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A large body of research has supported the use of client outcome monitoring and client feedback in psychotherapy. However, discussions between supervisors and trainee clinicians in supervision are still largely based on subjective appraisals made by the trainees. In this article, we discuss 3 strategies for integrating client outcome data and feedback into the supervisory process: training students to obtain and use objective client feedback, using specific client data to inform discussions of clients, and identifying patterns of outcomes across clients to facilitate supervisee growth and development.

Keywords: supervision, outcome tracking, client outcomes, training, practicum

Although tracking client change through norm-referenced standardized measures has become more common among clinicians; supervisees' reports of the treatment process and outcome to their supervisors continues to primarily consist of sharing subjective appraisals (O'Donovan, Halford, & Walters, 2011). In contrast, we present several methods for use of client outcome monitoring as a tool for use within supervision. Following a brief review of the theory and research behind outcome monitoring, we present three ways to more fully incorporate client outcome monitoring in supervision: (1) training students to obtain and use objective client feedback, (2) using outcome monitoring to inform discussions of specific clients in supervision, and (3) using patterns of outcomes across clients to facilitate supervisee growth and development. A brief description and a supervisory vignette are provided for each skill.[1]

Outcome Monitoring—Theory and Research

Outcome monitoring is defined as the process of routinely assessing client progress through objective measures to not just observe a client's degree of change, but to inform clinician decision making based on the individual pattern of progress or lack thereof. It typically involves the use of a standardized outcome monitoring system (e.g., Outcome Questionnaire system; OQ; Lambert, Kahler, Harmon, Burlingame, & Shimokawa, 2011; Partners for Change Outcome Management System; PCOMS; Miller & Duncan, 2004) on a session-by-session basis, comparisons of individual client change to expected empirically or theoretically derived patterns of change, and feedback to the providing clinician regarding whether the client is making adequate progress.

The idea of outcome monitoring was first formally introduced as patient-focused research by Howard and colleagues in the 1990s (Howard, Moras, Brill, Martinovich, & Lutz, 1996). Howard et al. indicated that although clinicians should be concerned with whether a particular intervention works under both experimental and naturalistic conditions, they should be most concerned with whether it is working for the particular client. However, research has indicated that even experienced clinicians have difficulty knowing if a treatment is working for a particular client based just on their own clinical judgment (Lambert, 2010). For example, in one study Hannan and colleagues (2005) tested the accuracy of clinical judgment for 48 different clinicians by asking them to indicate the progress of their clients. Although the clinicians predicted deterioration for only three of the 550 clients, 40 of them had actually gotten worse during therapy (only one of which was in the group of three that was predicted). In contrast, the clinicians predicted just over 500 of their clients to have a positive outcome, but only a little over 200 actually evidenced progress. A significant body of research has demonstrated that clinical prediction can be improved, and in turn better outcomes obtained, via outcome monitoring systems. In a meta-analysis of two outcome systems (OQ and PCOM), Lambert and Shimokawa (2011) found that when outcome monitoring and feedback were included in treatment, clients were three times more likely to make a reliable

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[1] To protect supervisor identities and maintain confidentiality, the vignettes included in this paper are amalgamations of several supervisory cases and all names have been changed.

change and half as likely to end therapy in a deteriorated state compared to clients in the no feedback conditions.

Given the value of outcome monitoring and obtaining patient feedback, some have suggested that it be used more fully in supervision (Lambert & Hawkins, 2001; O'Donovan et al., 2011; Sparks, Kisler, Adams, & Blumen, 2011; Worthen & Lambert, 2007). The existing literature has suggested several benefits associated with outcome informed supervision. First, and perhaps foremost, it allows supervisory discussions of clients to be based on client-reported clinical outcomes rather than the supervisee's reporting of his or her perceptions of client progress. When this process occurs in supervision it sets an example for trainees to follow in their later clinical work. Second, referring to specific client data can provide a road map to identify clients it might be most appropriate to discuss in a given supervisory session. Third, it can help supervisors step back and see the big picture with a trainee clinician's work, thus being able to target patterns that appear across clients with their supervisees.

Training Students in Obtaining Client Feedback

Many of the basics of training in outcome monitoring can actually happen outside of supervision. For example, in the classroom students can be taught about the rationale behind patient-focused research, they can read the research that supports the use of client feedback systems, and they can seek to gain an understanding of the meaning of clinically significant and reliable change. In addition, in an orientation to the specific clinic setting students can be taught about when, where, and how to administer the measures, how to use the site specific technology for the system/measures, and how to access software generated reports (if available).

However, the more complex aspects of obtaining and making the most of client feedback (e.g., assisting clinicians in developing an outcome monitoring plan) are better suited to occur during supervision. Given the complexity of these tasks, we recommend that supervisors personally learn about the process of outcome monitoring and also seek to integrate outcome monitoring into their own practice before adopting an outcome informed supervision approach (see Whipple & Lambert, 2011). Informed supervision may start by helping trainees select among available outcome monitoring systems, discussing issues of reliability and validity (e.g., focusing on accuracy in predicting treatment failure, sensitivity to change), ease of use, quality of the feedback that is given, cost, and other considerations. Although clinicians may have little choice about which system to use while in training depending on the policies of the specific clinic, students who have discussed how to think about these issues with their supervisors will be better prepared to evaluate future options and make decisions.

Supervisors also can augment the general outcome system/measures that are administered in a set way for all clients by helping trainees learn how to add measures that are suited to particular clients and/or theoretical orientations. As just a few examples, supervision may include discussion of adding a disorder specific symptom rating scale (for depression, anxiety, pain, etc.), or measures of hope, motivation, social support, or the therapeutic alliance. Given the unique pieces of information that many different measures could provide, it takes a certain level of skill to decide which measures are most appropriate while not taking up too much of the client's time. Helping trainees learn to strike this balance may be a concerted long-term goal of informed supervision. Among the therapeutic variables that could be assessed, a measure of the therapeutic alliance may be a particularly good place to start with this line of training, given the value that this variable plays in both treatment outcomes (Horvath, Del Re, Fluckiger, & Symonds, 2011) and premature termination (Sharf, Primavera, & Diener, 2010). One caveat worth keeping in mind and discussing during informed supervision is that client ratings of alliance tend to be negatively skewed (Horvath et al., 2011). As such, even slightly less than ideal ratings may be indicative of problems in the therapeutic alliance.

The task of discussing the results of outcome monitoring with clients includes many nuances and is perhaps a more advanced skill to acquire during informed supervision. However, work toward competency in this area should still begin early in training. Novice, prepracticum trainees can be taught how to word the results of the measures and the change patterns in a manner that is easily understood by clients even before they begin seeing clients. In contrast, more advanced practicum or internship trainees are more likely to benefit from supervision focused on how to discuss feedback in a way that improves understanding of the client's experience, leads to a specific therapeutic plan or modifications to the plan, increases the sense of collaboration between the client and therapist, and facilitates client insight into his or her problems and experience of change or lack thereof. In addition to overt instruction, we suggest that informed supervision also encompass good supervisor modeling. Just as trainee clinicians are asked to administer appropriate measures to their clients, supervisors may want to utilize appropriate measures of supervision outcomes (e.g., Bahrick, Russell, & Salmi, 1991; Efstation, Patton, & Kardash, 1990; Rousmaniere & Ellis, 2013) and model discussion of those results as illustrated in the following supervisory vignette.

Clinician: [While sharing a graph of a client's outcome scores plotted over sessions with the supervisor] *The client that we talked about last week didn't seem to be doing any better this week and he ended up rating our relationship lower than usual.*

Supervisor: *What did you think when you saw the lower ratings?*

Clinician: *I was really kind of surprised—I had been thinking our relationship was fine.*

Supervisor: *That is the real beauty of outcome monitoring. With the biases that we have, as clinicians we can often miss some of the client's feelings and thoughts about how things are actually going in psychotherapy. Now that you've seen the client's lower rating of the therapeutic relationship, what do you think you can do next?*

Clinician: *I am not really sure, I feel like we get along well and he says he likes me.*

Supervisor: *Sounds like you feel like there is a pretty good bond between you and the client, but the ratings were still low.* [Examines the working alliance

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measure more closely.] *If we look at the scores on the working alliance measure the items dealing with collaboration are all rated lower than the items pertaining to the bond. So what might be some ways to increase the client's sense of collaboration?*

Clinician: *I guess I can talk to him about it, but I am not really sure how?*

Supervisor: *Do you remember a couple weeks back when you completed that supervisory alliance measure and you rated our bond as being slightly lower than the other areas? Do you remember how I brought that result up to you?*

Clinician: *Yeah, I do. You thanked me for providing the feedback on the measure, mentioned that you noticed the lower score in that area, and then asked me how I had been feeling about the bond. After we talked about it some you asked for ideas about what we might be able to do differently to strengthen our bond.*

Supervisor: *How did you feel that conversation went?*

Clinician: *Really well—Even though we were talking about the bond, I have also felt a stronger sense of collaboration in supervision ever sense.*

Supervisor: *So how would you feel about taking a similar approach with your client?*

Clinician: *Makes a lot of sense now, I definitely think I can do that.*

Using Specific Client Feedback to Guide Supervision

Effective supervision depends, in part, on trainee clinicians identifying what they need help with during supervision. As a result, it is important for supervisors to engender in their trainees a habit of integrating quantitative evidence with their budding clinical intuition to determine how to prioritize clients for discussion within supervision (Worthen & Lambert, 2007). By using outcome data to prioritize clients for discussion in supervision, therapeutic rupture, premature termination, or the advent of a crisis (i.e., hospitalization or self-harm) may be curbed (Lambert, 2010). By encouraging consistent standardized outcome monitoring and reviewing that data within supervision, an atmosphere that fosters trainee's critical thinking (an essential competency; Kaslow, 2004) can be created. It also can provide a mechanism for determining whether a trainee is using supervision effectively and yield valuable information about whether a trainee is on track in their developing skills pertaining to integration of subjective and objective clinical appraisals of client change over time. An exchange illustrating a process of incorporating client outcome measurement into a challenging supervision interaction (i.e., needing to give corrective feedback to a somewhat resistant trainee who confuses a strong alliance with effective treatment) may underscore this point:

Clinician: *Sarah mentioned in our last session that her mom doesn't think she is progressing as fast as she should in therapy.*

Supervisor: *Hmmm, okay. What do you make of that?*

Clinician: *I'm not sure. I mean Sarah is really easy to engage and I feel like we have talked about some pretty important stuff. She always tells me how grateful she is at the end of sessions and how much she appreciates me.*

Supervisor: *But something about her mother's comment has given you pause . . . at least; it felt important enough for you to bring it into supervision to discuss.*

Clinician: *I think that maybe I don't like that her mom was kind of devaluing the work we have been doing together when I think it has been going really well.*

Supervisor: *That would linger with me as well. I think it's great that you recognized the potential salience of mom's comment. As I think about it though, it makes me wonder if bringing mom's comment into session might have been a way for Sarah to gently share with you her own concern about progress.*

Clinician: *Hmm* [looks uncomfortable].

Supervisor: *I'm really glad you brought this up; it actually helps me make sense of something I have been noticing in your progress notes and want to talk about with you. You consistently describe a lot of progress in your narrative description of each session, even though we have been noticing and discussing that Sarah's outcome scores have not reliably changed from session one. Your appraisals of Sarah and Sarah's actual report are not converging over time.*

Clinician: *Well, we have only been working together a few months* [sounds dismissive].

Supervisor: *True, there is still quite a bit of work to do . . . but, I would expect to see some early gains by now and a lessening in her distress.* [Discussion of the data and client change trajectories ensues to inform clinical decision making.]

The practice of monitoring client progress also can be seen as an ongoing effort to evaluate trainee progress (Dohrenbusch & Lipka, 2006). This comes with the caveat that progress tracking should not be punitive or grade dependent. Rather, as shown in the supervision vignette above, it can be used as another piece in the evaluative puzzle and a learning experience. Trainees that respond well in cases of client deterioration can gain confidence, while those who do not can learn from their missteps within the process of supervision. This is, of course, dependent on the atmosphere that the supervisor creates. While supervisory working alliance is conceptualized as an interaction between both trainee and super-

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visor, it is ultimately the supervisor who is responsible for maintenance of a nontoxic learning environment.

Using Patterns of Client Feedback to Guide Supervision

Another method for using clinical outcomes in supervision is teaching trainees how to examine their overall aggregate outcomes; to review the "big picture" of their clinical work. As shown in Figure 1, trainees may periodically be asked to create a spreadsheet that lists all of their clients. For each case, trainees put their clients' basic demographic data (age, gender, race), starting outcome score, final outcome score, number of sessions, primary presenting problem or clinical focus, and the trainees' subjective opinion about the major challenges and successes of each case. The supervisor and trainee then review the spreadsheet together, with an eye for trends in the trainees' work and identification of trainees' clinical strengths and weaknesses, which can help counter the tendency toward self-idealization or self-devaluation that may be commonly experienced by some trainees (Salzberger-Wittenberg, Henry, & Osborne, 1983). For example, a trainee might show a trend of positive gains with anxiety cases, but less effectiveness with depression cases. In this case, the supervisor could shift their training focus toward teaching techniques to address depression. In another example, a trainee may have a preponderance of dropouts with a certain demographic group, such as older women. The supervisor could help the trainee reflect on what may be limiting their effectiveness with these clients. In another example, a trainee might show initial positive gains with many clients, but thereafter a lack of progress. In this case, the supervisor could discuss the phase model of change (Howard, Lueger, Maling, & Martinovich, 1993), and how to help clients move from remoralization to remediation and rehabilitation.

Another tool to get a big picture look at a trainee's work is to use a spreadsheet function to compute the trainee's average outcome change score or effect size (for a review of different methods for computing effect sizes, see Seidel, Miller, & Chow, 2014). The trainee's average change score or effect size can be compared to other trainees, presuming they work in similar conditions with similar client populations (Minami, Brown, McCulloch, & Bolstrom, 2012). Note that this method is not recommended if the trainee has a small number of clients (e.g., fewer than 10–30 clients, depending on the measure). The following is a transcript of a supervision session that demonstrates how the spreadsheet can be used in supervision.

Supervisor: *Looking at these results overall, what trends stand out to you?*

Clinician: *I did notice that all three of my African American clients got better.*

Supervisor: *Right. It might be worth reflecting on what worked with these clients, and helped them stick around for more sessions. Do you notice any other trends? What about presenting problems?*

Clinician: *I seem to do better with anxiety and worse with depression.*

Supervisor: *I noticed that too. It looks like two, possibly three, of your four clients with depression may have dropped out. Do you have any ideas about that?*

Clinician: *Honestly, I never fully understood the treatment approach I was using. I felt like I was just reading out of the manual. The clients might have noticed that.*

Supervisor: *Okay, so sounds like we will want to talk more about what was working with your African American clients and also review the treatment for depression that you have been learning. Looking at the spreadsheet, do you notice anything else?*

	A	B	C	D	E	F	G	H	I	J	K
1	Trainee Name: XXXX										
2	Supervisor Name: XXXX										
3											
4	**Client #**	**Age**	**Gender**	**Race/Ethnicity**	**Start OQ**	**Final OQ**	**WAI-SR**	**# Sessions**	**Presenting Problem**	**Challenges**	**Successes**
5	1	22	f	Caucasian	75	96	40	4	Depression	deterioration	unclear
6	2	26	f	African-American	85	60	54	8	Anxiety	cultural differences	client growth
7	3	20	m	Caucasian	95	75	57	8	Relationships	none	good alliance
8	4	31	f	Asian	71	71	<none>	1	Depression	dropout?	unclear
9	5	28	m	Caucasian	65	63	51	6	Anxiety	countertransference	unclear
10	6	25	f	Caucasian	78	62	58	2	Depression	dropout?	rapid change
11	7	34	f	Asian	69	69	<none>	1	Depression	dropout?	unclear
12	8	21	m	Caucasian	99	85	59	5	Relationships	countertransference	good alliance
13	9	23	m	African-American	82	61	55	10	Anxiety	cultural differences	sustained symptom reduction
14	10	30	f	African-American	67	59	58	12	Relationships	none	good alliance
15											
16				Average:	78.6	70.1	54	5.7			
17				Average OQ Change:	8.5						
18				Change Effect Size:	0.7						

Figure 1. Example spreadsheet of client data for use in supervision to identify a clinician's strengths and training needs. OQ = come Questionnaire–45.2; WAI–SR = Working Alliance Inventory–Short Revised.

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Summary

Tracking client outcomes and feedback for use in psychotherapy has been credited with reduced deterioration and improved clinical outcomes (Lambert, 2010). Considering previously documented parallels between psychotherapy and supervision, it is logical to extend this evidence-based practice to guide and focus supervision. However, to date, supervision usually consists of only sharing primarily subjective appraisals (O'Donovan et al., 2011).

To our knowledge, only one study has examined whether outcome informed supervision impacts client outcomes. In this study, Reese et al. (2009) assigned 28 trainees and nine supervisors to feedback and no feedback conditions. Although those therapists in the outcome informed supervision condition had a mean pre–post therapy effect size of $d = 0.92$ for their clients, those in the no-feedback condition had a mean effect size of $d = 0.23$. This study provides preliminary evidence in favor of outcome informed supervision, but a design limitation obscures clarity. More specific, therapists in the no-feedback condition with supervisors were not able to independently review their client's outcome scores either. It cannot be ruled out that the observed outcome differences between groups resulted from differential clinician use of outcome monitoring rather than informed supervision.

We suggest three pathways for greater incorporation of standardized, norm-referenced client outcome data into the process of supervision, with corresponding vignettes to illustrate each application: (1) training students to obtain and use objective client feedback, (2) using outcome monitoring to inform discussions of specific clients in supervision, and (3) using patterns of outcomes across clients to facilitate supervisee growth and development. Although support for these techniques can be found in the literature on tracking client outcomes, research is needed to directly examine whether outcome informed supervision will have a positive impact on the supervisory process.

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