Incorporating Client Feedback about Outcome and Alliance into Supervision*

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This resource describes one systemic therapy educational program’s foray into using client feedback, via an outcome management (OM) system that uses instruments that assess therapeutic alliance and outcome, to inform treatment decisions by therapists in training.¹ (See Chapter 19 in the accompanying book for the importance of incorporating client feedback in supervisee evaluation.) This excerpt focuses on ways supervisors used it during various aspects of the training process. It illustrates the critical role client data plays in the effectiveness of therapy, the supervisee’s learning, and the supervisor’s decisions and effectiveness of supervision. We encourage supervisors to find avenues for implementing client-generated feedback into their supervision practices for supervisees in all stages of development and across all settings.

—Editors’ introduction

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 marriage and family therapists (Liddle, Breunlin, & Schwartz, 1988; Nichols, Nichols, & Hardy, 1990; Todd & Storm, 1997;


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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 marriage and family therapist 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 marriage and family therapist literature and practice.

Some of the original material is omitted and noted with *** (here and in similar occurrences).

**Outcome Management Adoption**

Despite its fit with our program, the road to implementation of an outcome management (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. 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; \( r = 0.74 \); Campbell & Hemsley, 2009; \( r = 0.59 \); 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, Duncan, & Sparks, 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, and 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, Moras, Brill, Martinovich, & Lutz, 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 prepracticum 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 prepracticum 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.

Prepracticum

In prepracticum, 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 prepracticum 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 prepracticum, 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 midrange SRS scores. The therapist, without hesitation, asked what she could do differently to make it a better experience at the next meeting. A lively postsession 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 nondistressed 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 the following sessions.

The examples in the succeeding text 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 postsession 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 is 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 supervisory 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 and then binging, 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 6C.1 indicates the client’s early change and change maintenance during the course of treatment.

The client exceeded the expected treatment response (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 a dialogue 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

![Trajectory of change](image)

**Figure 6C.1** Client trajectory of change graph.
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.

Notes

1 The Outcome Rating Scale, the Child Outcome Rating Scale, the Outcome Session Rating Scale, and the Child Session Rating Scale can be found at www.heartandsoulofchange.com.

References


Campbell, A., & Hemsley, S. (2009). Outcome Rating Scale and Session Rating Scale in


