used to provide more information about the client to be discussed. Trainees in the no-feedback condition received individual and group supervision as usually provided. The time spent in individual and group supervision was equal for both conditions.

Trainees in both conditions completed the counselor self-efficacy measure (i.e., COSE) at the beginning and end of the fall semester and again at the end of the spring semester. The SOS and the SWAI-T were completed by trainees in both conditions at the middle and end of the fall semester and again at the end of the spring semester to evaluate their perceptions of their supervisory experience. Supervisors were not permitted to review the results of these measures.

Results

Did Outcomes Improve Over the Course of an Academic Year?

Pre-post means for the feedback and no-feedback conditions for trainees in the marriage and family program help provide a context for the use of PCOMS with trainees. Trainees in the feedback group demonstrated better outcomes with clients than did trainees in the no-feedback group. Clients in the feedback group had a mean gain of 8.90 points from pretest to posttest (range = 19.25 to 28.15), whereas clients in the control group had a mean gain of 4.01 points (range = 18.56 to 22.56). These findings are consistent with research in which professional staff have used PCOMS (see Miller, Duncan, Sorrell, & Brown, 2005). Pretest score differences for both groups were not statistically significant. A repeated measures factorial analysis of variance, using supervisor as a covariate, found that trainees in both groups demonstrated statistically significant improvement overall with clients, $F(1, 92) = 47.76, p < .000, \eta^2 = .34$. Clients in the feedback condition showed better outcomes than did those in the no-feedback condition (Time \times Condition), $F(1, 92) = 6.88, p < .05, \eta^2 = .07$. The eta-square of .07 is considered to be a small to medium effect size (Cohen, 1988). The supervisor covariate was not statistically significant, $F(1, 92) = 0.11, p > .05, \eta^2 = .00$.

To look at individual trainee effectiveness, we computed effect sizes for each client who completed treatment. Cohen's d was computed by using the highest original standard deviation for each group mean rather than using a pooled standard deviation to avoid inflating the effect size common with measures (Dunlap, Cortina, Vaslow, & Burke, 1996). A mean treatment outcome effect size for each trainee was computed by aggregating the outcome effect size for each client in the trainee's caseload. Trainees in the feedback condition had a mean effect size of 0.92 (range = 0.43 to 1.72) versus a mean of 0.23 (range = -0.22 to 1.02) for trainees in the no-feedback condition. However, we found no statistically significant differences in the mean number of sessions attended by clients in each condition (feedback = 5.40, no-feedback = 4.19), $t(113) = 1.42, p > .05$.

To assess whether supervisees progressed during their training, we compared their effectiveness with clients across academic semesters. Specifically, we examined whether trainees in the feedback condition demonstrated more improvement (as evidenced by client outcomes) during the academic year as compared with trainees in the no-feedback condition. Trainees in both the feedback and the no-feedback conditions evidenced improvement from the first to the second semester as shown by aggregated effect sizes (see Figure 1). The feedback group demonstrated an effect size

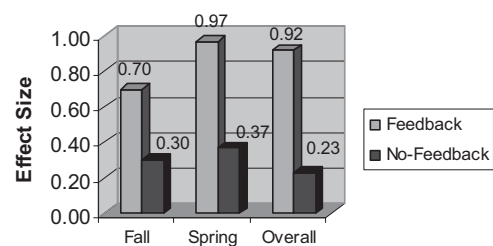


Figure 1. Aggregate effect sizes on the Outcome Rating Scale (ORS) by academic semester and overall for feedback and no-feedback conditions.

gain in effectiveness from 0.70 ($n = 35$ clients) in the first semester to 0.97 ($n = 26$ clients) in the second semester, whereas the no-feedback group demonstrated smaller effect size gains from 0.30 ($n = 31$ clients) in the first semester to 0.37 ($n = 23$ clients) in the second. Not only did the trainees in the feedback group have better outcomes from the beginning, they also evidenced more improvement in the second semester.

Did PCOMS Influence the Supervisory Relationship or Satisfaction With Supervision?

Scores on the SWAI-T and SOS indicated that trainees' perceptions of the supervisory relationship and satisfaction with supervision were similar for the no-feedback group across the academic year but more variable for the feedback group (see Table 1). However, a repeated measures multivariate analysis of variance revealed no differences between the groups, Wilks's $\Lambda = .03$, $F(2, 12) = 0.15$, $p > .05$, $\eta^2 = .03$. The interaction (Time \times Condition) also indicated no statistically significant differences. It appears that contrary to our hypothesis, using the continuous assessment system in supervision did not influence the supervisory alliance or overall satisfaction with supervision.

To investigate whether the supervisory alliance or satisfaction with supervision was related to trainee effectiveness as measured by client outcome, we examined correlations between the SWAI-T, the SOS, and the mean treatment outcome effect size for each trainee. Correlations between the SWAI-T and the SOS were .82 (middle of fall), .83 (end of fall), and .92 (end of spring). These strong correlations are consistent with previous research investigating the supervisory alliance and satisfaction with supervision (Ladany et al., 1999). Correlations between these variables and trainee effect sizes were much lower, ranging from .05 to .24 (see Table 2). A correlation of .23 was observed between outcome and the therapeutic alliance as measured by the SRS at Session 3. It is also worth noting that the correlation between the SWAI-T and SRS ($r = .89$) at the end of the academic year was statistically significant. These results indicate that as expected, the quality of the supervisory alliance was related to the quality of the therapeutic alliance.

Table 1
Supervisory Working Alliance Inventory: Trainee and Supervision Outcomes Survey Means and Standard Deviations for the Client Feedback and No-Feedback Conditions Across the Academic Year

Condition	Middle of fall		End of fall		End of spring	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
SWAI-T						
Client feedback	103.67	8.89	95.57	14.54	100.00	27.96
No feedback	99.09	15.69	99.10	19.08	106.45	24.02
SOS						
Client feedback	111.00	19.77	98.28	20.66	118.40	21.15
No feedback	112.91	19.42	109.50	23.27	115.36	26.13

Note. SWAI-T = Supervisory Working Alliance Inventory—Trainee Version; SOS = Supervision Outcomes Survey.

Table 2
Correlations of Trainee Supervisory Alliance, Therapeutic Alliance, Supervision Satisfaction, and Counselor Self-Efficacy With Trainee Outcome

Scale	1	2	3	4	5	6	7	8
1. Trainee outcome (overall)	—							
2. SRS (Session 2)	.23	—						
3. SWAI-T (end of fall)	.06	.37	—					
4. SWAI-T (end of spring)	.15	.89*	.04	—				
5. SOS (end of fall)	.05	.01	.83**	.12	—			
6. SOS (end of spring)	.24	.72	-.15	.92**	.01	—		
7. COSE (beginning of year)	.02	-.04	.01	.02	.14	.22	—	
8. COSE (end of year)	.19	.01	.02	-.24	-.35	-.16	.04	—

Note. SRS = Session Rating Scale; SWAI-T = Supervisory Working Alliance Inventory—Trainee Version; SOS = Supervision Outcomes Survey; COSE = Counseling Self-Estimate Inventory.
* $p < .05$. ** $p < .01$.

Did PCOMS Influence Counselor Self-Efficacy?

As can be seen in Table 3, the COSE scores for trainees in both conditions increased across the academic year. A repeated measures analysis of variance found the differences across time to be statistically significant within each group, $F(2, 12) = 4.50$, $p < .05$, $\eta^2 = .56$. However, the interaction effect (Time \times Condition) showed that the degree of change between the groups was not different, $F(2, 12) = 0.13$, $p > .05$, $\eta^2 = .04$. Contrary to our expectations, trainees who used PCOMS data in supervision did not report larger increases in counseling self-efficacy when compared with trainees who did not use PCOMS.

A secondary hypothesis was to investigate the relationship between counselor self-efficacy and client outcome. Although the correlations between the COSE and outcome increased over time, all of the correlations were low (see Table 2), with coefficients ranging from .02 (beginning of the year) to .19 (end of the year). With few exceptions, COSE scores did not correlate highly with measures of satisfaction with supervision or the supervisory alliance.

We also conducted the same correlational analyses for each condition (see Table 4). The correlations between counseling self-efficacy and outcome were surprisingly different for each condition; at the end of training, the self-efficacy scores reported by trainees in the feedback condition were strongly related to their aggregate therapy outcome (i.e., effectiveness) effect sizes ($r =$

Table 3
Counseling Self-Estimate Inventory (COSE) Means and Standard Deviations for the Client Feedback and No-Feedback Conditions Across the Academic Year

Condition	Start of fall		End of fall		End of spring	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Client feedback	140.90	17.32	150.50	14.83	167.78	13.71
No feedback	143.23	15.82	151.81	12.65	165.71	16.65

Table 4
Correlations of Counseling Self-Estimate Inventory (COSE) With Trainee Outcomes by Condition

COSE	Trainee outcome	
	Feedback	No feedback
Beginning of year	-.04	.06
End of year	.51	-.38

.51). For trainees in the no-feedback condition, however, self-efficacy scores had a correlation of $-.38$ with aggregate therapy outcome. Interestingly, the self-efficacy of trainees in both conditions measured at the beginning of the study demonstrated near-zero correlations with therapy outcome at the end of the study.

Discussion

Few psychotherapy supervision studies have investigated whether and how client outcome might inform psychotherapy training and supervision. Using outcome data that are collected from clients every session has been proffered as a way to help redress this limitation. Such continuous assessments offer other potential advantages as well. Monitoring client feedback could help provide rich information for use in supervision by enabling supervisors to monitor supervisee progress more closely (Lambert & Hawkins, 2001). The purpose of this study was to investigate the promise of using continuous outcome data in supervision and the manner in which these data influence the supervisory process. Results indicated that although most trainees experience positive outcomes with their clients and supervisors, trainees who used a continuous assessment system (i.e., PCOMS) with clients and shared the feedback data in supervision demonstrated better outcomes with their caseloads than did trainees in a control group who did not use continuous assessment. The treatment gain scores for trainees in the continuous feedback condition (8.90) versus those in the no-feedback condition (4.01) and the number of clients who demonstrated clinically significant improvement in each group (28% vs. 15%) indicates that **trainees who received continuous feedback from their clients were approximately twice as effective as those who did not receive feedback over the course of therapy.** This is consistent with previous research (Miller et al., 2005) and indicates that the usefulness of the ORS and SRS extends to master's-level psychotherapy trainees.

Trainee Improvement

Few supervision studies have directly examined the relationship between client outcome and the quality of training. Successful outcome in supervision has typically been operationalized from the supervisee's perspective. However, the overarching goal of supervision is to improve one's counseling skills, thereby increasing one's ability to help clients. The current study demonstrated that irrespective of group, trainees were generally helpful to their clients (average Cohen's $d = 0.56$). Client outcomes improved throughout treatment regardless of the trainee's group assignment. However, trainees in the feedback group had better outcomes in

the first semester and demonstrated even more improvement in the second semester than did those in the no-feedback group.

Comparing the client psychotherapy outcomes of trainees is fraught with threats to internal validity given that each supervisee's caseload consists of clients from diverse backgrounds who differ in any number of ways, including presenting problem and level of problem severity. Therefore, conclusions from this study about how to improve supervision training and therapy outcomes should be interpreted with caution. Ronnestad and Ladany (2006) noted that "there are significant obstacles to gathering data in a controlled fashion on the relationship between supervision process and outcome and psychotherapy process and outcome" (p. 263). However, having a better gauge of how trainees perform with their clients is one way to track trainees' progress and serves as a means of ensuring that trainees are capable of demonstrating a minimum level of competence. Direct outcome comparisons could be misleading but may also be meaningful if made in an ipsative fashion.

Supervisory Alliance and Satisfaction With Supervision

Although trainees who used PCOMS in supervision demonstrated better client outcomes, they did not report a better supervisory alliance or more satisfaction with supervision than those who did not use the feedback system. The results were surprising given the expectation that the use of outcome data in supervision would lead to more specific feedback, which is considered a marker of effective supervision (Lehrman-Waterman & Ladany, 2001). A concern expressed by both supervisors and supervisees before the study was that the likelihood of negative feedback would increase and hurt the supervisory relationship. Perhaps this anticipation led to heightened sensitivity on the trainee's part when discussing a client who was not progressing. Another possibility is that the supervisor focused more on the data and information from the measures and less on the supervisee, which may have affected the supervisee's perception of the supervisory relationship.

A more positive way of looking at the data is that the use of continuous feedback in the supervisory process did not negatively influence trainees' satisfaction with supervision or their perceptions of the supervisory alliance. When asked about the supervisory process after the study, supervisors explained that using the continuous assessment data in supervision made providing critical feedback easier and served as a starting point for providing more specific feedback. Hoffman et al. (2005) found that most supervisors withhold feedback regarding performance. Our results may help quell concerns that giving such feedback will harm the supervisory relationship.

Importance of the Supervisory Alliance

The supervisory alliance has been conceptualized to function similarly to the therapeutic alliance in that a good working relationship is foundational to effective training. Although the literature is clear that successful supervision is predicated on a good supervisory alliance (Nelson & Friedlander, 2001), the literature is less clear on how successful supervision is defined, particularly as regards the perspectives of the other stakeholders in the therapy process. The supervision literature is also decidedly mixed on how the supervisory relationship influences training outcomes (Ladany et al., 1999). The results of this study provide evidence that the

supervisory alliance is related to client outcome. The correlation between the supervisory alliance and client outcome is similar to correlations typically found between the therapeutic alliance and client outcome (Baldwin, Wampold, & Imel, 2007; Martin, Garske, & Davis, 2000). However, correlations between the supervisory relationship and counselor self-efficacy were all quite low. Past evidence for this relationship is unclear; some researchers have found such a relationship (Efstation et al., 1990), and others have not (Ladany et al., 1999). Although this study provides evidence that the supervisory relationship is important, the feedback condition was small and results cannot be generalized at this time. In general, this study's data indicated that trainees were generally happy with their relationships with supervisors and the quality of supervision received as indicated by the SWAI-T mean scores. More research is clearly needed to understand the role of the supervisory alliance in promoting psychotherapy training.

Counselor Self-Efficacy and Trainee Development

Two questions guided our investigation of trainees' counseling self-efficacy beliefs. First, we sought to examine whether the condition to which trainees were assigned, with or without client feedback, would differentially affect trainees' efficacy beliefs. Our results indicate that trainees in both conditions experienced statistically significant gains in counseling self-efficacy across the training year. Several explanations could account for this. First, consistent with Bandura's (1997) theorizing, the practical experience all trainees obtained could have served to boost their self-efficacy. Indeed, mastery experience has been shown to be the most powerful source of self-efficacy, and in this study such experiences may have overshadowed the social persuasions that trainees in each group received.

A second explanation could be that although trainees in both groups reported similar self-efficacy levels at the conclusion of the study, the self-efficacy beliefs reported by trainees in the no-feedback group were inflated. This seems plausible given the lower outcome scores for these trainees' clients. This is also consistent with past research. Researchers who asked therapists to rate their level of effectiveness found that therapists rated themselves equally, regardless of their actual level of performance (Hiatt & Hargrave, 1995). Perhaps this sort of "Lake Wobegon effect" was at work for those trainees who did not receive explicit feedback from their clients and who, given this missing feedback, assumed themselves to be equally capable of treating their clients despite their actual differences.

Our second aim for investigating counselor self-efficacy beliefs was to test Bandura's (1997) hypothesis that self-efficacy beliefs are positively related to actual performance. Specifically, we sought to examine whether trainees who reported higher counselor self-efficacy also experienced better client outcomes throughout the year. Research in a number of disciplines has found that those who believe themselves to be capable tend to put forth more effort, persevere in the face of difficulty, and set more challenging goals for themselves (Bandura, 1997). We found that self-efficacy was related to outcome ($r = .52$), but only for trainees in the client feedback condition. Providing consistent feedback on performance (e.g., Locke & Latham, 2002) has been found to lead to improved performance.

Comparing the correlation between client outcome and counseling self-efficacy for the feedback group to the low correlation obtained for the no-feedback group reveals that perhaps the efficacy beliefs of counselors in the feedback group was better calibrated with the clients. Those in the no-feedback condition, however, had limited information on which to base their efficacy judgments, namely their perceptions of the client's progress in therapy and the comments they received during supervision. With this in mind, it does not seem surprising that trainees who received regular feedback from clients on outcome and the therapeutic relationship had levels of self-efficacy that were more closely related to their actual performance with clients. These results nevertheless point to the complexity of counseling self-efficacy and suggest that increasing self-efficacy during training is not a panacea that automatically results in better client outcomes. This contention is supported by previous findings that outcome with career counseling clients may not have a linear relationship with counseling self-efficacy (Heppner et al., 1998).

Limitations of Study

There are limitations in this study that warrant mention. First, the sample of trainees and supervisors was small and consisted of only two master's programs. Tracking trainees' outcomes with their clients for an entire academic year is a strength of the study, but the generalizability of the results, particularly for doctoral training programs, is limited. The small sample size also limited the ability to conduct more powerful analyses. Hierarchical linear modeling would have been the preferred analysis to assess growth curves across the academic year for both clients and trainees and would have helped better capture individual growth, but the sample size was not adequate. A second limitation is the issue of treatment integrity. This study involved three levels of participants: clients, trainees, and supervisors, which made it difficult for us to ensure that participants complied with the study's protocol. Trainees were most enthusiastic about the project and expressed excitement that they would have an additional tool to use in therapy. Their supervisors were generally less enthusiastic, however, about an additional responsibility in supervision. Protocol adherence was evidenced by the positive anecdotal feedback from supervisors and supervisees and that the majority of clients completed measures consistently throughout the academic year. Participant compliance was encouraged via e-mail reminders sent to the supervisors during the midpoint of each semester.

Another limitation is that trainees from the marriage and family program were all placed in one setting and the clinical-counseling trainees were placed in different training sites. Although client outcomes with the clinical-counseling trainees were not used in comparing differences in outcome between treatment conditions, their placement in a variety of settings may have led to different levels of success with clients and, consequently, different experiences and perceptions of their training and supervision. However, trainees from all the programs rated their supervisory experiences and counseling self-efficacy similarly. A fourth limitation was that we used a continuous assessment system that has less empirical support than the OQ45 (Lambert et al., 1996), although initial research on PCOMS has been encouraging. The reason for using PCOMS was twofold: The study sites were resistant to using longer measures, and PCOMS provides additional information

about the therapeutic alliance that we believe was valuable feedback for trainees to receive. Last, it was not possible to know how to connect the effects of supervision directly to client outcome. Using a continuous outcome model appears to have been helpful for trainees to use with clients, but we are uncertain of its utility within the supervisory process. It is plausible that outcomes would have been equally as impressive if the client feedback data were not used in the supervisory sessions.

Future Study

We considered this study to be an exploratory investigation. We could not identify other studies that have assessed the utility of continuous client feedback in counselor training and supervision. Nevertheless, our findings point to several fruitful research possibilities to be pursued. First, a similar design with the addition of a third condition in which trainees use a continuous assessment model with clients but not in their supervision would help assess whether using outcome data in supervision leads to improved client outcomes. Second, studies in this area may also include using other continuous assessment measures such as the OQ45 and evaluating the utility of the different components of client feedback provided. For example, one of the reasons PCOMS was selected was to include a measure of the therapeutic relationship. How is the inclusion of this measure useful to trainees? Third, one of the proposed advantages of using continuous assessment is that it lends itself to more specific feedback in supervision. Using a measure that directly assesses this process may shed light on how using continuous assessment data contributes to the supervision process. Also, future research should continue to investigate how counselor self-efficacy and other person-level variables may mediate both supervisory and client outcomes. Although conducting supervision research that focuses on client outcome is difficult and challenging, such research is important and necessary given the centrality of supervision to counselor training. The question of whether supervisory training is beneficial is in part still unanswered because of limited research in this area (Stein & Lambert, 1995).

Conclusions

The main purpose of psychotherapy supervision is to help trainees become more effective clinicians. It makes sense that tracking client outcome would be helpful in this process. The results of this study demonstrated that with a sample of master's program trainees, using continuous assessment measures, the ORS and SRS, resulted in better client outcomes. Trainees in both conditions demonstrated improved client outcomes over the course of an academic year, although those in the feedback condition showed twice as much improvement. An informal qualitative analysis found that trainees in the feedback condition were pleased that they could monitor how they were doing with their clients as novice therapists. They also felt that feedback from clients gave them more structure and a good place to start with new or "difficult" clients. Supervisors generally felt that client feedback was less useful, but they agreed that client feedback assisted them in providing trainees with challenging feedback and helped to identify clients who needed more attention in supervision.

Using client feedback data in supervision did not enhance the supervisory relationship, satisfaction with supervision, or counselor self-efficacy reported by trainees when compared with reports from trainees in the no-feedback condition. Interestingly, the correlation found between the supervisory working alliance and client outcome is similar to correlations found for the therapeutic alliance and outcome. Additionally, we found moderate correlations between counseling self-efficacy and outcome for trainees who received client feedback data, whereas we found negative correlations between counseling self-efficacy and outcome for those in the no-feedback condition.

For practicum sites that have limited ability to video- or audio-tape consistently or for supervisors who have a large number of supervisees that makes keeping track of client caseloads cumbersome, the use of a continuous assessment model for trainees may be especially appealing. In both situations, a supervisor is often left to rely on a trainee's perceptions. We know such perceptions are not always accurate and that therapists tend to overestimate client progress (Grove et al., 2000). Trainees' ambivalence about wanting to share mistakes in the evaluative context of supervision also makes sole reliance on trainees' self-reported performance problematic. Using outcome data consistently in supervision may help therapists have a more accurate perception of their abilities and may also serve as a means of normalizing the process of sharing information about clients, particularly when things are not going well. Trainees need to know that even the best therapists are not successful with all of their clients. Conversely, seeing concrete evidence that clients are benefiting and improving from therapy can be motivating and may bolster one's sense of self-efficacy.

Specific feedback is considered a key ingredient in effective supervision, and the use of client outcome in supervision holds the promise of facilitating this process. Despite this optimism, caution should be taken in how client data are used as a supervisory tool. Care should be taken to help trainees recognize that monitoring client outcome is not to reduce their counseling skills to an effect size but rather to help them gain a clearer understanding of how they work with clients and to help them become more effective as therapists.

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