THE USE OF PER SESSION CLINICAL ASSESSMENT WITH CLIENTS IN A MENTAL HEALTH DELIVERY SYSTEM: AN INVESTIGATION INTO HOW CLINICAL MENTAL HEALTH COUNSELING PRACTICUM STUDENTS AND PRACTICUM INSTRUCTORS USE ROUTINE CLIENT PROGRESS FEEDBACK

A dissertation submitted to the Kent State University College of Education, Health, and Human Services in partial fulfillment of the requirements for the degree of Doctor of Philosophy

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May 2012
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The use of per session clinical assessment with clients in a mental health delivery system: an investigation into how clinical mental health counseling practicum students and practicum instructors use routine client progress feedback (227 pp.)

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The purpose of this study was to investigate how clinical mental health counseling practicum students and practicum instructors use per session assessment feedback with clients they served at a university counseling center. Per session assessment and feedback has been shown to increase the treatment outcomes that counselors achieve while treating clients, and has been shown to reduce drop out rates for clients who are underperforming during counseling (Lambert et al., 2001). This study used a mixed methods research design that was predominantly a qualitative multiple case study design. The researcher interviewed clinical mental health counseling practicum students and practicum instructors that had used the per session assessment and feedback program over the course of a semester with clients at a university counseling center.

The quantitative analysis of the counseling center clientele showed that clients left counseling with significantly less symptomology than when they appeared, measured by the pre counseling to post counseling Outcome Questionnaire 45 (OQ 45) scores. This finding suggested that clients at the counseling center found the counseling they received by the clinical mental health counseling practicum students to be effective. The qualitative analysis of the interview data collected from the clinical mental health
counseling practicum students and practicum instructors revealed the following themes: (a) perception of feedback, which included the sub themes of uncertainty, integration, and clients experience of feedback (b) application and use, which included the subthemes of process of using feedback, treatment planning, and supervision (c) feedback mechanisms, which included the sub themes of visual cue of client performance, red warning flags, critical item status areas, and tracking effectiveness, (d) discrepant feedback, and (e) suggestions for improvement.

This study included rich description about how clinical mental health counseling practicum students and practicum instructors incorporated the use of the feedback system, and found that per session assessment and feedback had a beneficial impact on practice. It was discovered that the use of the feedback program impacted treatment planning, and supervision positively, and created a negative feedback loop that appeared to help decrease anxiety and increase counselor self-efficacy in the clinical mental health counseling practicum students.
As I look back over the many months I worked on my dissertation, I find many people I’d wish to thank. First I wish to thank the participants of the study including the clients who gave so freely of their time, and volunteered so eagerly, the practicum students who I believe viewed me as a fellow learner, and the practicum instructors who could empathize with the strain of completing a dissertation. Without the help of these individuals my study would have never blossomed.

My guides through the dissertation and through my doctoral career have been Dr. Betsy Page, Dr. Jason McGlothlin, and Dr. Richard Cowan. The one truth I’ve learned through the dissertation experience is that you can never know what to expect until you have been through one. Luckily I have had a committee that has navigated many students, including myself, into their professional careers. Dr. Betsy Page has guided my dissertation from step one. I am grateful that she invested so much of her time and energy into my success as a growing professional. The gift I have received from Dr. Betsy Page has been the ability to temper my overzealous passion with discipline and focus. She has taught me that success not only demands enthusiasm but also the ability to present my ideas slowly and clearly. Dr. Jason McGlothlin has been an essential guide in my doctoral career and dissertation. He has witnessed my development from a first year doctoral student to now. He taught the class I met my wife in, and he has grown as a mentor and friend. He has modeled that successful counselor educators embrace relationships with their students. I hope I can model his values as I grow as an educator, pausing often from study to welcome students through my office door. Dr. Richard
Cowan has been a welcome breath of fresh air to my dissertation committee. I have appreciated his humor during our meetings and have been fortunate to have a third member whose understanding of evaluation and measurement has advanced my own. I believe his suggestions have made my dissertation more easily understood, so future audiences of my document will thank him as well.

My next round of thanks extends to my loving family. They have provided me with all the resources in the world, so that I could have achieved what I have today. Without their support I would not have been able to dream of pursuits like a doctorate, or enjoyed the luxury to continue my trek in school as far as I have. My father Russell, I want to thank the most. He has sacrificed much more than I will ever know to allow me to achieve my goals in life. I have learned the value of hard work through him, and the most important lesson of success: It does not take a genius to go far; just someone who is willing to work very hard. I am very thankful to all my family including my mother Kathy, my stepmother Sharon, and my four sisters Jennifer, Amy, Sarah, and Niki. I also want to thank my Grandmother Rita; she has always provided me with support and encouragement along my path, and has always been someone I can rely upon.

Lastly I wish to thank my wonderfully supportive wife Kristin. She has many roles in my life: wife, best friend, and classmate. She has taught me to be balanced during the dissertation process, and to place value on my work and my personal life. I would like to think that much of my drive on my dissertation was to impress her, even if she claims I no longer need to do that. I dedicate this document to her and feel I owe her for her supportiveness, love, and extreme patience with me, through this process.
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CHAPTER I

Introduction and Literature Review

Counseling has changed dramatically with the inception of managed health care. Clinicians are being tasked with providing proof that what they do in session is efficacious and cost effective (Barlow, 1996). Researchers attempting to answer the question of whether counseling works have explored the efficacy of counseling for some time. Researchers like Smith and Glass (1977) and Lambert and Ogles (2004) have demonstrated that counseling is indeed efficacious. These efficacy studies have become the gold standards in which psychotherapy is judged today. However, this efficacy research often poorly reflects the practice of counseling in non-laboratory settings. Lueger (2002) stated that clinicians are becoming increasingly dissatisfied with the efficacy studies in the literature today, as they fail to capture elements of genuine clinical practice.

Purpose and Rationale

This chapter includes a review of the evidenced based practice movement and how the outcome research movement influenced it. Summarized are the differing types of outcome studies that are adding credibility and accountability to the practice of counseling. A review of Evidence-Based Practice is also provided with suggestions on how to integrate new paradigms of research into our knowledge of best practices. Many of these new research paradigms support the use of divergent research methods that can be used in counseling to establish accounts of effective practice. One of these divergent research methods is client focused research; it is the main topic of this study.
Client focused research is grounded in feedback. However, feedback has differing meanings when applied to counseling. Feedback can range from explicit instructions governing the practice of counselors, to simple reflections based upon how one might believe the client is progressing. The necessity of feedback in some form is rooted in the belief that feedback is instructive and corrective, helping the receiver grow and develop. However the feedback message often varies, and the acceptance of it at any time is up to the belief in its veracity by the receiver. The feedback message used by the client focused research is evaluatory, and is given not to replace or stand alone as the only method of assessing the client’s progress, and the therapist’s interventions, but to be an additional tool that aids decision making and skill development within counselors.

Sapyta, Riemer, and Bickman (2005) explored feedback methods to counselors. They expressed that the typical practice of counseling provides little opportunity to assess specific skill development and intervention effectiveness. When counselors use their judgment alone, to assess overall treatment effectiveness for clients, they are terribly inaccurate. Counselors have difficulty assessing when clients are receiving no benefits from specific interventions, or when making accurate predictions on rates of recovery for clients.

Hannan et al. (2005) explored the effectiveness of counselors when assessing the progress their clients were making, and their ability to identify clients who were deteriorating. The researchers surveyed 49 counseling center staff made up of 27 licensed psychologists and 22 doctoral level trainees. The clients the counseling center staff saw were routinely tracked with a feedback system in which the counseling center
provided the counselors with weekly client feedback on their clients’ progress, provided by the Outcome Questionnaire 45 (OQ 45). The participants were asked to discontinue the use of the feedback system for three weeks, during which the OQ 45 was still administered to every client every session. However, the scores were not given to the therapists. During these three weeks the participants were surveyed whenever they saw a client. The survey asked, “In your clinical judgment alone, predict this client’s end of treatment outcome” (Hannan et al., 2005, p. 160). The responses were (a) recover, (b) improve but not recover, (c) make no progress in treatment, or (d) get worse. The second question was, “Considering this client’s initial session with you, rate this client’s progress as of today’s session. Base your rating on your clinical judgment and clinical experience alone” (Hannan et al., 2005, p. 160). The responses were (a) recovered and ready for termination; (b) improving as expected, but in need of continued treatment; (c) making no progress or poor progress; or (d) getting worse. All therapists in the study were informed that the deterioration rate for clients at the counseling center averaged 8%. Deterioration was defined as a client worsening significantly based upon the client’s initial OQ 45 score’s movement to a higher, or more symptomatic, score. There were a total of 944 survey responses for the 550 clients who qualified for feedback, which entailed having more than two sessions. The results showed that therapists were over-predictors of client success and under-predictors of client deterioration. The therapists predicted only 3 clients as deteriorated when 40 clients of the 550 clients actually deteriorated. Therapists also predicted approximately 500 clients as having positive outcomes when only a little
over 200 did have positive outcomes. Therapists also rated clients who made no change in treatment at lower rates compared to the OQ 45 results (Hannan et al., 2005).

The argument for clinician judgment alone is damaged when results like Hannan et al. (2005) are shown. However it is aspiring that per session assessment and feedback provides an alternative to clinician judgment alone, and helps reduce the rates of deteriorating clients, and lowers drop out rates, all findings supported by Lambert, Whipple, et al. (2001) study on per session assessment and feedback to clinicians.

Even with the wealth of information available on the effectiveness of per session assessment and feedback (Lambert et al., 2003), little information exists in the literature as to how clinicians use per session assessment and feedback. There is also a lack of literature on the training implications that per session assessment and feedback may have on beginning counseling students. This research study hoped to rectify this gap in the literature, adding to the comprehension of the effects and utility of per session assessment and feedback.

Additionally, Sapyta et al. (2005) called for information on feedback, seeking investigations into the complex process of per session assessment and feedback. The authors stated that information on the format of the feedback, an understanding of how counselors interpret the feedback, and knowledge about how counselors come to value the feedback responses are still needed. This study investigated the use of per session assessment and feedback on two levels: Clinical Mental Health Counseling Practicum Students and practicum instructors involved in teaching the practicum course in which the students were enrolled, and supervising the students clinical work. These two levels
of participants used the weekly feedback system outlined in Lambert, Whipple, et al. (2001) for a semester of treating clients, and were interviewed throughout the semester to explore the application and utility that per session assessment and feedback played in their monitoring, treatment approach, and goal formation with clients.

**Definitions**

In explaining the research question of this study it is important to illustrate and define several key terms. Outcome research is a field that has several key terms that define its practice. Below is a list of several words commonly encountered in client focused research and the outcome research literature.

*Client focused research:* Client focused research is an emerging trend in outcome research that uses systematic and periodic outcome evaluation either every session or several times throughout counseling. This outcome is then delivered to the counselor in a manner that allows them to utilize the outcome findings while their client is still in counseling (Newham & Page, 2007)

*Dose effect relationship:* An area of research which examined the relationship between the time spent in therapy and symptom recovery (Howard, Kopta, Krause, & Orlinsky, 1986). The dose effect relationship sought to capture expectable timelines of client recovery that could be used to make predictions about new clients entering counseling.

*Early alarm system:* The cycle in the feedback programs that warns counselors that clients are not on track with their expected recovery curve. For the purposes of this study early alarm was defined as red or yellow color feedback.
Effectiveness outcome research: Effectiveness outcome research is a trend in outcome research that utilizes settings similar to real life counseling practice that allows research to use less rigid methodological process to capture the effectiveness of counseling. These types of studies are often more relevant to clinician-based consumers of research; however, they are less able to isolate the variance of counseling interventions and often show lower effect sizes (Howard, Moras, Brill, Martinovich, & Lutz, 1996).

Efficacy outcome research: Efficacy outcome research is a trend in outcome research that utilizes strict methodological procedures that work to control confounds and helps isolate variance attributable to the specific intervention or experimental condition being studied. The random clinical trial is often associated with this trend of outcome research (Howard et al., 1996).

Evidence-based interventions: Any intervention that has been deemed by research as efficacious and effective in treating a specific emotional or psychological disorder. These interventions have fulfilled research criteria in their testing such as control groups, randomization, and manualization of treatment and are considered methodological sound.

Evidence-based practice: The American Psychological Association adopted the final definition of evidence-based practice in psychology (EBPP) as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA Presidential Task Force, 2006, p. 273).

Feedback program: A system of per session assessment and feedback that is delivered to a counselor in an accessible format that allows him or her to observe whether
his or her client is maintaining expectable gain in treatment, or is deviating from normal recovery curves (Lambert, Whipple, et al., 2001).

*Model treatments:* Treatments outlined by the National Registry of Evidence-Based Programs and Practices (NREPP) that have been proven efficacious by at least two research studies that use the research methodology of Random Clinical Trials (Chambless & Ollendick, 2001).

*Probably efficacious:* Treatments outlined by the National Registry of Evidence-Based Programs and Practices (NREPP) that have been shown to be efficacious by outcome researchers; however, these studies may not use the methodology of random clinical trials, or may have less than two of these random clinical trials on their efficacy (Chambless & Ollendick, 2001)

*Promising Treatments:* Treatments outlines by the National Registry of Evidence-Based Programs and Practices (NREPP) that have preliminary evidence of their efficacy; however this evidence does not meet the criteria of random clinical trials. These studies are labeled promising because they show ingredients of successful psychological interventions (Chambless & Ollendick, 2001).

*Reliable change index:* An algorithm that established score estimates of when clients made reliable change on a specific measure. Reliable change signifies when the client has made enough improvement or deterioration on the measure to surpass the reliable change index. Jacobson and Truax’s (1991) algorithm for the Realizable Change Index is $RC= \frac{X_2-X_1}{S_{\text{diff}}}$, $S_{\text{diff}} = \sqrt{2 (S_e)^2}$. 
Review of the Literature

Evidence-Based Practice

It is no surprise to clinicians who practice in the field that counseling is becoming driven by the forces of outcome efficacy, efficiency of sessions, and stipulated care standards proposed by managed health care. Beutler (2001) explored the sociopolitical ramifications of managed care. He wrote that with the cost of healthcare rising throughout the western world, many private businesses and political forces have looked to decrease the cost of health care services. Many of the political responses have advocated for higher scrutiny of the process of therapy, and mandated evidence of the efficacy and effectiveness of psychotherapy interventions. Beutler (2001) expressed that the lack of prior standards on mental health care ushered in abuses such as excessively long and expensive treatments, as well as redundant care.

Organizations like the American Psychological Association (APA) have suggested best practice guidelines and supported evidenced based practice movements to meet the needs of health care providers, and to create a new era of training for clinicians and researchers that is grounded in best practices (APA Presidential Task Force, 2006). The APA established Division 12 in 1995 to examine how evidenced based interventions fit within psychotherapy. Division 12 was created based upon the following premises: (a) patient care can be enhanced by the acquisition of up to date empirical knowledge; (b) it is difficult for clinicians to keep up with newly emerging research pertinent to their practice; (c) if clinicians do not keep up on their knowledge of the research their clinical performance will decrease over the years; (d) clinicians need summaries of the evidence
provided by expert reviews and instruction on how to obtain this information during their routine practice. The division’s task force report concluded that evidenced based interventions would be the future of mental health and allow clinicians to demonstrate their practice was efficacious and increase their accountability to the public (Chambless & Ollendick, 2001). The task force created a list of several interventions that had proved efficacious, and set guidelines for researchers that wished to conduct research on efficacious treatments. The requirements to be on the list involved: (a) having at least two separate studies that showed the treatment to be more effective that a placebo or other psychological treatment, (b) the use of control groups, (c) manualized treatments, and (d) randomization in their studies. Interventions that did not meet these requirements were included in two separate categories: (a) probably efficacious for studies which showed results, but did not use rigorous research methods; and (b) promising for studies where either no research appeared, or limited rigorous studies were present. Promising was used to denote that the intervention held potential and signaled researchers that key research was needed to support its use (Chambless & Ollendick, 2001).

In 2005 the APA’s Presidential Task Force reevaluated the above criteria and created a new definition labeled evidenced based practice in psychology. The criteria were less stringent and more inclusive to research methodology to accept more interventions on the list. The APA task force adopted the final definition of evidence-based practice in psychology (EBPP) as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA Presidential Task Force, 2006, p. 273). The aim of the task force was
to create guidelines that served the many interests of the psychological community, without running the risk of being misconstrued by health care companies who were not informed about psychological research and therapeutic treatments. In constructing these guidelines the APA Task Force examined the evolution of outcome research that helped prove the efficacy and effectiveness of today’s clinical practice.

**Evidence-Based Interventions**

The literature often uses the terms evidence-based practice and evidence-based interventions interchangeably; however, the two are separate ideas that derive from differing movements. Evidence-based interventions refers to the collection of interventions that are tested through research and are proven to show therapeutic change (Kazdin, 2008). Because of the many types of evidence-based interventions in the field, clinicians must use the best clinical judgment that takes in account multiple variations in which clients present. The importance of clinical judgment, cultural understanding, and clinical experience are all associated with evidence-based practice. Underscored in those factors is the understanding of evidence-based treatments. This understanding of what constitutes evidence-based treatment requires an understanding of the differing types of outcome research (Kazdin, 2008).

**Types of Outcome Research**

Howard et al. (1996) helped to broaden the field of outcome research when they posed three important questions relevant to outcome studies. The first question was, “Does this treatment work under specially controlled research settings?” This type of study is called an efficacy study, or the random clinical trial. Examples of such are the
studies investigated under Smith and Glass (1977) and Lambert and Ogles (2004). The second question was, “Does this study work under real practice settings?” An example of a study like this is Seligman’s (1995) Consumer Reports study on mental health care. These studies are typically called effectiveness studies. The third type of study asks the question, “Does this treatment work with this client?” This type of study fits into an area called client focused research. Lambert, Whipple, et al. (2001) investigated this area and have been large contributors to this research area.

Evidence-based practice calls for the application of evidence in the practice of counseling. However, the definition of what constitutes evidence has changed throughout the history of psychotherapy. Howard et al.’s (1996) questions are not the only research questions of interest in the field of outcome research. However, they do represent the evolution of the types of studies that researchers have been using to justify the evidence of the effectiveness of counseling. These next sections explore the major tenets of Howard et al.’s (1996) three research questions, examining the changing context of outcome research as it is applied in counseling. Readers will observe a shift in the research questions, from proving the general efficacy of psychotherapy as a whole, to proving its effectiveness in clinical settings, to proving its efficacy concerning individual client concerns on a per session basis. The narrowing of outcome research models its advances through history. The majority of the literature that is explored is upon client focused research, as this is the main topic of investigation during this study.

**Efficacy research.** The type of outcome research that explores psychological interventions while under specially controlled research settings is called efficacy
research. This is the most popular outcome research trend, and it compiles the majority of outcome research available in the literature today. Researchers like Eysenck (1952), Smith and Glass (1977), Luborsky, Singer, and Luborsky (1975), and Lambert and Ogles (2004) have all added to the dense findings of this research trend. The grounds of treatment efficacy are in contrasting a specific treatment group to a compassion group. The contrasting procedures are often well regulated to control for confounds and to help isolate the variance of change attributable to the specific treatment condition (Seligman, 1995). The parameters of treatment efficacy studies typically include: (a) patients are randomly assigned to treatment and control conditions; (b) the control group conditions are rigorous, often using no treatment, placebos, or wait lists to ensure isolation of effect; (c) treatments are typically manualized, and clinicians have closely monitored supervision to assure for fidelity of treatment; (d) clients are seen for a fixed number of sessions; (e) guidelines for successful treatment outcome are highly operationalized; (f) single and double blind raters are used; (g) clients typically only meet criteria for one diagnosis; clients who do not meet this criteria are often excluded; and (h) the clients are assessed following treatment for follow-up evaluation (Seligman, 1995). The benefit of the imposed rigor on efficacy research is that it isolates the variance associated with treatment, as well as excludes possible confounding variables that reduce the ability to isolate the true treatment effect (Clarke, 1995). Efficacy research also allows for reliability of findings that help safeguard the research field from erroneous conclusions of misleading studies (Chambless & Hollon, 1998), and culls the field of untested or dangerous therapy modalities. There exist several hundred types of treatment in the field
claiming efficacy for clients; however, many of these treatments remain untested. Efficacy studies can be thought of as tested and reliable to use, ensuring best results (Kazdin, 2008).

Substance Abuse and Mental Health Services Administration’s National Registry of Evidence-Based Programs and Practices. Efficacy research has been the gold standard by which outcome research has been generated in the past. In an effort to gather these types of studies the Substance Abuse and Mental Health Services Administration (SAMHSA) has adopted a large database called the National Registry of Evidence-Based Programs and Practices (NREPP) to collect the myriad types of studies classified as efficacy research. This research has grown so large the literature has become saturated with works comprised of individual studies, meta-analyses of these studies, reviews of multiple meta-analyses, and reviews of the reviews (Kazdin, 2008). The NREPP began its database in 1997 reviewing over 1,100 treatment programs. It classified 150 of these treatments into three types: model, effective, and promising. Model meant the treatment was highly effective and easily disseminated. Effective meant that the treatment had showed high rates of consistent success, though not as high as model treatment. Promising meant that the treatment showed at least some positive treatment outcomes. These treatment types closely scrutinized studies, and only research based upon tightly controlled efficacy studies were regarded by SAMHSA (History of NREPP and Recent Changes, 2008).

In 2004 SAMHSA updated its registry to be more in line with the emerging statement from the APA Task Force, and by 2007 had an updated registry that included
multiple definitions of outcome research. The inclusion of effectiveness studies and other studies that did not meet the criteria of efficacy studies was included to expand the possible treatment options to providers (History of NREPP and Recent Changes, 2008).

**Limitations of efficacy research.** Even though efficacy research has been established as the gold standard of the outcome research field, there still exists many who criticize its true utility and application in typical practice settings (Clarke, 1995). One of the major limitations of efficacy research is that it hardly resembles clinical practice. The rigors imposed in empirical studies are often unobtainable within a practice setting. For instance, clients often present with clinical presentations that are more severe and share higher rates of comorbidity. Empirical studies regulate the types of disorders being treated. Treatment itself is often different, the time limitations and manualized treatment approaches of empirical studies are hard to replicate in practice (Kazdin, 2008). Health care management might acquire faulty assumptions of the way in which counseling is performed in practice settings based upon the disproportional amount of research that is performed within laboratory setting. Laboratory settings differ from typical clinical practice in that they control for conditions in practice that help promote the isolation of the variance of psychological interventions (Beutler, 2001; Clarke, 1995). This disproportional amount of research has also led to clinician dissatisfaction with outcome research, and has led some clinicians to completely ignore any of the rich resources of treatment contained in the literature (Kazdin, 2008; Weisz, Donenberg, Han, & Weiss, 1995). In the absence of any practice-based research on outcomes of psychotherapy, researchers began to study treatment as it appeared in normal practice. These types of
studies became known as effectiveness studies; they sought to answer the second question of outcome research proposed by Howard et al. (1996); does it (treatment) work in practice?

**Effectiveness research.** Does treatment produce beneficial results as it is administered in clinical settings? (Lutz, 2003). This research question began to be asked by mental health researchers in their attempts to find applicability of outcome research in clinical practice (Howard et al., 1996). Weisz et al. (1995) conducted a meta analysis on studies that shared common elements thought of as clinic based outcome studies, rather than laboratory based outcome studies. The criteria they defined for clinic based outcome studies were: (a) treatment of clinic referred not recruited populations, (b) treatment in service orientated clinics or agencies not research settings, (c) therapy conducted by practicing clinicians not research assistants, or (d) therapy conducted as a part of regularly occurring programs based through the clinic. At the time of Weisz et al. (1995) study, only nine studies were found that met the above criteria, and most of these were long outdated. The meta analysis yielded differing characteristics of treatment variables than those of efficacy outcome research. Examples of these differing characteristics were: more severe pathology in clients, greater heterogeneity of sample, higher rates of comorbidity, large clinician caseload, little pre-therapy preparation, increased duration and length of treatment, multiple modalities of therapy (eclecticism), no treatment manualization, and less monitoring or supervision of clinician (Weisz et al., 1995).
The findings of these effectiveness studies showed on average lower effect sizes of therapy; although, these effect sizes were still significant enough to demonstrate the utility of therapy in a practice setting. Efficacy research preformed by Smith and Glass (1977) found effect sizes near 0.70 whereas Shapiro and Shapiro (1982) found effect sizes of 0.93. Weisz et al. (1995) concluded that the smaller effect sizes, averaging 0.30 to 0.50, found in clinic based outcome studies were not necessarily predictive of less effect gained through counseling in these settings; rather, it may be more predictive of the artificial and inflated effect sizes found within laboratory settings. The authors further explained why differences are so varied in effect sizes of clinic and laboratory outcome studies. Some of these explanations are: (a) pretherapy preparation of the laboratory therapist, (b) clinic therapists see a wider breadth of client problems, (c) laboratory therapy is highly structured and formulated, (d) laboratory settings are often more conductive to therapy gains than community clinic settings, and (e) laboratory therapists are motivated and trained in the use of the studies prescribed modality of therapy gaining more supervision and guidance (Weisz et al., 1995). However despite the differences in research design and implementation, both laboratory and clinic based outcome studies did show considerable evidence that treatment was effective in both research modalities. The way was paved for more researchers to build cases for effectiveness studies and try to answer the question: Does treatment produce beneficial results as it is administered in clinical settings?

**The Consumer Reports studies.** To determine the effectiveness of psychotherapy the commercial publication *Consumer Reports* conducted an investigation
into the responses of clients who had been involved in counseling at some point in their lives. The publication *Consumer Reports* included a survey in 1994 annual customer inquiry, which circulated to its 180,000 subscribers (Seligman, 1995). The annual customer inquiry contained questions that covered diverse areas of consumer behavior and purchasing questions pertaining to automobile, refrigerators, and mental health. The survey was responded to by approximately 7,000 individuals who answered the mental health question, which asked responders if in the last three years they had been troubled from stress or other emotional problems and had looked for help from either friends, relatives, or clergy or spiritual support. Of the 7,000 persons who responded, 3,000 reported that they had talked to friends or clergy and over 4,100 had talked to a family doctor, mental health professional, or a support group (Seligman, 1995). The number of individuals who had sought a mental health professional was near 2,900. Of these 2,900, 37% saw psychologists, 22% saw psychiatrists, 14% saw social workers, 9% saw marriage and family counselors, and 18% saw other forms of mental health professionals. Nearly 1,300 survey respondents reported that they had been involved in a support group, and 1,000 went to their primary physician initially. The survey contained 26 mental health related questions, including type of provider, duration of treatment, and how many sessions of counseling the consumer had (Seligman, 1995).

The survey included three rating scales to assess three areas of client improvement. The first question was on specific improvement: “How much did treatment help with the problem?” (Seligman, 1995, p. 967). It was measured using a 4-point rating scale with items from: *made no difference, made things somewhat worse,*
made things a lot worse, and not sure. The second question was on satisfaction of counseling; it asked, “Overall how satisfied are you with this therapist’s treatment of your problem?” (Seligman, 1995, p. 968). The question was answered using a 5-point rating scale with items from: completely satisfied, very satisfied, fairly well satisfied, somewhat satisfied, very dissatisfied, and completely dissatisfied. The third question was on global improvement. It compared responders’ ratings of their emotional state at two different times: one before they entered treatment, and one at the time of the survey. The respondents circled the corresponding rating box to rate how they had been at each point in time. The ratings asked for the clients to describe their emotional states before and after treatment: very poor, I barely manage to deal with things, fairly poor, life was usually pretty tough for me, so-so, and quite good. The researchers then subtracted the rating scale of emotional state at the time of the survey from the emotional state rating score at the time of entering treatment to calculate the global improvement.

The Consumer Reports study researchers found that counseling by a mental health professional worked most often. The majority of respondents reported that they got better. A breakdown of the global improvement data showed that 426 respondents described that they were feeling very poor before entering treatment, and 87% of them left feeling very good. In addition, 786 respondents reported they felt fairly poor before treatment and 92% left treatment feeling very good, good, and so-so (Seligman, 1995). The researchers also found minimal differences between types of mental health professionals with psychologists, psychiatrists, and social workers all doing about as well as each other, and only slightly better then marriage counselors. The authors found no
differences between responders who took medication and received treatment and those who only received treatment. Another surprising finding was that family physicians did just as well as mental health professionals in short term effectiveness; however, family physicians were surpassed in effectiveness in longer-term treatment. No specific therapy modality outperformed any other, determined by a general query of therapy modality in the survey. The author also found that the effectiveness of treatment increased when the time spent in treatment was longer (Seligman, 1995).

A replication of this study was performed using the German publication of *Consumer Reports (Stiftung Warentest)*. The researchers Hartmann and Zepf (2003) used the American *Consumer Reports* survey, translated into German, and sent out a call for participants to the subscribers of *Stiftung Warentest*. The magazine advertised the study and instructed responders to send back a letter of request for the survey. After the researchers sent out the surveys, they received back 2,147 completed surveys; however, the authors did not disclose the amount of surveys initially sent out. The authors excluded responders who were in two forms of treatment at once giving them a total of 1,772 remaining responders. Of these responders 1,426 were receiving mental health services and 191 were seeing their family doctor, and 155 were active in some form of self-help group. The gender distribution of the respondents was 25% male and 75% female (Hartmann & Zepf, 2003).

Hartmann and Zepf (2003) found similar results to the original *Consumer Reports* study. Of the respondents who reported that they were feeling very poor before treatment, 86% reported that they were feeling very good, good, or adequate at the time
of the survey. Of the clients who reported that they felt fairly poor before treatment, 92% reported that they were feeling very good, good, or adequate at the time of the survey (Hartmann & Zepf, 2003). The length of treatment was again a predictor of better treatment improvement with more treatment showing a significant influence on overall improvement, $F(4, 1390) = 23.84, p < 0.001$. No difference was found between responders who took medication and received treatment and those who only received treatment, $F(1, 1399) = 3.26, p > 0.05$. The researchers explored if there were differences between treatment effectiveness when psychologists, psychiatrists, medical psychotherapists, or other types of mental health providers administered it. The authors concluded no differences between these groups existed, $F(3, 1347) = 2.40, p > 0.05$ (Hartmann & Zepf, 2003). Differing from the original study, the authors found that family doctors did worse in the short term and in the long term of treatment. Support groups still remained effective sources of treatment for both studies. The modality of therapy was also not significantly different in the German replication, $F(2, 988) = 1.59, p > 0.05$ (Hartmann & Zepf, 2003).

Both these studies helped to further what researchers and clinicians know today about the effectiveness of psychological treatment. While the methodological processes differ dramatically from other research studies, especially efficacy studies, these outcome studies were the first of their time to query the reactions of participants to psychological treatment. While many methodological limitations exist for these studies, there exist several advantages of them as well.
Critics of the *Consumer Reports* study and of effectiveness outcome research often cite that these studies offer limited internal validity to bolster their findings. Seligman (1996) explored the limitations in the *Consumer Reports* study when he reviewed multiple critics’ challenges to the study. Seligman reviewed the inherent sampling bias of the *Consumer Reports* study. Only a 13% response rate was obtained from over 180,000 subscribers. The poor return rate might be attributable to the length of the survey, often administering over 100 questions to the readers. Seligman (1995) concluded that the *Consumer Reports* study was not necessarily a representation of the United States. Seligman (1996) pointed out that responders to the survey might be more representative of clients who were more treatment favorable and have stayed in therapy for much longer than the usual amounts of time. Sampling bias is a limitation in all survey studies; however, efficacy studies are not immune to its effects either. Efficacy studies usually include participants who have volunteered for treatment and agree to be randomized into differing experimental groups. Participants might be more likely to endorse higher ratings of therapy because of their initial volunteering.

The study was also limited by its reliance on a single perspective of measure, the client’s assessment. Outcome research often involves multiple points of observation, including the researcher, the participants, and other assessors. Another limitation was the cross sectional research design of the *Consumer Reports* study compared to other outcome studies or case control studies. The participants were only measured at one point during this study by survey. A large limitation of this study, and one in which effectiveness studies often are missing, is the inclusion of a control group. Because a
control group is missing, the researchers can not say definitively if the effectiveness of psychotherapy, the results of feeling better, are attributable to talking with a mental health professional or just a friend or support system (Seligman, 1995). Another cited flaw was the lack of randomization; however, Seligman contended that lack of randomization was a strength of the study. He explored the remoralization effect that is often lost when efficacy studies conduct randomization. Clients experience large bursts of improvement from the initial session into the second and third session. Randomization to control or treatment groups inhibit practicing clinicians’ choices in what type of therapy modality to administer, and to the extent of the severity of the problem and the intensity of the treatment condition. Seligman (1995) explored the assumptions that this non-randomization of clients, that is similar to real practice, was an essential ingredient in the effectiveness of psychotherapy in this study.

Effectiveness studies, in their attempt to capture the true to practice conditions of clinicians, often exclude control groups and randomization. Many critics express that these omissions decrease the internal validity of the study, making any attempts at isolating variance or effect of treatment improbable. The claims by researchers that efficacy research is the gold standard of outcome research might be exaggerated, because of the phenomenon that these studies fail to uncover. Seligman (1996) stated that efficacy research is good at telling researchers if a treatment that is being given to a client works for the client and those clinicians who choose to use it. Efficacy studies help rule out placebo effects or spontaneous remission, and help isolate mediators and moderators in treatments that either help or detract from overall outcome. Efficacy studies can tell
researchers if a treatment works well when it is added to the already available list of treatments readily available to counselors practicing in the field.

However, these conditions do not make up the bulk of research questions asked today by outcome evaluators. Efficacy studies cannot study treatment long term, because controlling for the uniformity of all treatment sessions through supervision or guided treatment manuals is a difficult task. Effectiveness studies often excel when ethical considerations prevent the exclusion of participants or wait listing certain members (Seligman, 1996). Clarke (1995) explored the benefits to effectiveness research saying it explores real world problems of clients, which are often complex and layered upon one another. Ignoring comorbid clients ignores the difficulty of these challenging cases which counselors treat every day. Another benefit of effectiveness studies is the availability of exploring treatment in integrated treatment environments that have more than one clinician administering services to a client. These levels of service can be from individual counseling, group counseling, case management, and psychoeducation classes (Clarke, 1995). However effectiveness outcome research is not without its limitations.

Limitations of effectiveness outcome research. Despite the findings of the Consumer Reports studies many researchers critiqued its results and generalizability to the findings of outcome research. Mintz, Drake, and Crits-Christoph (1996) critiqued Seligman’s (1995) study by suggesting that it does not represent an outcome study but rather a client satisfaction study. They stated the study has major limitations in its retrospect data collection, when it asked consumers to remember how counseling was in the past, and the studies overreliance on self-rated recovery estimates. The authors
concluded that if the assumptions that efficacy research fails to study the real practice experience of clinicians, then the watered down methodology of effectiveness studies does no better in expanding what researchers know in psychotherapy to be effective.

However, the implementation of methodologically sound studies that balance rigor and relevance are being investigated in the research today. Studies that balance the methodological soundness of treatment in clinical studies appear in Stuart, Treat, and Wade (2000) when the authors investigated the use of cognitive behavioral therapy for panic disorder over a year in a community clinic; and studies such as Franklin, Abramowitz, Levitt, Kozak, and Foa (2000) investigated exposure therapy for obsessive-compulsive disorder in clients who had been withheld from participating in a random clinical trial. More studies are continuing to develop in areas where methodological soundness and real clinical practice go hand in hand.

**Client focused research.** Howard et al.’s (1996) third question, “Does this treatment work for this client,” illustrates the tenets of client focused research. This type of outcome research is known by names such as patient focused research and treatment focused research. This form of outcome research was grounded on several major assumptions: (a) research can be both internally and externally valid, (b) typical research is not easily accessible to clinicians, and (c) research can be ecologically friendly and accessible to clinicians. Lueger (2002) stated that the rift between clinicians and psychotherapy researchers is a product of misunderstanding of the science of therapy on the clinician’s side, and a misunderstanding of the relevant information that the clinician wants. For instance the skepticism of the clinician in regards to a researcher exploring
how one therapy might be more effective for a particular set of symptoms than the other sets of psychological symptoms might cause the clinician to feel that they are being told how to conduct their own type of therapy by a person they have never met. Alternatively the researcher, who is interested in helping clinicians approach their clients with the best set of tools based upon research, might feel spurned when the clinician regards the hard work of the researcher with distaste and irrelevance. The evolution of this argument is based upon an integration of clinician and researcher. It established a system where the clinician is both the researcher and the practitioner.

Lueger (2002) explored the types of information most needed by research and concluded that clinicians wish to know accurate information on the mental health picture of the client early on in treatment, and to have accurate information periodically delivered that would help the clinician, and work to inform the treatment planning and monitoring of the routine care of the client. This stance differs dramatically from the pre- and post-designs of efficacy and effectiveness studies. The goal of client focused research lies within its specificity not its generalizability (Lambert, Hansen, & Finch, 2001). Client focused research does not advocate abandoning efficacy research or effectiveness research; it is interested in advancing many of the same positions of efficacy research such as the accountability of health service providers and efficiency of clinical practice. Researchers like Barlow, Hayes, and Nelson (1984) have also advocated for additional outcome research paradigms on top of more traditional outcome research approaches. These researchers expressed that the scientific methods of traditional means, meaning random clinical trials, cannot wholly account for the many questions that relate to the
treatment of mental illness. They called for the measurement and observation of successful counselors in the field treating real clients.

The advantages of client focused research are numerous. Newnham and Page (2007) outlined several of these advantages and how they differ from traditional outcome research. Through routine individualized assessment of client symptomology client focused research is more sensitive to observing client change, than pre- and post-test designs are. The efficacy of psychological interventions has been well documented through the literature (Lambert & Ogles, 2004; Smith & Glass, 1977). The assurance of efficacy comes from generalized findings of pre- to post-group changes through interventions. Client focused research goes one step further than simply recording efficacy; it manipulates counseling to intercept those clients, who, for whatever reasons, may have not found counseling helpful or effective. Client focused research is helpful in identifying non-responders before treatment termination and allows clinicians to alter existing treatment directions. Client focused research also meets several of the criteria for research that is clinically representative, according to Shadish, Matt, Navarro, and Phillips (2000). These criteria were: (a) a representation of clients with the behavioral and emotional disorders that community clinical services typically treat, (b) treatment existing at sites in which community clinical services are typically provided, (c) clients who are referred through the typical systems of community clinical services as well as walk ins, (d) clinicians who administer psychological interventions as their primary profession, (e) treatments that are typical of the types of treatments most routinely administered in community clinical service sites, (f) treatments that are not intensely
monitored for exact uniformity in application, (g) a heterogeneous client population, (h) no specialized intensive pre treatment training in treatment administration, (i) counselors have freedom to choose from multiple treatment approaches at their discretion, and (j) flexibility in the number of sessions allowed in treatment.

However one type of research alone cannot answer the numerous research questions present in the psychological outcome community. Efficacy, effectiveness, and client focused are all effective paradigms that advance the body of scholarly research. Many researchers have advanced research practices that integrate the tenets of each paradigm. Nathan (2007) explored three ways that researchers are integrating hybrid type research efforts. The first is Intervention Research Centers. The National Institute of Mental Health (NIMH) has funded and organized the collaboration of mental health professionals and researchers fluent in both efficacy and effectiveness outcome research to plan and conduct research on a multitude of issues. Already the NIMH has sponsored research on mood disorders that looked to investigate how the clinical effectiveness and cost efficiency of the treatment of depression could be maximized in regards to diverse settings and populations. The second way the paradigms are coming together is through Efficacy/Effectiveness clinics. These clinics would be a hybrid of mental health service and research. The goals of such clinics are to serve a wide volume of clients who have a high rate of comorbidity, substance abuse, psychiatric disorders, and medical illness. The clinics would serve as excellent sources of information for studies that investigate the mediators and moderators associated with treatment, in underserved populations (Nathan, 2007). The last hybridization of the research paradigms is the Stage/Hybrid Model of
Therapies Research. Created by Onken, Blaine, and Battjes (1997) the Stage/Hybrid Model incorporates three types of outcome research to validate a particular intervention. The intervention begins at stage one, pilot/feasibility testing. In this stage the researchers manualize the treatment, develop training protocols, and develop measures for the outcome based assessment and clinician adherence measure. During stage two the researchers evaluate the efficacy of the study through a random clinical trial. This trial includes control groups, randomization, and manualization of treatment. Following the RCT the researchers move the study into stage three which consists of studies that evaluate the transportability, generalizability into routine clinical practice, implementation issues, and cost effectiveness evaluations.

These new paradigms blend both efficacy and effectiveness research. Investigators have come to compromises that follow for new understanding of the research. The researchers blend essential features of efficacy studies like randomization, and the use of control groups; with features of effectiveness studies like diversity in clinical settings, broader ranges of typical disorders treated, cost effectiveness evaluations, and client and counselor satisfaction with treatment.

While these paradigms have yet to include client focused research, it is expectable since this outcome research trend is still in its infancy, and has yet to build its reputation to the point of efficacy and effectiveness studies. However, numerous studies have investigated the outcome of feedback studies and have demonstrated the remarkable effects that routine client assessment along with feedback to clinicians can provide.
Below is an investigation of the paramount studies associated with client focused research and its growth in the decade since its inception.

**History of client focused research.** This section explores the historical trends associated with the client focused research movement. An examination of the dose effect relationship model, and the efficacy of per session assessment and feedback programs are explored in depth.

**Dose effect relationship.** The research that client focused research grew out of was the work of Howard et al. (1986). In their work on the dose effect of psychotherapy, the authors explored the mean number of sessions that it took to identify the relationship of how much time in psychotherapy produced results in treatment. The authors examined meta-analytic data with over 2,400 clients from 15 studies that studied psychodynamic or interpersonal therapy. The types of mental illness treated in the 15 studies represented diverse sets of diagnosis. Howard et al. (1986) found that 29% to 38% of clients improved within the first three sessions. Between the 4th and 7th session, 48% to 58% of clients improved. By the 26th session, 75% of clients improved through counseling. This study was important because it was the first of its types that demonstrated that the course of treatment and improvement in counseling could be identified and predicted for clients (Kopta, 2003).

Kopta, Howard, Lowry, and Beutler (1994) continued the investigation into the dose effect relationship by adding the Symptom Checklist-90 Revised (SCL-90-R; Derogatis, 1983) to the dose effect study. The authors were able to assess what types of pathology improve and in what order during counseling. Kopta et al. (1994) examined
854 clients from five mental health centers. The client’s symptoms were divided into three classes: acute distress, chronic distress, and characterological symptoms. Acute distress was categorized as recently manifested symptoms of anxiety, depression, and obsessive compulsive symptoms; chronic distress included similar pathological feature as acute distress. However, these symptoms had been experienced longer and had periods of latency and remittance. Characterological symptoms included hostility, paranoid ideation, and psychosis, which were often slow to respond to psychological interventions (Kopta et al., 1994). The authors administered the SCL-90-R at the initial session and at least one other point during counseling. Measurement procedures differed according to the site of data collected, with some sites collecting continuous data while others collected one at pre- and post-treatment. The authors found that acute distress symptoms improved by 24% between the initial contact and first session. At session 10, over 50% of clients reported improvement in acute distress. Chronic distress symptom’s remission rates were found for 50% of clients between 7–24 sessions with a mean of 14 sessions. At 52 sessions, chronic distress symptoms were typically in remission for between 60–86% of clients. Characterological symptoms showed the slowest rate of remission; 59% of clients reported reduction in symptoms at 52 sessions (Kopta et al., 1994). The authors concluded that to reach a 75% remission rate for all three symptoms clients would need an average of 58 sessions, typically one session weekly for a year.

This study is subject to several limitations and not intended for generalizability to specific types of diagnosis, due to the wide range of variability between sampled clients. However, the findings do show that evidence of certain types of symptomatic reduction
exists, and how it proceeded during counseling (Kopta et al., 1994). This study set the stage for future studies that looked to assess the amount of change that was produced by clients in an established time period. This research provided much of the foundation of client focused research that used the principles of measuring symptom change in individual clients to assess outcome. The concept was that if improvement in treatment could be tracked and predicted, would alerting clinicians to instances when clients deviated from normal treatment progression increase client outcomes and help curb the effects of ineffectual treatment (Lambert, Whipple, Bishop, et al., 2002).

Lambert’s feedback program. In the first study of the client focused research movement Lambert, Whipple, et al. (2001) conducted a study at a large western university on 609 clients from a university-counseling center. The authors randomly assigned all the clients into two conditions: feedback (FB) and no feedback (NFB). The authors had clinicians in the study hand the Outcome Questionnaire 45 (OQ 45) to the clients during session, and then compared each client’s per session score with his or her baseline or initial score. The OQ 45 is a 45-item self-assessment of psychological symptomology that takes 5 minutes to complete. The test/retest of the measure is good at .84 and the internal consistency of the items was .93. The test had good convergent validity when compared to other symptom checklists like the SCL-90 (Derogatis, 1983).

Lambert, Whipple, et al. (2001) used cut off score criteria from Jacobson and Truax (1991) that allowed the researchers to measure if the client was making Realizable Change (RC) during therapy. Realizable change is an estimate of change from a specific instrument that differs from clinical significance or effect size. Reliable change is
computed by measuring the differences between the normative samples mean score and a treatment samples mean score on a particular measure. The OQ 45’s RC score was computed by comparing normative data of a population of non-patients who took the OQ 45 \( (N = 1353) \) against the scores of clients entering treatment \( (N = 1467) \). The resulting RC score was found to be at 14-points, suggesting that clients whose scores either increased or decreased on the OQ 45 by 14 points were thought to have made reliable change (Lambert et al., 1996). Lambert, Whipple, et al. (2001) predicted that the cut off score on the OQ 45 that would predict the score between normal and dysfunctional populations was 64. This was close to one standard deviation above the mean of non-patient sample \( (M = 45.31, SD = 19.42) \).

In addition to giving feedback in the form of line graphs with the per session OQ 45 score, Lambert, Whipple, et al. (2001) used color-coded flags that allowed counselors to observe quickly the client’s movement from previous sessions. The four flags corresponded to the following message for clinicians.

- **White.** The client’s score is similar to populations not engaged in counseling, consider discussing new treatment goals or consider discussing the gradual discontinuation of counseling services.

- **Green.** The client is making adequate change during treatment, no recommendations for altering treatment plan.

- **Yellow.** The rate of change the client is making is less than expected, compared to normative data on clients who have been in treatment for this period of time.
before. Consider altering or intensifying the client’s treatment, or the client may make no significant improvement during counseling.

Red. The client is not making any progress during counseling, consider altering treatment dramatically, reformulating the plan of action, intensifying treatment, or seek a referral for a psychiatric evaluation. The client may be at a higher risk for dropping out of treatment or at risk for having a negative treatment outcome.

(Lambert, Whipple, et al., 2001, p. 55)

The flags were computed using the client’s response to treatment score, which was obtained by subtracting the current score from the initial score. The color codes were computed based upon score matrixes computed by Lambert and Gray (Lambert et al., 2002). Lambert and Gray computed three matrixes for assessing client progress in treatment. The first matrix was for sessions 2–4; the second was for sessions 5–9, and the third for sessions 10 and above.

Lambert, Whipple, et al. (2001) posed their research question: does feedback on client progress improve client outcome? The authors found no significant difference at pretreatment between the feedback group and the no feedback group. Following treatment and the administration of the feedback program, the clients were broken up into four groups representing the treatment conditions: (a) Not On Track, Feedback; (b) Not On Track, No Feedback; (c) On Track, Feedback; or (d) On Track, No Feedback.

Lambert, Whipple, et al. (2001) found that for participants who were in the not on track feedback condition post treatment OQ 45 scores were significantly improved compared to the group of client who were not on track and whose therapist received no
feedback ($F_{(1,599)} = 4.196, p = 0.05$). Clients who were in the not on track, no feedback condition worsened considerably post treatment with change scores averaging -5.58. Negative scores indicate client’s scores on the OQ 45 went up, suggesting more symptomology. There was minimal support for the feedback condition based upon comparisons between the on track feedback group and the on track, no feedback group. The authors concluded that when clients were successful during counseling the use of feedback on improvement was negligible.

Lambert, Whipple, et al. (2001) conducted two other analyses of the data upon completion of the feedback study. The first analysis was to assess if timing of the feedback warning, a yellow or red code, had any effect on improvement. The authors compared early warning feedback between sessions 1–5, with late warning feedback, between sessions 6 and above for differences. The authors reported no significant differences between late to early feedback warning. The authors, however, did discover that feedback had an effect on number of counseling sessions attended by the client. The authors found that for participants in the not on track feedback conditions the number of therapy sessions was higher: $t(56) = 4.49, p < 0.01$, compared to participants in the not on track, no feedback, who had lower numbers of sessions attended: $t(431) = 2.10, p < 0.05$. The authors also found that participants who were in the on track feedback group had lower amounts of sessions attended, compared to the on track, no feedback group. The authors concluded that feedback provided clients who were not on track with more sessions, and decreased the amount of sessions needed for clients on track (Lambert, Whipple, et al., 2001).
This study illustrated the benefits of per session assessment and feedback. However limitations to the study included the relatively small amount of participants in the not on track conditions ($n = 66$). The study was subject to self-report bias inherent when any self-report measure is used to gauge participant information. While other studies address this issue by adding multiple types of screens, both self-report and clinician report, Lambert, Whipple, et al. (2001) insisted on keeping the study ecological friendly. The authors’ rationale for this was to represent, as much as possible, true treatment conditions. The authors also suggested several possible areas of alteration in their experimental design. Addressing the comparison of graphical representations of client scores versus color-coded feedback, to assess if there were differences in the effectiveness of either feedback format, and assessing the response of clinicians in how they modified their existing treatment were a few treatment designs alterations.

**Lambert’s replication.** Lambert, Whipple, Vermeersch, et al. (2002) attempted to replicate the original findings of Lambert, Whipple, et al. (2001), while adding a few significant differences such as larger sample size ($N = 1020$), and a tracking form that allowed the researchers to track what actions were taken by counselors following red or yellow color feedback. The researchers changed the administration of the feedback condition during their replication. The counselors at the university counseling center ($n = 49$) who were in the study were assigned to the feedback condition for all clients during the winter and spring semester, and in the no feedback condition during the summer and fall semesters. In the experimental feedback condition, 528 participants were treated, compared to the 492 participants treated in the control, no feedback condition. No
significant differences were found between the groups on their initial OQ 45 scores prior
to treatment.

Lambert, Whipple, Vermeersch, et al. (2002) posed three research questions
during their study. Their first question was whether the results of Lambert, Whipple, et
al.’s (2001) study, that feedback can improve client outcome in clients who are
responding poorly to treatment, can be replicated. The second question was, whether the
timing of feedback, early versus late delivery, is at all associated with outcome. The third
question was whether trainees profit more from feedback conditions compared to
licensed clinicians. The authors used the same system of feedback as Lambert, Whipple,
et al. (2001). Following the procedure of subtracting the current score from the initial
score and then comparing that score to the appropriate color feedback matrix, the client’s
feedback color could be computed. Like the original study the researchers provided the
feedback condition with a visual (line graph) representation of the client’s progress based
upon the client’s OQ 45 scores, and the color-coded flag system. Like the first study, no
attempt was made to manage the counselor response to the feedback. However, Lambert,
Whipple, Vermeersch, et al. (2002) did use a tracking form that asked the counselors
specific questions about what actions they were taking in therapy when they received
yellow or red feedback, and asked counselors if they had referred clients out for
medication or if the clients were involved in other treatments.

Lambert, Whipple, Vermeersch, et al. (2002) divided the participants into the
same four groups as the first study. The authors concluded that the effects of feedback
were effective in increasing outcome scores for clients. They found that the mean scores
on the OQ 45 for clients whose counselors received feedback \((n = 528)\) and of the clients whose counselors received no feedback, was significantly different \((F(1,1011) = 12.16, p = 0.001)\). Clients who were not on track and whose counselor received feedback had significantly lower post treatment scores on the OQ 45, compared to clients who were not on track and whose clients received no feedback \(F(1,1011) = 7.71, p = 0.006)\). When the data were explored further, no differences were found between participants in the on track feedback group, and the on track, no feedback group. This was similar to Lambert, Whipple, et al.’s (2001) study. Similar to the first study, Lambert, Whipple, Vermeersch, et al.’s (2002) replication study found feedback to be most effective when it was provided to counselors seeing clients who were not progressing.

Addressing the second research question, early versus late delivery feedback results, Lambert, Whipple, Vermeersch, et al. (2002) found no differences that would suggest that the timing of feedback, early versus late, had any type of effect on outcome. Similarly to the previous study this study found that clients in the not on track feedback group had more sessions than clients in the not on track group feedback group \((F(1, 1012) = 5.178, p = 0.023)\). The authors found that less experienced counselors benefited less than experienced clinicians. The authors also found that the use of tracking sheets had little effect on the feedback condition leaving the authors to conclude that the tracking form including when yellow or red feedback was given had minimal relationships with increased outcome.

**Clinical support tools.** The above studies showed that feedback improved the outcomes and attendance rates of clients who were flagged early during treatment as
non-responders. However a major limitation of these studies was that the clients of counselors receiving feedback, that were not on track, still had less improvement than clients identified as on track. This signaled that a major improvement was warranted in the type of feedback that counselors received when the feedback program signaled client as not responding compared to treatment as usual (Whipple et al., 2003). Whipple et al. included a series of clinical support tools, which were instrument based assessments, when the authors replicated the feedback program outlined in Lambert, Whipple, et al. (2001). The clinical support tools consisted of three additional measures; they were implemented to identify key areas of attention. The measures were the Revised Helping Alliance Questionnaire (HAq-II; Luborsky et al., 1996), the Stages of Change Scale (SCS; McConnaughy, Prochaska, & Velicer, 1983), and the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988).

The HAq-II is a self-report measure that assesses therapeutic alliance between the counselor and client. The internal consistency of the HAq-II is high (Cronbach’s $\alpha = 0.90$) with a test/retest score at three weeks of $r = 0.78$. The measure also had good concurrent validity ($r = 0.71$) when compared to measures like California Psychotherapy Alliance Scales (CALPAS; Luborsky et al., 1996).

The Stages of Change Scale (SCS) is an 8-item measure on a five point Likert scale that is used to assess the readiness of change in clients based upon the Transtheoretical Model. Internal consistency scores ranged from (Cronbach’s $\alpha = 0.79$ to 0.84; McConnaughy et al., 1983). The highest score on the SCS determines the highest level of readiness of change ranging from pre contemplation to maintenance.
The Multidimensional Scale of Perceived Social Support (MSPSS) is a 12-item self-report that assesses the perception of social support in a client’s life from family, friends, and significant others. Internal consistency scores for the measure are Cronbach’s $\alpha = 0.88$. Test/retest values were ($r = 0.85$; Zimet et al., 1988).

Whipple et al. (2003) conducted the feedback study on 981 clients who attended a university counseling center. All clients were assigned randomly to the experimental, the feedback condition, or to a control group that received no feedback. Following the same feedback criteria designed in Lambert, Whipple, et al. (2001), Whipple et al. (2003) added the administration of clinical support tools following any yellow or red early warning feedback that counselors received. The administration of the CSTs was left to the discretion of the participating counselors; they could either give all of them out at once or use their personal judgment in choosing which CST to give out.

Whipple et al. (2003) found that the use of clinical support tools was successful in lowering post treatment outcome scores largely by increasing the number of sessions of identified non-responding clients whose counselors received feedback. The decision rules for identifying non-responding clients were more successful in identifying clients not on track, than in previous studies. Whipple et al. found that the decision rules found 28.3% of clients not on track compared to 18.8% of clients who were identified in Lambert, Whipple, et al. (2001). Prior to analysis of the data Whipple et al. (2003) found significant differences between the pre treatment OQ 45 scores for clients who were considered not on track ($m = 78.64$), regardless of either the feedback or the CST conditions, compared to clients in the on track ($m = 67.80$), for both feedback and no
feedback conditions. It appeared that clients who were in the not on track groups entered therapy with higher OQ 45 scores. Whipple et al. found that there were between group differences for clients who were not on track \( [F (2,274) = 8.394, p < 0.05] \). Table 1 illustrates the post hoc analysis results between the not on track groups.

The tests showed that adding CSTs to feedback greatly improved feedback for clients who were non-responders. The CSTs added to the already present effect of feedback by increasing gains in treatment. Whipple et al. (2003) stated that the resulting increase in sessions for clients, not on track, whose counselors used feedback and clinical support tools allowed clients who traditionally dropped out early, to remain in treatment and reach both significant amounts of post session change and reliable change.

One limitation of this study was the OQ 45 and the three self-report clinical support tools. These four measures were all self-report and are susceptible to self-report bias. The ecologically friendliness of the study, that valued leaving counselors to practice freely by their discretion, can be viewed as a limitation as the study can not

<table>
<thead>
<tr>
<th>Comparison between group</th>
<th>Mean difference on OQ 45 / Standard deviation</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not on Track, Feedback, CST / Not on Track, Feedback</td>
<td>6.60 / 3.78</td>
<td>( p &lt; 0.05 )</td>
</tr>
<tr>
<td>Not on Track, Feedback / Not on Track, No Feedback</td>
<td>5.19 / 3.77</td>
<td>( p &lt; 0.05 )</td>
</tr>
<tr>
<td>Not on Track, Feedback, CST / Not on Track, No Feedback</td>
<td>11.79 / 2.92</td>
<td>( p &lt; 0.05 )</td>
</tr>
</tbody>
</table>
comment on how or if the counselors used the feedback. However Whipple et al. (2003) and Lambert, Whipple, et al. (2001) stressed that retaining the ecologically friendliness of the studies will encourage the implementation of feedback programs into routine practice without discouraging already busy counselors with mandates on how to use feedback.

**Supplying feedback to clients and counselors.** Hawkins, Lambert, Vermeersch, Slade, and Tuttle (2004) added another dimension to the feedback program literature when they conducted a study at a hospital based counseling clinic and provided feedback to clients along with counselors. Hawkins et al. asked the following research questions: (a) does feedback increase the number of sessions in clients identified as non-responders, and decrease the number of client sessions for clients identified as on track; (b) do the outcomes of clients, who were in the experimental group, client and counselor feedback, have lower end of treatment outcomes on the OQ 45 compared to the control condition of no feedback? Hawkins et al. sampled participants from 715 clients who attended outpatient counseling at a hospital clinic. This was the first study of its kind that used a non-college population. The researchers believed that pretreatment OQ 45 scores would be on average higher for clients identified as on track and not on track. This was due to the participants being sampled from a community based counseling clinic, which typically serves clients with more distress and psychopathology, than university counseling centers. The authors used inclusionary criteria to identify their final sample of 201 clients. The criteria was that all clients in the study were required to have a minimum of two sessions in which they were able to complete a baseline and termination OQ 45 measurement. The participants were randomly assigned to three treatment
Hawkins et al. constructed delivery messages that clients in the counselor-client feedback condition would receive upon the start of each treatment session. The feedback messages were organized according to the color feedback coding used by Lambert, Whipple, et al. (2001). The feedback was delivered according to the session number the client was in currently and what specific color-coding feedback the client progress showed. The counselor was instructed to begin each session in the counselor-client feedback condition saying, “I’d like you to look at some information about your progress. After you are finished, if you would like, we can talk about any questions you might have” (Hawkins et al., 2004, p. 314). However no direction was given by the researchers on ways to use the per session assessment and feedback during the study, in order to keep the treatment approaches investigated as similar to routine clinical practice as possible. The precise wordings of each feedback message can be seen below.

*Sessions 2-4: White feedback.* Please note that the following information is based on your responses to the questionnaire that you complete before each therapy session. It appears that you are experiencing low levels of distress as measured by your responses. If your level of progress is maintained, you will likely have a positive therapy outcome. Your responses to the questionnaire suggest that you feel more like those persons who are not overly burdened by their distress and who do not believe they have a need for treatment. We encourage you to continue working as hard as you have to obtain the most you can from therapy. (Whipple et al., 2004, pp. 321-324)
*Green feedback.* Please note that the following information is based on your responses to the questionnaire that you complete before each therapy session. It appears that your level of improvement is similar to that of the majority of patients who are receiving treatment. Although your current level of progress suggests that you are on course for a positive outcome, we encourage you to continue working hard so that you may receive maximum benefit from treatment. You may also want to consider discussing with your therapist the aspects of treatment that have been most and least helpful to experience the greatest benefit from your treatment. (Whipple et al., 2004, pp. 321-324).

*Yellow and red feedback.* Please note that the following information is based on your responses to the questionnaire that you complete before each therapy session. It appears that you have not experienced a reduced level of distress. Because you may not be experiencing the expected rate of progress, it is possible that you have even considered terminating treatment, believing that therapy may not be helpful for you. Although you have yet to experience much relief from therapy, it is still early in treatment and there is the potential for future improvement. However, we urge you to openly discuss any concerns that you may be having about therapy with your therapist because there are strategies that can be used to help you receive the most out of your therapy. It may also require your willingness to complete additional questionnaires that may shed light about why you are not experiencing the expected rate of progress. (Whipple et al., 2004, pp. 321-324)
Sessions 5-8. White feedback. Please note that the following information is based on your responses to the questionnaire that you complete before each therapy session. Your distress level is less than most patients in treatment because you appear to be more similar to those persons who believe they have no need for therapy and do not feel overly burdened by their levels of distress. It appears that you have experienced significant benefits from treatment. It is also possible that you may believe that you have benefited as much as you can from treatment. If you believe this to be true, you may want to consider discussing with your therapist the possibility of stopping treatment in the near future. (Whipple et al., 2004, pp. 321-324)

Green feedback. Please note that the following information is based on your responses to the questionnaire that you complete before each therapy session. Currently, your level of progress approximates that accomplished by most patients in therapy. However, there is likely still time for additional improvement. We urge you to continue working as hard as you have to experience the greatest benefit possible from treatment. If you have not already done so, now may be the right time to discuss with your therapist the aspects of treatment that have been the most helpful as well as aspects of treatment that have not been helpful. (Whipple et al., 2004, pp. 321-324)

Yellow and red feedback. Please note that the following information is based on your responses to the questionnaire that you complete before each therapy session. Compared with the majority of patients, it does not appear that
you are experiencing the expected levels of progress that most patients have experienced at this stage of treatment. Additionally, it is highly likely that you may stop attending treatment before any benefits are realized from therapy. Although you may not be as hopeful of improvement as you once were, we strongly encourage you to discuss your concerns and feelings with your therapist. It is possible that you may want to consider treatment alternatives such as talking more about what you want from treatment with your therapist, specific aspects of your treatment that have not been helpful, and consideration of medication or a change in medication. It may also require your willingness to complete additional questionnaires that may shed light about why you are not experiencing the expected rate of progress. (Whipple et al., 2004, pp. 321-324)

*Sessions 9 and above. White feedback.* Please note that the following information is based on your responses to the questionnaire that you complete before each therapy session. You should be commended for your hard work in treatment. It appears that your current level of distress is more similar to that of persons who function well in society and who do not feel overly burdened by their levels of distress. Given the stage of your treatment and significant improvements that you have accomplished, you may want to seriously consider discussing with your therapist a plan to stop treatment in the near future. (Whipple et al., 2004, pp. 321-324)

*Green feedback.* Please note that the following information is based on your responses to the questionnaire that you complete before each therapy
session. Your progress is similar to that of most patients in treatment. However, there is likely still time for additional improvement. We urge you to focus on the aspects of your treatment that you consider most helpful as well as work to accomplish your personal goals from treatment. (Whipple et al., 2004, pp. 321-324)

*Yellow and red feedback.* Please note that the following information is based on your responses to the questionnaire that you complete before each therapy session. Despite the late stage of your treatment, compared with most patients, it does not appear as though you have experienced much relief from treatment. There is a strong possibility that you will not experience a noticeable benefit from therapy unless something changes in your treatment. We strongly encourage you to consider, with your therapist, a new course of action aimed at providing the benefits that you would like from treatment. It may also require your willingness to complete additional questionnaires that may shed light about why you are not experiencing the expected rate of progress. (Whipple et al., 2004, pp. 321-324)

There were no pre treatment OQ 45 differences or age differences represented in any of the three experimental conditions. Hawkins et al. (2004) results showed that all three conditions had significant differences between pre- and post-test scores ($F_{(1, 196)} = 4.75, p < 0.05$). When the counselor feedback and counselor-client condition were compared there was a significant difference ($F_{(1, 196)} = 4.95, p > 0.05$). This suggested that feedback when provided to the counselor and client had superior results to counselor
feedback alone. When counselor and client feedback was compared to treatment as usual
the authors found the largest difference ($F(1, 196) = 8.92, p > 0.05$).

An important indicator in the feedback programs has been their ability to identify
and help decrease the overall outcome score on the OQ 45 prior to termination. The
previous studies have been able to successfully track the non-responding clients who
trigger the early alarm system designed to signal the counselor that the client was at risk
for continuing in a direction not consistent with normal recovery curves (yellow
feedback), or possibly deteriorating during treatment (red feedback). Hawkins et al.
(2004) found no significant differences when comparing groups of non-responders, those
who either deteriorated or made no change, with treatment responder groups, those
making reliable and clinically significant change. This was a surprising finding given
that all three previous studies Lambert, Whipple, et al., 2001; Lambert, Whipple,
Vermeersch, et al., 2002; Whipple et al., 2003) found conclusive evidence of differences
post treatment between those clients identified as on track and not on track. Hawkins et
al. (2004) reported that this result may have been due to the relatively small treatment
sample of non-responders collected. However, during the client and counselor feedback
condition 64% of clients reliably improved in 7.8 sessions, an increase from the 50% of

Before conducting the study, Hawkins et al. (2004) were concerned that providing
clients feedback might create demand characteristic in the counselor-client feedback
condition. The clients might respond in socially desirable fashions that would skew data
in this condition. However, the clients were interested in receiving weekly feedback, and
were able to be objective about their progress during treatment without the anticipated adverse responding effects. The study faced a limitation in the number and experience level of counselors in the study. There were only five therapists in the current study and their mean number of years practicing was 20. This study similar to the above only used a single source of measurement—the OQ 45. Despite these limitations, however, the study showed that giving feedback to counselors and clients concurrently yielded superior results to the other two conditions.

**Immediate electronic feedback.** The use of technology has advanced the method of per session evaluation and feedback dramatically. Allowing clients to use electronic methods to input data on the OQ 45 has made the turn around time for results almost instantaneous. However until Slade, Lambert, Harmon, Smart, and Bailey (2008) tested the use of instant feedback the advantageousness of this feedback delivery method was contested. The authors proposed four research questions: (a) clients who are not on track and whose counselor received immediate feedback on the OQ 45 will have higher outcome than clients who are not on track and whose therapists received one week delayed feedback; (b) clients who are not on track whose counselor received one week delayed feedback will have higher outcomes than clients not on track whose counselor received no feedback, or treatment as usual conditions; and (c) clients who are not on track and whose counselor received immediate feedback on the OQ 45, and gave feedback to them as well, will have higher outcome than clients who are not on track and whose therapists received one week delayed feedback, and gave feedback to them as well. Clients who are in the not on track condition have obtained either yellow or red
feedback as detailed in Lambert, Whipple, et al.’s (2001) study. Slade et al. (2008) sampled 1,294 clients from a large university counseling center. Of these clients 192 discontinued the study or did not meet the inclusion criteria of attending 2 sessions of counseling. Control conditions of client whose therapists did not receive feedback were obtained from archival data of previous feedback studies. This totaled 3,919 clients for this study, a combination of the study’s sample clients and the archival treatment as usual clients.

Slade et al. (2008) found no significant differences between clients in any of the conditions between pretreatment OQ 45 scores and the level between immediate and time delayed feedback. The authors found there were significant differences between treatment as usual, no feedback, and the combination of immediate and week delayed feedback ($F_{(2,979)} = 18.36, p < 0.001$). However there were no differences between any of the conditions of immediate feedback to client and counselor compared to week delayed feedback to client and counselor. There were also no significant differences between immediate feedback to counselor only, compared to week delayed feedback to counselor only. Though this study failed to capture any benefits to immediate electronic feedback, the authors still contended that the benefit of feedback is in capturing a routine evaluation of the client’s progress through counseling. Implementation which was not studied might yield differing results of the usefulness of immediate feedback as the counselor might find it increasingly useful to evaluate the client’s progress immediately as opposed to a week later, when the counselor has seen several other clients and may not have the freshest picture about the client (Slade et al., 2008). The test developers of the OQ 45
have adapted to clinician preferences in providing means of immediate assessment by ways of handheld computers, and kiosks in the lobbies of counseling clinics. The test developers also provide week delayed instrumentation like paper and pencil version with electronic scanning and imaging software for measure interpretation. This study may have not produced results that show immediate feedback to be more effective; however, in no way did the study show it to be ineffective. Slade et al. (2008) made a call for additional studies that may capture the effectiveness of immediate feedback with more sensitivity in the future.

**Considerations for supervision.** Supervision is an integral part of counseling in that it provides the counselor with direct training and monitoring throughout their working life. This structure and training are essential components of early counselors’ work. However, no feedback study has examined the role that supervisors play during the feedback programs. Worthen and Lambert (2007) explored five key contributions to supervisors that feedback gives. Based upon their anecdotal experiences of seeing supervisors and counselor use feedback programs. These contributions were (a) feedback provides a standard feedback mechanism that is beneficial to training, (b) feedback curbs overestimated benefits of therapy and helps predict client deterioration better than intuition alone, (c) feedback may provide information about the client that might be otherwise missed; supervisors can keep track of this information on clients from a second source, (d) the use of clinical support tools when clients are not on track may help supervisors steer their supervisees to what areas of disturbance in the client needs the most attention, (e) the additional information the feedback program provides may help
supervisors and counselor to make better decisions about treatment progress and direction than pure clinical intuition alone.

No experiments have been conducted on supervisors’ use and implementation of feedback programs on their supervision practices to this date, and this area of research is needed as routine evaluation of counseling sessions has already positively impacted the work of counselors. Future studies might examine how supervisors incorporate the use of feedback into their monitoring of their supervisees’ client issues, their determination of which clients to review in supervision, how they may use feedback to monitor supervisee performance and skill building, and how they use the feedback data to guide their counselor treatment planning.

Other Types of Feedback in the Literature

Students’ experience of receiving performance feedback. Whereas no study to date has explored the perceptions of counselors or counselors in training perception of feedback while working with clients, Daniels and Larson (2001) explored counseling students enrolled in a basic skills course perception of receiving feedback after conducting a mock interview sessions. The researchers administered the counseling self-estimate inventory (COSE; Larson et al., 1992) and the state trait anxiety inventory (STAI; Spielberger, 1983) to the counseling students who participated in the study. The researchers administered both instruments before and after the mock interview session to 42 students enrolled in the basic skills course. Daniels and Larson (2001) randomly assigned each participant to either the positive feedback or the negative feedback condition. The participants in the negative feedback condition regardless of their
performance in the mock session were told that they received a score of 15 out of 100 on the session. The positive feedback group received a report that they got an 85 out of 100 on the session, regardless of what the student’s actual progress was. Following administration of the second round of measures, the researchers debriefed each participant. Daniels and Larson hypothesized that participants who received positive feedback on the mock interview would report increases in counselor self-efficacy on the COSE, and that participants who received negative feedback would report decreased counselor self-efficacy. The researchers’ second hypothesis was that participants who received positive feedback on the mock interview would report decreases in anxiety reported on the STAI and that participants who received negative feedback would report increases in anxiety. The researchers confirmed both of their hypotheses following the study. Participants who received positive feedback on the mock interview had significantly lower anxiety \((p < 0.001)\) and higher self-efficacy scores \((p = 0.017)\). Participants who received negative feedback had higher anxiety \((p = 0.007)\) and lower counselor self-efficacy scores \((p < 0.001)\).

The researchers concluded that even though the participants received feedback on a mock interview, the impact of the performance feedback had implications in how they viewed their ability as a counselor as well as drastically influencing their anxiety levels. Daniels and Larson (2001) concluded that instructors and supervisors should focus performance feedback on positive aspects that relate to what students are doing well, avoiding criticalness. The researchers suggested that instructors should give students specific feedback on what they can do to improve rather than global negative evaluations.
This study illustrated that the effects of performance feedback are powerful and can increase counseling students’ self-efficacy, raising their confidence levels in their ability, and helping to reduce their anxiety.

**Specific strategies for giving feedback.** Daniels and Larson (2001) suggested that instructors and supervisors should use specific strategies to give feedback to their students. These strategies would increase the chances that the students are able to benefit from feedback. Brookhart (2011) listed seven principles to giving effective feedback. The first principle is that feedback should show students something about their work that they may not have known before. The second principle was that effective feedback is timely and when possible immediate. The third principle was that feedback should focus on one or more strengths the student has and provide a suggestion for the student’s next step. The fourth principle was that feedback should focus primarily on the student’s work and not the student personally. The fifth principle was that feedback should be descriptive and compare the student’s work to criteria that he or she is aware of and understand. The sixth principle is that feedback should compare a student’s present performance with his or her past performance. The last principle for feedback was that feedback should be clearly stated and specific to the situation.

Riemer, Rosof-Williams, and Bickman (2005) investigated performance feedback and suggested that in order for feedback to be effective recipients must pay attention to the feedback and also accept the feedback. The authors suggested that to increase the attention to performance feedback recipients should be aware of its validity and reliability. They also suggested that the feedback be delivered in a way that is simple to
understand. To help recipients become more attenuated to the performance feedback, the authors suggested that feedback should provide information on performance and provide suggestions for improvement. To help recipients accept the performance feedback

Riemer et al. (2005) suggested that the feedback be relevant to the needs of the recipient. If the feedback differs too dramatically from what the recipient perceives, there may be a greater chance that he or she will reject the feedback altogether. For feedback to be most effective the authors suggested that feedback coincide with the recipient’s motivation to improve his or her task performance and with the recipient’s realization that the actions he or she is taking in performing the task are not consistent with reaching performance goals. The performance feedback is useful at this point because it allows the recipient to gauge how his or her performance is matching the goals and provides them with instruction. This instruction can be that his or her actions are congruent with his or her goals or that his or her actions need to be altered. This continuous process allows a recipient to better gauge the specific actions that need alteration and the actions that have been effective.

Rationale for Study and Research Design

Lambert, Whipple, et al. (2001), Lambert, Whipple, Vermeersch, et al. (2002), Whipple et al. (2003), and Hawkins et al. (2004) have demonstrated that providing per session feedback was effective in lower early termination for clients identified as not on track by the OQ 45, and have shown that per session feedback increased overall treatment outcome in clients who are not on track during counseling. However to this date no researcher has examined how clinicians use per session feedback. This study examined
how counselors, and practicum instructors used per session feedback, and how it influenced their treatment approach, client monitoring, and evaluation of counselor’s skill development. The research questions are:

1. How do clinical mental health counseling practicum students use per session assessment and feedback from the OQ 45?

2. How do practicum instructors use per session assessment and feedback from the OQ 45 provided to their students?
CHAPTER II

METHODOLOGY

Introduction

The effectiveness of per session assessment and feedback has been well documented (Lambert et al., 2003); however, the understanding of how per session assessment and feedback is used is still uninvestigated in the literature. Researchers such as Sapyta et al. (2005) have called for investigation into how per session assessment and feedback is used, what format of feedback is best, a further understanding of how counselors interpret the feedback, and how recipients of the feedback come to value its responses. This study investigated the use of per session assessment and feedback on two levels: (a) clinical mental health counseling practicum students, and (b) the instructors involved in teaching the practicum course in which the students are currently enrolled. These two levels of participants used the weekly feedback system outlined in Lambert, Whipple, et al. (2001) for a semester of treating clients, and were interviewed throughout the semester to explore the application and utility that per session assessment and feedback played in their treatment and goal formation for clients.

Rationale for Design

This study used a holistic multiple case study design. Case study design is a useful methodology in exploring “how” and “why” questions” (Yin, 2009). Case study design looks to explore and describe the experiences of a bounded sample defined by the researcher. Case study design is helpful in exploring these five issues: explaining, describing, illustrating, exploring, and meta-evaluation. Case study design is appropriate
when the researcher wishes to explore the context of a particular system (Yin, 2009). Single case studies often focus on one primary case or system in depth; whereas, multiple case studies explore several cases and seek similarities and dissimilarities (Stake, 1995). Unlike phenomenological studies, which seek to uncover shared experiences of a group, case study design looks to explore the depth and complexity of an experience for an individual or group. Due to the design of interviewing practicum students, supervisors, and practicum instructors who all use varying psychological approaches and supervision styles with clients and supervisees, a case study design was useful in exploring the complexities of this heterogeneous group (Yin, 2009).

**Multiple Case Study Design**

Yin (2009) stated that multiple case study designs are “more compelling” and “more robust” (p. 46). The advantages stem from the disadvantages of single case design studies in which Yin stated, “single case designs are vulnerable only because you put all your eggs in one basket” (p. 53). However, the disadvantages to using multiple case designs is that they require extensive time commitments and resources on part of the researcher.

The goal of multiple case study design is to produce replicated results that either confirm or disconfirm results of the study. This process helps researchers to develop rich theoretical frameworks that help to explain a case. This replication logic is dissimilar to sampling logic, which entails that the sampled pool accurately reflects that of the population. Yin (2009) stated that case study design is not appropriate for assessing the prevalence of an explored phenomenon. Every case study in a multiple case study
consists of a whole study. The researcher then explores each case carefully and seeks convergent evidence regarding the facts and conclusions of each study. The bounded case for this research was the group of practicum students, supervisors, and practicum instructors in the clinical mental health counseling practicum.

**Participants**

**Clinical Mental Health Counseling Practicum Students**

The clinical mental health counseling practicum students were from a midsized Midwest university. The practicum students were selected due to their position as active treatment providers of mental health services at the Counseling and Human Development Center, and for their ability to implement the feedback program into their routine practice of counseling. The participants were enrolled in a clinical mental health counseling, second semester practicum class. These classes are the second semester practicum classes; students in these classes have served clients for one previous semester during practicum one and have obtained at least 14 direct client hours. Students in the second semester practicum classes typically have been enrolled in the Clinical Mental Health Counseling Program for at least a year, and have taken courses in Theories of Counseling, Procedures in Counseling, Orientation to the Profession, Group Work, Assessment, and Career Counseling. Students in practicum have taken a practicum entrance examination that covered material from the above classes. Students who pass the examination are able to move into the next phase of their study: the practicum and internship phase. Students in the study had to be in good standing with grades with the university, receiving no lower than a B- in any of their classes in their practicum
prerequisite courses. Any student who was failing the course or who was acting unprofessionally, or was in violation of behavior, according to the standards and rules provided in Counseling and Human Development Center’s manual or the Clinical Mental Health Counseling Program’s handbook were asked to leave the study. Non-participation in the study had no impact on the practicum student’s grade for the practicum course or standing in the program.

**Practicum Instructors**

The practicum instructors were from a midsized Midwest university. The practicum instructors were selected due to their ability to monitor clinical mental health counseling practicum students’ development and training, while using the per session assessment and feedback program. Their ability to use the per session feedback that their clinical mental health counseling practicum students receive is also of interest, because of how this feedback may focus instructors’ attention to clients who are underperforming during counseling, or to clinical mental health counseling practicum students who are having difficulty with certain clients who may not be progressing well during counseling. Practicum instructors are typically full time faculty, part time instructors from the surrounding community, or part time instructors who are doctoral students in the Counselor Education program. All practicum instructors hold an Ohio Professional Clinical Counselor license with a supervisor designation. Instructors teach a practicum class one night a week for 2.5 hours, and provide one-hour supervision sessions weekly with each student. They also watch and review the video recorded sessions of their supervisees, and have between 2–6 clinical mental health counseling practicum students
assigned to their supervision. All representation of the clinical mental health counseling practicum students and the practicum instructors can be found in Table 2.

Table 2

*Representation of the Clinical Mental Health Counseling Practicum Students and the Practicum Instructors*

<table>
<thead>
<tr>
<th>Clinical Mental Health Counseling Practicum Students</th>
<th>Gender</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Direct Service Hours Before Study</th>
</tr>
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<tbody>
<tr>
<td>Elisabeth</td>
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<td>White</td>
<td>37</td>
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<td>Jane</td>
<td>Female</td>
<td>22</td>
<td>White</td>
<td>35</td>
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<td>Caroline</td>
<td>Female</td>
<td>67</td>
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<td>54</td>
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<td>African American</td>
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<td>Kitty</td>
<td>Female</td>
<td>24</td>
<td>White</td>
<td>32</td>
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<table>
<thead>
<tr>
<th>Practicum Instructor</th>
<th>Gender</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Hours of Direct Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charles</td>
<td>Male</td>
<td>42</td>
<td>White</td>
<td>300 hours</td>
</tr>
<tr>
<td>George</td>
<td>Male</td>
<td>48</td>
<td>White</td>
<td>400 hours</td>
</tr>
</tbody>
</table>

*Counseling and Human Development Center Clients*

The clients who completed the OQ 45s were students and members of the surrounding university community or from areas surrounding the university. These clients are typically college aged students aged 18 and above, who attend a midsized Midwest university. No client at the Counseling and Human Development Center, who was under the age of 18 years, was asked to participate in the study. The community population that
attends the counseling center are typically seeking mental health services that are priced at sliding scale fees. The age range for these community clients varies. A presentation of each counseling practicum student’s client figures can be found in Table 3.

**Sampling**

**Practicum Instructors**

All Practicum II instructors were asked, by an independent designated associate who was trained by the researcher and who had been approved by the IRB board, if they would participate in the study. An independent IRB designated associate also asked if they would permit their clinical mental health counseling practicum students to participate in the study, if their practicum students were interested. These instructors were informed of the purpose of the study and to the terms of participation, which included the voluntary nature of participation in the study, the procedures of the study that would require their participation, and how many hours they would be required to give to the study during the semester. Practicum instructors were advised that this study would require 2 hours of their participation for interviewing and member checking, and on average 5–10 minutes a week in class reviewing the weekly printout the researcher provided them detailing the progress their clinical mental health counseling practicum students were making with their clients.

**Clinical Mental Health Counseling Practicum Students**

Following permission from the practicum instructor the clinical mental health counseling practicum students were contacted and asked if they would be interested in
Table 3

*Clinical Mental Health Counseling Practicum Students’ Client Information*

<table>
<thead>
<tr>
<th>Client’s name</th>
<th>Gender</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Sessions</th>
<th>First Score</th>
<th>Last Score</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane’s clients</td>
<td>4 female</td>
<td>$M = 22.5$</td>
<td>4 Caucasian</td>
<td>$M = 4.75$</td>
<td>$M = 53.5$</td>
<td>$M = 41.7$</td>
<td>$M = 11.7$</td>
</tr>
<tr>
<td></td>
<td>$n = 4$</td>
<td>$SD = 3.1$</td>
<td></td>
<td>$SD = 3.0$</td>
<td>$SD = 16.5$</td>
<td>$SD = 20.3$</td>
<td>$SD = 19.2$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$R (20-27)$</td>
<td></td>
<td>$R (2-11)$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caroline’s clients</td>
<td>3 female, 3 male</td>
<td>$M = 31.0$</td>
<td>3 Caucasian</td>
<td>$M = 3.5$</td>
<td>$M = 61.2$</td>
<td>$M = 56.4$</td>
<td>$M = 4.8$</td>
</tr>
<tr>
<td></td>
<td>$n = 6$</td>
<td>$SD = 16.2$</td>
<td></td>
<td>$SD = 2.0$</td>
<td>$SD = 15.5$</td>
<td>$SD = 17.5$</td>
<td>$SD = 6.0$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$R (21-60)$</td>
<td></td>
<td>$R (2-6)$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elisabeth’s clients</td>
<td>3 female, 1 male</td>
<td>$M = 21.7$</td>
<td>4 Caucasian</td>
<td>$M = 5.0$</td>
<td>$M = 53.5$</td>
<td>$M = 37.75$</td>
<td>$M = 15.7$</td>
</tr>
<tr>
<td></td>
<td>$n = 4$</td>
<td>$SD = 4.1$</td>
<td></td>
<td>$SD = 2.1$</td>
<td>$SD = 16.6$</td>
<td>$SD = 14.2$</td>
<td>$SD = 21.7$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$R (19-28)$</td>
<td></td>
<td>$R (3-8)$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fitzwilliam’s clients</td>
<td>1 female, 1 male</td>
<td>$M = 29.0$</td>
<td>2 Caucasian</td>
<td>$M = 45.0$</td>
<td>$M = 67.5$</td>
<td>$M = 31.0$</td>
<td>$M = 36.5$</td>
</tr>
<tr>
<td></td>
<td>$n = 2$</td>
<td>$SD = 12.7$</td>
<td></td>
<td>$SD = 2.1$</td>
<td>$SD = 16.2$</td>
<td>$SD = 16.9$</td>
<td>$SD = 7.07$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$R (20-38)$</td>
<td></td>
<td>$R (3-6)$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kitty’s clients</td>
<td>2 female, 1 male</td>
<td>$M = 25.6$</td>
<td>3 Caucasian</td>
<td>$M = 5.3$</td>
<td>$M = 90.3$</td>
<td>$M = 68.6$</td>
<td>$M = 21.6$</td>
</tr>
<tr>
<td></td>
<td>$n = 3$</td>
<td>$SD = 0.57$</td>
<td></td>
<td>$SD = 2.5$</td>
<td>$SD = 11.5$</td>
<td>$SD = 5.5$</td>
<td>$SD = 9.0$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$R (25-26)$</td>
<td></td>
<td>$R (3-8)$</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

$R =$ Range
participating in the research study, by a staff member of the Counseling and Human Development Center, who was trained by the researcher and who had been approved by the IRB board. These students were informed of the purpose of the study and to the terms of participation, which included the voluntary nature of participation in the study, the procedures of the study that would require their participation, and how many hours they would be required to give to the study during the semester. Clinical mental health counseling practicum students were advised that this study would require (a) 4 hours of their participation for interviewing and member checking; (b) approximately 3–5 minutes per session, for every session, explaining and handing out the OQ 45 to clients; (c) 3–5 minutes a week per client examining the OQ 45 test results and interpretation, from the previous week; and (d) 5–10 minutes a week in supervision reviewing with their practicum instructor the weekly printout the researcher provided the practicum instructor. This printout included the weekly progress the client was making during counseling, and their corresponding weekly color-coded feedback message.

Counseling and Human Development Center Clients

Following permission and agreement from the clinical mental health counseling practicum students to participate in the study, the counseling and human development center clients were asked to participate in the study by staff members of the Counseling and Human Development Center, who were trained by the researcher and who had been approved by the IRB board. Using a script, the staff members of the Counseling and Human Development Center asked the clients to participate in the study during the first non-intake session with their counselors. If the clients agreed to participate, the
counseling staff members of the Counseling and Human Development Center reviewed the study’s consent form (found in Appendix N) with the client and asked the client to sign it. The clients were informed of the benefits and risks of participation in the study including the benefit of the ability to track their progress through counseling more effectively, and the knowledge that their information was used in the study to help further the advantages of providing per session feedback to the mental health service consumers. The clients were informed of the risks including that the clients may encounter or discover unknown aspects about themselves through the per session assessment. The clients were informed also that these aspects might make them feel upset or uncomfortable; however, these aspects that are discovered can often be therapeutic and essential to their success in counseling. The clients were instructed that at any time their participation could be stopped with no consequences to their mental health service delivery.

**Procedures**

**Clinical Mental Health Counseling Practicum Students Training**

Before the practicum student started the study, a staff member of the Counseling and Human Development Center, who was trained by the researcher and who had been approved by the IRB board, reviewed the informed consent form with the clinical mental health counseling practicum student and had him or her sign it. The clinical mental health counseling practicum student’s informed consent can be found in Appendix J. The researcher held an hour training session during the fourth and fifth week of class. During this training the researcher included (a) rationale for the study, (b) completion of the
demographic form, (c) the audio taping consent (found in Appendix O and K), (d) explanation of the OQ 45 and instructions on how to administer and use the measure, (e) training on how to give informed consent to the client they would serve during the study, and (f) information on how to reach the researcher through email or phone. The counseling practicum student training can be found in Appendix Q. During the training, the clinical mental health counseling practicum students were instructed to hand the measure, at the end of the first non-intake session, to the client, and at each subsequent session to capture the client’s post treatment outcome. The clinical mental health counseling practicum students were then directed to ask their clients to complete the measure in the lobby of the counseling center, and to hand it to the counseling center staff at the front lobby window before leaving. The complete set of instructions for the clinical mental health counseling practicum students can be found in Appendix A. The researcher graded the previous day’s completed OQ 45s each morning the counseling center was open, to provide the feedback for the counselors to review, without much delay. The researcher used the OQ 45 test developer software, the OQ Analyst, to grade and interpret the measure. The OQ Analyst software provided cut off score data and a corresponding color feedback score computed from comparing the client’s current session score against their initial score and session number. The OQ Analyst also provided a visual representation, a line chart, of the client’s progress during counseling, along with a recommended feedback message to the client based upon his or her last session score and his or her overall progress in counseling. After scoring and interpreting the OQ 45 the researcher placed the scored measure along with its color-coded message
upon the case note for the corresponding session in the client’s clinical record. The researcher also placed a new OQ 45 measure to use during the next session with the client in the chart. The participants were instructed to discuss in supervision any client who received red color-coded feedback, suggesting the client was deteriorating during treatment, before the next session with the client. If the clinical mental health counseling practicum student was not able to meet in supervision to discuss the red color-coded feedback before seeing the client, the counselor was instructed to contact the practicum instructor by phone. The clinical mental health counseling practicum student was instructed to call the practicum instructor from the telephone located at the Counseling and Human Development Center. He or she was instructed not to use any identifiable information regarding the client. The clinical mental health counseling practicum student was to either say directly to his or her practicum instructor or through a voice message that he or she had a client who had been identified as not responding to treatment, receiving a red color coded feedback message. He or she was then instructed to ask for a time when they could meet to discuss this client’s progress, before the clinical mental health counseling practicum student met with the client again.

**Practicum Instructors Training**

Before the practicum instructors started the study, an independent designated associate who was trained by the researcher and who had been approved by the IRB board reviewed the informed consent form with the instructor and had them sign it. The informed consent form can be found in Appendix L. The practicum instructors received an hour training the second week of the semester, by the researcher. The training
included (a) rationale for the study, (b) completion of the demographic form, (c) the audio taping consent (found in Appendix P and M), (d) explanation of the OQ 45 and instructions on how to interpret the measure, and (e) information on how to reach the researcher through email or phone. The training that the practicum instructors received can be found in Appendix R. Instructions for practicum instructors can be found in Appendix B. The researcher told the instructors that they would receive updates weekly on the clients being served by their clinical mental health counseling practicum students. These weekly updates consisted of printouts of the overall progress each client had made, and listed the client’s color coded feedback message, to help practicum instructor easily monitor the clients who were either doing well or were not benefiting during counseling.

**Counseling and Human Development Center Clients Training**

Before a client who agreed to participate completed his or her first OQ 45, a staff member of the Counseling and Human Development Center, who was trained by the researcher and had been approved by the IRB board, reviewed the informed consent form with the client and instructed him or her to sign the consent form before completing the measure. The client’s informed consent form can be found in Appendix N. The client was instructed to complete the measure in the lobby of the counseling center and then to hand the measure to the staff at the front window of the Counseling and Human Development Center before leaving. The counseling practicum student instructed each client that he or she would receive a brief review of his or her results during the beginning of their upcoming session. Instructions for Counseling and Human Development Center clients can be found in Appendix C.
Counseling and Human Development Center Staff Training

The staff members of the Counseling and Human Development Center were instructed that the clients of the clinical mental health counseling practicum students involved in the study would be handing in completed OQ 45s at the front window. The staff was directed to take these completed OQ 45s and place them in the folder labeled as completed OQ 45s, in the Counseling and Human Development Center’s locked filing cabinet. The staff was instructed to give out a blank copy of the OQ 45 from the folder labeled as blank OQ 45s, if the client made a mistake and needed a fresh OQ 45 form. The staff was instructed to shred the client’s OQ 45 with the mistake on it after they handed the client the new one. The staff was instructed to lock the filing cabinet every night, when the counseling center closed. Instructions for the Counseling and Human Development Center staff can be found in Appendix D.

Interviews

Clinical Mental Health Counseling Practicum Students

The practicum students were interviewed twice during the study. The interviews were scheduled during the 5th week and the 10th week of the semester. The 5th week was chosen due to its location as approximately one third of the way through the semester, whereas the second interview, at the 10th week, was chosen because it was approximately two thirds of the way through the semester. Both interviews lasted approximately one hour and were held at the Counseling and Human Development Center. During the first series of interviews the practicum students were asked the following questions:

1. What are your thoughts and feelings about using the feedback program?
2. How accurate would you describe the feedback in assessing your clients?

3. How has the feedback program influenced your treatment planning?

4. Please describe step by step, in detail, how you use the per session assessment and feedback.

During the second series of interviews the counseling practicum students were asked the same questions as the first interview, with one additional question.

5. Since the last time we talked, during the first interview, have you noticed any changes or had any new ideas regarding the feedback program?

On the 15th week of the semester the clinical mental health counseling practicum students completed an exit survey on their experience of the research study (found in Appendix S). Clinical mental health counseling practicum students interview questions can be found in Appendix E.

**Practicum Instructors**

The practicum instructors were interviewed once during the 14th week of the semester. The 14th week was chosen due to its location at the end of the semester, and to allow the instructors to have a full semester’s worth of interactions with the feedback program. During the interviews the practicum instructors were asked the following questions:

1. What are your thoughts and feelings about using the feedback program?

2. How accurate would you describe the feedback in assessing your student’s clients?
3. How has the feedback program influenced the process of treatment planning with you and your supervisee?

4. Please describe step by step, in detail, how you use the per session assessment and feedback to inform your supervision practices.

5. Please describe how receiving weekly feedback logs on your student’s clients helped inform your classroom instruction.

6. Did your class have any in class discussions about the per session assessment and feedback program; if so what were these discussions about?

On the 15th week of the semester the practicum instructors completed an exit survey on their experience of the research study (found in Appendix T). Practicum instructor interview questions can be found in Appendix F.

**Member Checking**

The process of member checking is a fundamental way to ensure the credibility of qualitative interviewing findings (Lincoln & Guba, 1985). Member checking involves prior full transcription and analysis of the interview data before taking this data back to the participants to ensure its accuracy. Researchers typically query participants about their interview transcripts and the themes the researcher initially finds. Participants are asked if the themes make sense, if the themes have been developed with sufficient evidence, and if the themes are accurate and realistic (Creswell & Miller, 2000).

In order to keep the member checking process consistent between participants the researcher followed the following procedure. The researcher first began by contacting the participant to set a date to meet. During the established meeting the researcher began...
by explaining the purpose and rationale of member checking, to help the researcher explore the themes that were created from the participant’s interviews, and establish a credible link between the transcription data and the theme discovery process. The researcher brought in the themes established during the open and axial coding sequences of the data analysis, along with the full transcription data from the interview. The researcher then began going over each theme, drawing links with the participant’s transcription data. After each theme the researcher asked the participant if the theme had stayed consistent with the participant’s intended meaning. If the participant agreed the theme was consistent, the researcher then moved on to the next theme. In cases when the participant disagreed with the researcher’s identified theme, feedback was elicited from the participant, and then was incorporated into the theme to make it more consistent. If the theme was unable to be altered to be truer to the participant’s experience and transcription data, the researcher would then move on from the theme telling the participant that it would be reorganized and brought back to the participant at a future date. The researcher then planned to contact the participant in the future to go over the restructured theme following the procedures identified above.

Before conducting the member checking meetings with the participants the primary researcher fully transcribed both interviews for the clinical mental health counseling practicum students and the single interviews of the practicum instructors. Upon completing the transcriptions the researcher wrote a detailed narrative of each individual interview, which included the significant statements of the interview, the themes and meaning statements extrapolated from the interviews. The participant’s
description of how he or she used per session assessment and feedback in the treatment of clients was recorded in great detail in the interview narrative write up. The researcher checked with each participant that their detailed description of how they used the per session assessment and feedback was complete and was missing no relevant detail. The description of when the researcher conducted member checking with the participants can be found below.

Clinical Mental Health Counseling Practicum Students

Following the practicum students’ interviews, the researcher fully transcribed the interviews and scheduled meetings during the 8th and 12th week of the semester to read over the transcript with the interviewees. This timing was chosen to give the researcher adequate time to fully transcribe the practicum students’ interviews.

Practicum Instructors

Following the interviews with the instructors, on the 14th week of the semester, the researcher scheduled a meeting to review the fully transcribed interviews. These meetings were scheduled for the 16th week of the semester to allow adequate time for the researcher to fully transcribe the interviews. A full procedures schedule is located in Appendix G.

Instruments

The Outcome Questionnaire 45 (OQ 45) is a brief self-report measure that assesses clients’ current symptomatology. It can be completed in 5–6 minutes. The OQ 45 was designed to be given multiple times throughout counseling to help track a client’s progress during counseling from first session to termination. The OQ 45 contains three
subscales and a full scale. The subscales are symptomatic distress, interpersonal relations, and social role. The full score represents the sum of all the subscales, and is used most often to monitor the overall treatment progress during counseling. The OQ 45 has 45 items that are rated on a 5-point Likert scale. Scores can range from 0 to 180; higher scores suggest higher rates of disturbance (Lambert et al., 1996). A sample of the OQ 45 can be found in Appendix H.

The symptomatic distress scale measures psychological symptoms taken from the 1988 National Institute of Health (NIMH) epidemiological survey. This survey showed that in the general public, one third of patients report to counseling with an affective disorder, whereas another one third report to counseling with an anxiety disorder. The OQ 45 symptomatic distress scale was loaded with questions relating these two symptomatologies and left the other one third for various other psychological symptomatology (Lambert et al., 1996).

The interpersonal relations scale measures client’s interpersonal problems. The scale is sensitive to interpersonal distress and has items that relate to problems with friendships, family members, and intimate partnerships (Lambert et al., 1996).

The social roles scale measures issues in the client’s life related to his or her level of dissatisfaction with employment, family, and leisure roles. This scale was based on the assumption that a client’s satisfaction or dissatisfaction with his or her social role can affect his or her ability to have positive interactions in work, in meaningful relationships, and activities related to fun (Lambert et al., 1996).
The OQ 45 was normed using two reference populations: a not in counseling group, and an in counseling group. The not in counseling group consisted of 424 college undergraduates at a large western university, and the community group consisted of 102 clients from the community drawn randomly from nearby cities around the university. The representation of clients involved in counseling included 504 clients who were in counseling with a psychologist through the employee assistance programs of several states. One hundred clients were from a local community agency, and 76 were from the university counseling clinic (Lambert et al., 1996).

Reliability

The OQ 45 has good test/retest reliability and internal consistency reliability scores. Test/retest reliability was determined by administering the OQ 45 to 157 undergraduate students, and 21 days later, administering the measure again. The test/retest reliability coefficients were: full scale (r = .84), symptomatic distress (r = .78), interpersonal relations (r = .80), and social role (r = .71; Lambert et al., 1996). The internal consistency values were determined by using Cronbach’s alpha. The Cronbach’s alphas were: full scale (α = .93), symptom distress (α = .91), interpersonal (α = .74), and social role (α = .71; Lambert et al., 1996).

Validity

The OQ 45 had good concurrent validity with general psychiatric symptom assessments assessed by the General Severity Index (GSI) of the Symptom Checklist 90-Revised (SCL-90-R; Derogatis, 1977; r = .78, n = 115); and symptom specific measures such as the Beck Depression Inventory (BDI; Beck, Steer, & Garbin, 1988; r =
the State-Trait Anxiety Inventory (STAI; Dreger & Brabham, 1987; \( r = .64, n = 115 \)); the Zung Self-Rating Depression Scale (ZSDS; Zung, 1965; \( r = .88, n = 71 \)); and the Zung Self-Rating Anxiety Scale (ZSAS; Zung, 1971; \( r = .80, n = 71 \)). The interpersonal scale was validated using the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988; \( r = .63, n = 238 \)). The social role scale was validated using the Social Adjustment Scale (SAS; Weissman & Bothwell, 1976; \( r = .62, n = 71 \); Lambert et al., 1996).

**Scoring Procedures**

The OQ 45 is scored by keying in the values of each item on the measure into the software bundle, the OQ Analyst. The OQ Analyst then adds all the items together and computes the full scale score and each subscale score. The OQ Analyst then computes the color-coded feedback by comparing the client’s current score against the client’s initial score and current session number. The OQ Analyst has internal algorithms that compute if the client’s score falls within the range of scores consistent with the expected recovery curves of treatment. Color-coded feedback is provided on the client’s current progress in therapy based upon algorithms that determine their current treatment status (Lambert et al., 1996). The four color-coded feedback messages include:

**White:** The client’s score is similar to populations not engaged in counseling, consider discussing new treatment goals or consider discussing the gradual discontinuation of counseling services.

**Green:** The client is making adequate change during treatment, no recommendations for altering treatment plan.
Yellow: The rate of change the client is making is less than expected, compared to normative data on clients who have been in treatment for this period of time before. Consider altering or intensifying the client’s treatment, or the client may make no significant improvement during counseling.

Red: The client is not making any progress during counseling, consider altering treatment dramatically, reformulating the plan of action, intensifying treatment, or seek a referral for a psychiatric evaluation. The client may be at a higher risk for dropping out of treatment or at risk for having a negative treatment outcome.

(Lambert, Whipple, et al., 2001, p. 55)

A sample interpretation from the OQ Analyst can be found in Appendix I.

Decision Rules

The OQ 45 uses cut off scores derived from Jacobson and Truax (1991) Reliable Change (RC) Index. The OQ 45’s RC score was computed by comparing normative data of a population of non-patients who took the OQ 45 ($N = 1353$) against the scores of clients entering treatment ($N = 1467$). The resulting RC score was found to be 14 points, suggesting that clients whose scores either increased or decreased on the OQ 45 by 14 points were thought to have made reliable change (Lambert et al., 1996). Lambert, Whipple, et al. (2001) determined that the OQ 45 score that would serve, as a cut off, between normal and dysfunctional populations was 64. This was close to one standard deviation above the mean of non-patient sample ($M = 45.31, SD = 19.42$).
Data Analysis

Qualitative Interview Data Analysis

Following replication logic, the data were analyzed in a way that explored within and between similarities and differences of the participant’s interview data (Yin, 2009). Using NVivo 8, the qualitative analysis software, the researcher uploaded all interview data and used the software to help detect these similarities and differences within and between participants on all three participant levels. The different levels of participants defined for this study were the practicum students, and the practicum instructors.

Replication logic for multiple case study design suggests that the researcher analyze every case by itself first and write a data analysis summary. This data analysis summary is similar to open coding strategies of qualitative data analysis. Open coding, a procedure of grounded theory research, was developed by Strauss and Corbin (1998). During this stage each participant’s data analysis summary is reviewed in detail to identify key statements and themes that arrive from the participant’s answers to the interview questions. After each participant’s data analysis summary was reviewed they were then compared to each other, seeking similarities across themes.

During open coding the researcher engaged the participants who were interviewed within the process of theme development. This was performed during the member checking procedures described above. The participants were asked to corroborate the themes the researcher discovered through the interviews, and clarify and expand themes as needed. Participants who disagreed with the interpretation of the interview data were invited to explore multiple interpretations of the interview data with the researcher. The
researcher and participant then co-wrote the theme to encourage a collective understanding and validity of its meaning (Creswell, 2007).

The researcher then utilized axial coding techniques (Strauss & Corbin, 1998) to compile similar themes and meaning statements into categories. Axial coding allows researchers to view the connections between the participant’s individual statements into one similar bundled meaning category. During this phase the researcher investigated the participant’s data analysis summary for contradictory statements that disconfirmed the unifying category formations. These statements and themes were seen as evidence that were contradictory and used to help reformulate the categories, adding to their credibility.

To ensure the credibility of the emerging categories and themes the researcher consulted a peer reviewer, independent from the study, who had received training in advanced qualitative research methodology. The IRB board approved the peer reviewer. The peer reviewer reviewed the category and themes taken from the participants’ interviews and rated their accuracy on a scale from 1 to 4. Armstrong, Gosling, Weinman, and Marteau (1997) found that inter-rater reliability was a reliable method that helped to improve the validity of the themes. The ratings used by the raters were:

1. The theme was not at all consistent or true to the participant’s statement.
2. The theme was somewhat not consistent or true to the participant’s statement.
3. The theme was somewhat consistent or true to the participant’s statement.
4. The theme was very consistent and true to the participant’s statement.

The researcher reviewed the peer reviewer’s rating and reorganized any themes that rated below a 2. Consistency of the theme was determined based upon the accuracy of the
theme as it related to the transcription and interview data. Following this revision the researcher resubmitted the contested categories and themes, integrating the feedback from the peer reviewer, and had the peer reviewer rerate them. This process was replicated until the researcher and peer reviewer were in agreement. Agreement was defined as both the researcher and peer reviewer’s ratings being above a rating of 2, based upon the rating scores described above.

The researcher then used selective coding procedures (Strauss & Corbin, 1998) to organize the data. Selective coding allows researchers to compare the categories from the axial coding stage of data analysis and relate them to one another. Comparing categories of themes between each other added to the understanding of the data and helped further refine the categories. The final categories of themes are outlined during the results section of the study.

**Quantitative OQ 45 Data Analysis**

The OQ 45 data was used as a triangulation source to help corroborate the interview data. Attention was paid to particular data points that showed the recovery curve of treatment. The OQ 45 data provide a change trajectory for each client; by comparing the baseline OQ 45 score of each client with their final session OQ 45 score, the researcher was able to determine a numerical value of how much change a client made. However comparisons of the individual change scores of each client to different clients are difficult to explore due to the ipsative nature of the measurement. The researcher used the individual change scores of the clients that each therapist served during the qualitative interviewing, asking about instances where large change scores
occurred. While there existed no control group comparison in this study to isolate the effects of the feedback on the client change score, the researcher explored narratively how the feedback might have been related to such pronounced change within clients.

The collected data of the clients completed per session OQ 45s were entered in SPSS 18 to analyze the descriptive data relating to the average amount of change. The average change score was computed by subtracting each client’s baseline OQ 45 score from their final session OQ 45 score. The client’s average baseline OQ 45 score was compared to the client’s last OQ 45. To measure the difference between the average baseline and final session OQ 45 score the researcher conducted a student’s $t$ test. See Appendix U for a complete Data Analysis Flow Chart.
CHAPTER III

RESULTS

The previous chapter outlined the specific methodology of this study. This study investigated the use of per session assessment and feedback by clinical mental health counseling practicum students and practicum instructors involved in teaching and supervising the practicum students enrolled in the practicum course. The researcher used a multiple case study qualitative research design to answer the following research questions:

1. How do clinical mental health counseling practicum students use per session assessment and feedback from the OQ 45?

2. How do practicum instructors use per session assessment and feedback from the OQ 45 provided to their students?

This chapter outlines the results of the investigation. It is divided into three sections. Section one includes participant demographic and exit survey data. Section two includes a review of the quantitative and qualitative data analysis. Section three includes the main themes and subthemes taken from the analysis of the interview data, and specific client responses that highlight the themes and subthemes.

Participants

Five clinical mental health counseling practicum students, and two practicum instructors who supervised the clinical mental health counseling practicum students, participated in the study. The age range for the clinical mental health counseling practicum students were between 23 and 67 years of age. The clinical mental health
counseling practicum student’s number of direct service hours before beginning the study ranged between 21 to 54 hours. The practicum instructors were 42 and 48 years old and had between 300 to 400 reported hours of direct supervision experience. From this point forward in the chapter the term participants refers to the five clinical mental health counseling practicum students and the two practicum instructors combined. The clients who were served by the clinical mental health counseling practicum students are referred to as clients. A full representation of the participants’ demographic data can be found in Table 2.

**Quantitative Data Analysis**

Upon completion of the study each participant took an exit survey found in Appendix S and T. The clinical mental health counseling practicum students’ exit survey questions were:

1. I found the per session assessment and feedback helpful and informative.
2. The per session assessment and feedback accurately reflected my client’s progress per session.
3. The per session assessment and feedback influenced my treatment planning and interventions with my client.
4. I would use the per session assessment and feedback again in my routine clinical practice.

The practicum instructors’ exit survey questions were:

1. I found the per session assessment and feedback helpful and informative during supervision.
2. The per session assessment and feedback accurately reflected my supervisee’s clients progress per session.

3. The per session assessment and feedback influenced treatment planning and intervention choice for the client during supervision with my supervisee.

4. I would use the per session assessment and feedback again in my routine clinical supervision practice.

The clinical mental health counseling practicum students and the practicum instructors answered each question on a scale from 1 to 5 with 1 as Strongly Disagree; 2 as Disagree; 3, Neither Agree or Disagree; 4, Agree; and 5, Strongly Agree. Table 4 represents a depiction of the average answer to each question by the clinical mental health counseling practicum students and the practicum instructor.
### Table 4

*Exit Survey Results*

<table>
<thead>
<tr>
<th>Clinical Mental Health Counseling Practicum Student</th>
<th>Average Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I found the per session assessment and feedback helpful and informative.</td>
<td>3.66</td>
</tr>
<tr>
<td>2. The per session assessment and feedback accurately reflected my client’s progress per session.</td>
<td>3.33</td>
</tr>
<tr>
<td>3. The per session assessment and feedback influenced my treatment planning and interventions with my client.</td>
<td>3.66</td>
</tr>
<tr>
<td>4. I would use the per session assessment and feedback again in my clinical routine.</td>
<td>3.66</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practicum Instructor</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I found the per session assessment and feedback helpful and informative during supervision.</td>
<td>3.5</td>
</tr>
<tr>
<td>2. The per session assessment and feedback accurately reflected my supervisee’s clients progress per session.</td>
<td>4.0</td>
</tr>
<tr>
<td>3. The per session assessment and feedback influenced treatment planning and intervention choice for the client during supervision with my supervisee.</td>
<td>3.5</td>
</tr>
<tr>
<td>4. I would use the per session assessment and feedback again in my routine clinical supervision practice.</td>
<td>3.5</td>
</tr>
</tbody>
</table>

The clinical mental health counseling practicum students and the practicum instructors made several comments when asked on the exit survey to: Please give any suggestion to how you might like to see the per session assessment and feedback differently in the future. A review of the only three comments can be seen below.

1. Excellent Instrument, thank you.
2. I think that the assessments were very helpful, but I was uncertain about a few components and how to explain them, maybe include a short training on how to explain assessment to client, very helpful tool though.

3. Possibly more specific to the clients presenting problem, if not suicide or substance abuse have mood disorder or distorted thinking, as a category to monitor.

The researcher collected information about the clients served by the clinical mental health counseling practicum students during their practicum. The information collected included each clinical mental health counseling practicum student’s average number of clients, average number of sessions, and the average amount of change produced by their clients on the OQ 45. Only clients who had more than one session were presented in the data analysis during this study. A presentation of each counseling practicum student’s client figures can be found in Table 3.

As illustrated in Table 3, Jane’s four female clients ranged in age between 21 and 27 years. The number of sessions that Jane had with her clients ranged from 2 to 9. Caroline had 3 males and 3 females as clients. Her clients’ ages ranged between 22 and 60 years. The number of sessions that Caroline had with her clients ranged between 2 and 6. Elisabeth had 3 female and 1 male client, ranging in age between 19 and 28. The number of sessions that Elisabeth had with her clients ranged between 3 and 8. Fitzwilliam had 1 female and 1 male client. His clients were 20 and 38 years of age. The number of sessions that Fitzwilliam had with each of his clients was 3 and 6. Kitty had 2
female and 1 male client. Her clients’ ages ranged between 19 and 28. The number of sessions that Kitty had with her clients ranged between 3 to 8 sessions.

The client change number was calculated by subtracting the end of treatment OQ 45 score from the client’s baseline measurement. For this study the average number of clients seen by the clinical mental health counseling practicum students was 3.6 (SD = 1.14). The average number of sessions for the clients in this study was 4.3 (SD = 2.31). The average age for the clients in this study was 25.4 (SD = 8.9). Of the 20 clients who participated in the study, 17 were Caucasian and 3 were African American. The average baseline OQ 45 score for the 18 clients, who had both baseline and final OQ 45 scores, was 63.4 (SD = 18.8); the average final session score was 47.7 (SD = 18.7). To measure the difference between the average baseline and final session OQ 45 score the researcher conducted a student’s t test. The formula for a student’s t test is:

\[ t = \frac{\bar{x} - \mu_0}{s / \sqrt{n}} \]

The amount of client change in counseling during the study was significantly different at, \( t(18) = 2.52, p = .017 \). The finding that clients who were served by the clinical mental health counseling practicum students left counseling significantly less symptomatic than before they entered is important because it serves as an excellent reference in which to judge the validity of the OQ 45 feedback system. Several studies have documented that the OQ 45 measure is sensitive to client change and improvement (Shimokawa, Lambert, & Smart, 2010). The OQ45’s sensitivity to client change helped add more validity to the qualitative inquiry about its usefulness in this study. During the interviewing and
qualitative analysis the OQ 45 feedback forms were used frequently to open up discussions on specific client’s movement during counseling, and as a source to triangulation the themes derived from the qualitative analysis

**Qualitative Data Analysis**

The clinical mental health counseling practicum students in this study were interviewed twice during the semester. The practicum instructors were interviewed once during the semester. They were only interviewed one time because they spent considerably less time using the OQ 45 feedback.

Once the clinical mental health counseling practicum students and the practicum instructor had been interviewed, the researcher transcribed their recordings. The recordings and transcriptions were then reviewed together to ensure accuracy. Once all the interviews were fully transcribed and reviewed, the researcher uploaded the transcriptions into NVivo 8, a qualitative research software program on May 28, 2011. NVivo 8 assisted the researcher by allowing the transcription data to be organized per participant and interview number. NVivo 8 also assisted the researcher in highlighting key statements in the transcriptions, as well as adding memos and annotations to them.

The researcher began the open coding portion of the data analysis by reading over each interview transcription in order, starting with the first interview followed by the second interview. The researcher highlighted all the significant statements in the interviews and coded each highlight about what it entailed. For instance, Elisabeth’s statement, “Just knowing that we are going somewhere, we are doing something and there is proof,” was highlighted and coded as quality assurance. This statement was coded as quality
assurance because the statement showed that the clinical mental health counseling practicum student thought she was able to see, using the OQ 45 measurement and feedback, that what she was doing in session was effective and helpful.

After the researcher completed the highlighting and coding of the transcriptions, the peer reviewer and the researcher merged statements into similar themes and meaning statements. The researcher and peer reviewer used a rating system on a scale of 1 to 4, to determine the consistency of the theme and subthemes to the participants’ interview statements. The ratings the raters used were

1. The theme was not at all consistent or true to the participant’s statement.
2. The theme was somewhat not consistent or true to the participant’s statement.
3. The theme was somewhat consistent or true to the participant’s statement.
4. The theme was very consistent and true to the participant’s statement.

The researcher reviewed the peer reviewer rating and reorganized any themes that rated below a 2. The rating level 2 was chosen because it was believed that anything below a 2 was an unrepresentative depiction of the participant’s statements. Consistency of the theme was determined based upon the accuracy of the theme as it related to the transcription and interview data. Following this revision the researcher resubmitted the contested categories and themes, integrating the feedback from the peer reviewer, and had the peer reviewer rerate them. This data analysis process known as axial coding helped the researcher and peer reviewer unify the themes to help support each other and also worked to separate out themes that had little backing elsewhere or did not fit logically into the themes and subthemes.
Following the axial coding the researcher and the peer reviewer organized the themes into similar categories and meaning statements. For example, the researcher found several themes that centered around the perception of feedback. The subthemes included in that theme were uncertainty, integration, and client’s experience of feedback. This process was the first phase of selective coding. The researcher and the peer reviewer used the same rating system described above to place the themes into the categories. Once the subthemes were placed in the themes they were brought back to the participants for member checking. The researcher signified which theme and subtheme each participant’s interview data was entered into, and asked the participant if the theme and subtheme had stayed consistent with the participant’s intended meaning. If the participant agreed the theme was consistent, the researcher then moved on to the next theme. In cases when the participant disagreed with the researcher’s identified theme, feedback was elicited from the participant, and then was incorporated into the theme to make it more consistent.

The above analysis yielded the following themes and subthemes. Theme 1 was titled Perception of Feedback. This theme included three subthemes that explored the perceptions that the clinical mental health counseling practicum students began to use the feedback and integrate it into their work with clients. Theme 2 explored the clinical mental health counseling practicum students’ and practicum instructors’ application and use of the OQ 45 measurement and feedback. The subthemes explored how the participants in the study used the feedback, how the feedback was used during treatment planning, and how it was used during supervision. Theme 3 explored the mechanisms of
the feedback and how they were used by the clinical mental health counseling practicum students and practicum instructor. The subthemes detailed how certain areas of the feedback measure were used, specifically the visual representation of the client’s progress, the red warning flags, the critical item status areas, and the ability to track the effectiveness of the client’s treatment. Theme 4 discussed instances when the clinical mental health counseling practicum students received differing or discrepant feedback on the OQ 45 than what they perceived in session with the client. Theme 5 explored specific suggestions that the clinical mental health counseling practicum students and practicum instructors gave to improve the measurement and feedback system.

Description of Results

Theme 1: Perception of Feedback

This theme described the participant’s perception of using the OQ 45 feedback, and their perceptions of their client’s experience of taking the feedback weekly. The participants began the study feeling skeptical and uncertain about the feedback system, but after continued use began to feel more comfortable with the feedback, and began to integrate it more into their counseling sessions. The clinical mental health counseling practicum students described that their clients were accepting of the routine measurement with the OQ 45, and found it helpful once they began to get the results back during the session. A representation of Theme 1 can be seen in Figure 1.
Figure 1. Theme 1: Perception of Feedback

**Uncertainty.** While most of the participants endorsed favorable reactions to giving the OQ 45 and receiving feedback, some described early feelings of uncertainty and skepticalness while beginning to use the feedback program. During the participants’ Practicum I class, they were not exposed to using any type of feedback program. For instance, when Fitzwilliam was asked his initial thoughts about the feedback program, he remarked:

I felt a little uncertain because I didn’t really know what all it entailed and also thought about the client because when they get the questionnaire I wondered how long the questionnaire would take for the client or what would their feelings be towards it, but I found that the questionnaire wasn’t that long, and you’re able to
pull out information from it to make it meaningful, I’m glad it gave me an
opportunity to be able to use it and convey more information to the client and also
to help build that relationship, while being able to let them know that you’re
coming into counseling and we’re trying to make it as effective as possible.

Other clinical mental health counseling practicum students shared similar
reactions that dealt with their skepticism and uncertainty about the implementation of the
feedback into their sessions. Often participants described their uncertainty relating to
their uneasiness of having their clients evaluated by a routine assessment and feedback
measure. Elisabeth described:

I think the results are really interesting to be honest, but I was concerned when I
heard about it, I was worried it was going to show how horrible of a counselor I
was, like if I harmed the client or anything like that, so that was my first concern.

Elisabeth also stated that she felt uncertain about the timing the feedback was given, and
what it may capture:

I guess like when the client is in session, depending on what they talk about, it
kind of influences how they take the measure, during that session, so if something
is heavy in session, then they are going to maybe feel more down or upset.

The clinical mental health counseling practicum students’ concerns were related
to inexperience using the measure and were often resolved as the participants gained
more experience. Most participants were cognizant of their early uncertainty and found
ways to compensate. Although uncertainty was prevalent early on, most participants
overcame it as their experience grew while using the instrument and feedback.
Examination of the exit surveys on May 28, 2011, showed a dramatic shift towards acceptance and integration of the feedback into the participant’s clinical work. The second subtheme within this category explored the participants’ acceptance of the feedback program and the process by which the participants began to rely on the feedback.

**Integration.** This subtheme explored examples of the participant’s integration of the feedback program, specifically their process of implementing the feedback into their routine clinical practice, and how they learned to trust the feedback and see it as useful. For instance Elisabeth developed a less skeptical view of the feedback than she described above when she revealed that:

I was very nervous at the beginning, I thought my gosh, they are going to rate me and how my progress as a student is going. I guess it helped to see the first graph and the first print out of it. I think that helped see how it is going to look. Also, like the clients that I saw, they had good progress, and I do feel more comfortable with it now definitely.

Often the clinical mental health counseling practicum students would observe the direct benefits of feedback, and begin to see the feedback as not just another instrument that added extraneous information, but as a tool that was relatable to what they were observing in session. Described above, Elisabeth observed the connection between the graph and the progress her client was making (decreasing scores on the OQ 45). The other clinical mental health counseling practicum students described what they thought helped them begin to see the feedback as useful and begin to see its utility in their
treatment of clients. For instance Kitty described in her second interview how she integrated the feedback into her major treatment decisions:

I still feel like it’s been very helpful. So that’s still the same. Since I have a longer timeline now, I can see more progress. It has helped me see what fluctuates, like the critical item status, some weeks it’s high, and sometimes it says sometimes, and sometimes it says rarely [she is describing the critical item status section of the feedback]. So that’s helped me monitor weekly feelings with him [one of her male clients].

Kitty’s client had several sessions where he endorsed suicidal ideation, both verbally in session, and on the feedback. Kitty went on to describe that she was able to add credibility to her judgment of his severity during the weeks she saw him, by comparing what she observed in session to his scores on the feedback.

While some participants like Kitty benefited directly from the OQ 45 feedback in her decision-making, other participants like Jane reported she integrated the feedback program to help her make sure that her interventions were effective:

Well, I like using the OQ 45 and feedback because to me it is easier to see my effectiveness on paper opposed to, as I said with [one of her female clients] it is like okay what do I have to do different. Is there something I can help her with? With [another one of her female clients], she definitely represents what she brings to session. She is better with her anxiety and she is learning to organize herself and actually stick to her organization, and so with that it [the feedback] has been basically mirroring how I have pictured her progressing.
Jane described that her different clients progressed on the feedback in unique ways; this allowed her to determine how to better tailor her interventions in upcoming sessions.

The clinical mental health practicum students described that integration of the feedback involved giving back the feedback to their clients. Fitzwilliam described how his integration of the feedback mirrored his client-focused approach. Fitzwilliam brought the completed feedback from the previous session to all of his clients’ sessions. He discussed that this helped him engage his clients more actively during treatment.

Fitzwilliam described:

I think that it’s very helpful because it allows clinicians to be able to convey what the information means because a lot of people, they take assessments and never get information relayed back to them. They never know the meaning of it, so it helps the client understand that the information is meaningful and it’s relevant to them, so I think that it gets the client more interested in filling out the information.

Fitzwilliam expressed that the majority of times when he shared the feedback with his clients, he had good reactions and felt they appreciated the time he took to do it. The third theme of this category is client’s experience; it related directly to the participants’ descriptions of how their clients perceived and experienced taking the OQ 45 weekly, and getting the results a week later.

Client’s experience of feedback. The clinical mental health counseling practicum students reported through their interviews that their clients, who participated in the study, had favorable reactions while engaging in the feedback program. No clinical
mental health counseling practicum student stated that their clients ever had large objections to filling out the measure. Elisabeth noted the opposite reactions in a few of her clients:

I have forgotten to give it to them and they have asked for it, I’ve had like two or three clients ask me to take it at the end, because sometimes I’m really bad about remembering it. They will say, do I need to fill that thing out again, and I’ll say oh yeah, yes you do thank you. They actually seem pretty interested in it too.

Elisabeth explained in more detail that one of her clients was uncertain of taking the OQ 45 measure at first, but than became more engaged as he received the feedback from the counseling practicum student. Elisabeth stated:

One of my clients, he was a little unsure about what the whole research project was about . . . He asked more about it and I don’t know if it was that session or the one after that where I showed him the graph and kind of explained to him this part [the graph] and I explained the critical item status. I do not think that was ever a concern for him, but I guess just having him see it was helpful, I think he is very visual learner.

Clients who might have felt uncertain about taking the measure might have been further reassured when they were given chances to observe what progress they had been making during sessions. Often the clinical mental health counseling practicum students described that they attempted to translate the measure and to give back information to clients answering any questions that they might have had to continue to reinforce the client’s interest in filling out the weekly OQ 45. Fitzwilliam reported that giving back the
feedback to the clients was useful because it made the client more aware of what was going on during the course of counseling. Fitzwilliam stated:

   It is a very interesting way to connect with the client. For example a client came in during midterms, she was really stressed out. So when I explained that her OQ 45 score went up prior to the last week I could tell by her nonverbals she wanted to know what that meant. So I explained the information to her and what was different. I also asked her questions. The next week she filled it out and she was done with midterms and her distress level went down.

   Fitzwilliam continued to explain that he and his client were able to see an observable indicator that described her stress and anxiety, and that this helped the client and himself see that this feedback had some credibility in measuring the client’s changing distress levels.

   The clinical mental health counseling practicum students continued to describe how giving back the feedback to their clients became an important aspect in their therapeutic process. Kitty expressed that she saw the feedback as therapeutic. The following segment illustrates a client who scored very high and had received a red feedback color code during his previous week’s session. Kitty had prepared to discuss the high response during supervision and with the client when he arrived for the next session. Kitty explained the incident:

   I really didn’t need to bring it up with him. In this case he brought it up first, so he was aware and he thought about it all week. He was like, I thought about it all week and when coming in. It was interesting how that affected him throughout
the week. He said, “I thought about it all week” and I came in and that was the first thing he said before he even sat down, so it was interesting to me because I said, “I’ve brought it with me, we’re going to talk about it.” And he responded, “I figured.” He was aware and he’s had a lot of insight and I think that instrument helped him.

The clinical mental health counseling practicum students explored their clients’ reactions towards the feedback when the clients were going through termination. The feedback proved to be especially helpful as the clients could relate their progress during counseling to the graph of their session scores. Kitty discussed two closing sessions and how using the feedback impacted them:

Yeah, [deleted client’s name] was definitely like, Oh yeah, this is working . . . As the sessions went by, she [the client] was unsure. So she was not shocked, but almost surprised or excited to see it [seeing the feedback] was indeed going down showing she had made progress. With [deleted client’s name], he knows that things are changing. But for him to actually visualize it, its was good for him, or to hear it from someone else . . . [Kitty described what she explained to the client] I have noticed that this, this, and this have changed. He needs a lot of affirmation that way. So seeing his amount of change, for me on the charts and seeing what has physically changed for him, it has been helpful for me to give that feedback to him.

The feedback was impactful to both the clinical mental health counseling practicum students and the clients. It allowed the clients to become much more engaged in the path
their treatment was taking, and gave the clinical mental health counseling practicum students more confidence to explore how well their interventions with their clients were working.

**Theme 2: Application and Use**

The theme of application and use explored how the clinical mental health counseling practicum students used the feedback program in their routine clinical practice. Attention was paid to the process that each participant used from the moment they received the feedback form, to the time they took it back in with the client. The clinical mental health counseling practicum students discussed the routines they used with the feedback system during their treatment planning and supervision. George and Charles (practicum instructors) described how they utilized the feedback the clinical mental health counseling practicum students received and how they used it to influence their supervision processes. A representation of Theme 2 can be seen in Figure 2.
Figure 2. Theme 2: Application and Use

Process of using feedback. The clinical mental health counseling practicum students individualized how they used the feedback from the OQ 45; however, most of them shared similar experiences. The OQ 45 feedback form was designed to show different types of information in different locations. The OQ 45 feedback form contained four sections, the graph areas, the most recent critical item status area, the color feedback section, and the subscale and total score section. The graph area charted the per session progress of the client; it provided a line graph of the clients’ per session OQ 45 score, and showed what type of feedback color coding the session had. The next most commonly referenced area was the most recent critical item status section, which showed the clients’ response to questions on the OQ 45. These questions related to substance abuse, suicidal ideation, and work place violence. This section showed what the clients’ most recent OQ
45 questionnaire response for question #8 (suicide), “I have thoughts of ending my life;” #11 (substance abuse), “After heavy drinking, I need a drink the next morning to get going;” #26 (substance abuse), “I feel annoyed by people who criticize my drinking;” #32 (substance abuse), “I have trouble at work/school because of drinking or drug use;” #44 (work violence), “I feel angry enough at work/school to do something I might regret.”

The other area of the feedback most often discussed was the color feedback alert status section. The color feedback discussed the client’s progress during counseling and reported if the client had made expectable progress or was deteriorating. The color feedback was divided into the following messages:

- **White**: The client’s score is similar to populations not engaged in counseling, consider discussing new treatment goals or consider discussing the gradual discontinuation of counseling services.
- **Green**: The client is making adequate change during treatment, no recommendations for altering treatment plan.
- **Yellow**: The rate of change the client is making is less than expected, compared to normative data on clients who have been in treatment for this period of time before. Consider altering or intensifying the client’s treatment, or the client may make no significant improvement during counseling.
- **Red**: The client is not making any progress during counseling, consider altering treatment dramatically, reformulating the plan of action, intensifying treatment, or seek a referral for a psychiatric evaluation. The client may be at a higher risk for
dropping out of treatment or at risk for having a negative treatment outcome.

(Lambert, Whipple, et al., 2001, p. 55)

Another section of the feedback form was the OQ 45 subscales. This section provided information upon the total OQ 45 score and the three subscales of symptom distress, interpersonal relationships, and social role. The subscale area included separate norm information that pertained to the outpatient and community norm populations.

The clinical mental health counseling practicum students reported that the graph region on the OQ 45 feedback was one of the first places that drew their attention. The line graph was centrally located on the page and provided a clear picture that showed the client’s current score, and how it related to previous session scores. Jane described how she used the feedback form when she first received it:

Well when I receive it back I look at the graph first, then I look at where they [her client] are at with the color feedback [pointing to the alert status section], I see if it’s in the normal zone or if there is something I need to really worry about, especially like this suicidal or homicidal questions, to see if we need to assess any of that stuff [suicide or substance questions] in next session. Then I look at where they are going and what they’re wanting to accomplish in counseling, and also what they’re treatment plan was, and I try to see if we are kind of moving in the right direction, evidenced by the graph and stuff, and then I check to see if there’s anything I need to like bring up in session [she was looking at the client answer sheet for responses that were especially high].
Jane developed a procedure early on in the study that allowed her to evaluate the feedback once it was received and developed a system for implementing it into her treatments. Her procedure stayed consistent even towards the end of the study when she described,

Well I definitely go on alert status. I kind of look at that and then I look at the recent critical items, and then I look at the graph too because I am trying to process all the other stuff to see where they are at on the graph.

Kitty discussed a process that was similar to Jane’s. Kitty’s process entailed:

First, I look at the graph and see where they went. If they went down, then I’m happy. If they went up, I’m like okay I need to look into that. Then I read the feedback [the feedback message below the graph] to see what exactly the graph is saying, and then I look at the color coded feedback area to see if they got green, white, or red feedback. I then look at the critical items, and finally the subscales.

The clinical mental health counseling practicum students often described that their routine process of using the feedback was more tailor fit for specific clients who may have required more intensive monitoring. For instance Kitty described that for one of her clients, who endorsed suicidal ideation for several sessions, she frequently examined critical item status section when she received the feedback back. Kitty explained:

Usually once I get the feedback and I check out the critical item status areas, it kind of helps me see what I’m going to do. So in [deleted client’s name] case, the suicide and the substance abuse questions, those are things that we talk about every week. I go in there, we talk about substance abuse, we see how much
progress he’s made and looking at the chart, I want to see if his number have come down . . . So it’s helped me to see if what we’re talking about is going on in his head.

The two areas used often on the feedback were the graph area and the critical item status areas. During the study the participants overwhelmingly endorsed the usefulness of the graph. Caroline described that graph was most useful to her; she discussed that it provided an easy and quick way to observe the progress of her clients, because often she felt very busy and immersed in the workload of her many clients. Elisabeth similarly described the usefulness of the graph. Elisabeth described:

Honestly, it is just a real quick way of seeing how both of our progress has been [her and the client], and, I think the next thing I go to is this [the critical item status]. I feel like this is a critical part whether anything changes or not. I feel that if the critical item status areas change that would be something I have to address at the beginning of the next session.”

The clinical mental health counseling practicum students reported that the most recent critical item status section on the OQ 45 feedback forms were helpful because they were reassuring and helped them feel that they did not miss anything in session. They also reported that it gave them insight into the severity of the client’s presenting problem and helped them structure their treatment planning.

**Treatment planning.** The clinical mental health counseling practicum students’ descriptions of how they used the feedback provided a glimpse of how they used the feedback to inform their treatment plans. The participants often reported that the client’s
progress on the feedback was tied directly to their process of creating new treatment plans and evaluating the effectiveness of treatment plans in place. Jane reported early during the study when she was just beginning to use the feedback:

I think it will influence my treatment planning like a good bit honestly, for example if your working with a client and then you do a treatment plan, and then you go and reassess or redo another treatment plan, and you have a bunch of discrepancies between what they are presenting to you and what is on the feedback, you know you can bring it up in session and confront them about it or see if there might be something deeper to work on. I think it'll be good overall because your getting to those deeper issue a little bit quicker, and you have a little more support or evidence for them, like this [the OQ 45 feedback] has been showing that you have been having been feeling very distressed for the last three weeks, we should find new ways to work on that in session.

Jane discussed how she viewed the link between being able to track the progress that her client was making and her client’s goals and objectives on his or her treatment plan. Being able to identify with the client the correct treatment goal and objective was essential to effective treatment. Jane continued to describe her experience of treatment planning towards the end of the study:

I think with that it’s been good [the feedback], it’s been good because it kind of backs up where we [her and the client] are going and what they are doing right now. Like it shows that I’m kind of going in the right direction with her. And like with [names a client], I think okay maybe I should step this back, and
reevaluate really where we are going, and how we can keep her progressing further.

Other participants found the feedback to be helpful in the creation of treatment planning. Developmentally treatment planning and case conceptualization can be difficult steps for beginning counselors, so adding a tool, like the OQ 45 assessment and feedback to aid the beginning counselors was helpful. Elisabeth described how the feedback helped her improve her treatment planning skills:

For the treatment plan, honestly many of my clients are not very sure what they want to focus upon in session, that’s been a really big struggle, I think that is where I find the feedback most helpful, because I can assess and rule out if the client has any suicidal ideation, or may have a substance abuse disorder. So depending on how they respond to these questions I know that it is something that I might want to focus upon, and bring up to her in session.

The critical item status and the graphs were large contributors to the treatment planning process. The clinical mental health counseling practicum students described that they were most helpful by allowing them and the client to know how the sessions had been going, and if the clients had made any change. Being able to share the feedback with the client was also a beneficial step in treatment planning. Fitzwilliam described an instance when he shared feedback with one of his clients.

I think that it’s been helpful to him because he’s able to look at those numbers [points to the graph on the feedback], and in the past session when he came in and was telling me that he’s concerned about being able to handle big projects and his
ability to turn them in on time for his job. So the last session he was like well I handled it pretty well and I felt like I didn’t get stressed out as much, that was part of his treatment plan . . . I’m able to relay the numbers back to him, like his distress level was this amount and I’m able to tie it in with the treatment plan with what kind of things he did to get it down, for it to be measurable for the client on the OQ 45.

During treatment planning the clinical mental health counseling practicum students described that they were able to make connections between the objectives and goals the clients were making with them, and the progress the clients were making in session. Often sharing this information with the client proved helpful because it produced an increased level of engagement for the client. Charles, the practicum instructor of four of the participants, described his view of the feedback for the participants as helpful because it let them see what they were doing, and was helpful and allowed them to build confidence in their skill. The participants were able to explore their client’s feedback within supervision often.

**Supervision.** During supervision the clinical mental health counseling practicum students described that they were able to review the clients’ progress with their practicum instructor to gain additional insight about where to go. The clinical mental health counseling practicum students and the practicum instructors described that the feedback was not a cumbersome portion of the time spent together; rather, it was beneficial because it provided common discussion points about each client. Fitzwilliam discussed how he and his practicum instructor Charles discussed the feedback during supervision.
We look over the case notes, the treatment plans, and we reflect about what’s in the case notes and treatment plans, I’m able to say well, the client, she met a new friend or she did well on her test, and she’s looking to get a 4.0.

Often participants were able to briefly review clients who were on track, making expectable gains and getting consistently lower OQ 45 scores, and also discuss clients who needed more attention, warranted by red feedback flags, or critical item status reports that showed suicidal ideation or substance abuse concerns. Charles, the practicum instructor, backed up the brevity of the feedback in supervision, reporting:

I think the supervision was really pretty brief. We talked about it a good deal when we got started and we went over it and they had all sorts of questions about what do I do because they said this but that’s not what this says. And then they just sort of took to it and now they come in and they’ve gone from long question and answer sessions to like hey, I saw this in here and I can’t wait to ask my client . . . I think it gives them a little bit of backbone for that mild confrontation for the client and where they can feel like they are not out there in limbo saying “seems to me that,” they can say “I just wanted to talk about this. I noticed you said everything seemed to be going pretty good in this one area, but when you filled this out [the OQ 45] it seemed that you weren’t feeling the same way. Could you tell me a little more about that?”

George, the practicum instructor of the other two clinical mental health counseling practicum students, described that he viewed the feedback as beneficial because it allowed him to streamline his supervision activities. George described the
feedback as a tool that allowed him to briefly gauge the progress of each client, helping him decide which clients to discuss in supervision, and what tapes to observe during supervision. The feedback was also useful as a learning tool for the entire practicum class. Charles described that in group supervision typically done with the entire class, once in awhile the feedback would be beneficial to share with the group. Charles described:

We certainly talked about making use for the both of them [the clinical mental health counseling practicum students] and for their clients [described last group supervision] we talked about Caroline’s case and I had everyone take a look at the feedback and we watched the session, it gave them a sense of its usefulness.

Oftentimes when the participants were uncertain about the feedback or had large discrepancies on what they observed in session or what was on the feedback, the participants used supervision to clarify their impressions, or to get another source to confirm the discrepancy. Jane discussed using supervision to clarify the feedback for one of her clients.

I go over with Charles [her practicum instructor] like okay first, she [her client] seems to be in the normal range, it seems like she is presenting on paper and in person like the same. And with the other ones it was like okay, she’s not presenting the same so, and that was weird so let’s see what’s going on. We kind of discuss what I should do about that, and whether to confront her not.

In other instances the clinical mental health counseling practicum students discussed that they knew they need to get supervision and figure out where to go with a
client, when they begin to feel at a loss for what to do next. Kitty explained that in supervision for one particular client she asked her practicum instructor:

What’s my next step especially with [one of her male clients] because his number was so high on the chart; I just wanted to make sure because I knew there was something going on. I wasn’t positive if his distress was this high, but now that I have something written down [the OQ 45 feedback form], what’s my next step? How should I use this? Can I take it to the client and let him see? These types of questions have helped me with how I’ve used the feedback system.

Supervision was impacted through the use of OQ 45. It appeared throughout the participant’s interviews that the OQ 45 provided them with direction in supervision, and worked as a first step for the clinical mental health counseling practicum students to follow up with the client, or decide who to discuss in supervision.

**Theme 3: Feedback Mechanisms**

This theme explored the feedback mechanisms of the OQ 45 per session assessment feedback. The feedback mechanisms are in the order of the frequency the clinical mental health counseling practicum students and practicum instructors reported. For instance the clinical mental health counseling practicum students all reported that observing their client change visually on the graph was one of the key benefits of participation in the study. For clinical mental health counseling practicum students who received red flags of their client’s progress, they described these red feedback flags as helpful, based on the fact that they knew immediately to reevaluate the case and take it into supervision for consultation. The critical item status area was the other most
beneficial tool for the participants. Lastly, the ability for the clinical mental health counseling practicum students to track their effectiveness they reported as helpful because it helped them observe the direct relationship between the work being done during counseling, and their clients’ increased functioning. A representation of Theme 3 can be seen in Figure 3.

![Figure 3. Theme 3: Feedback Mechanisms](image)

**Visual cue of client performance.** The participants discussed several advantages of the graph feature of the feedback sheet. The graph was centrally located on the page, and drew participant’s attention immediately upon looking at the feedback. Caroline described her experience as:
Well, once again I’m concentrating largely on the graph. I looked at the other areas, but sometimes things are happening so rapidly . . . Visually, it sets it right up, this is tremendous because it tells me that I’m seeing he increased here and then decreased. And as we referenced earlier, he’s increasing a little bit toward the end here. That tells me something. And that tells me that, in this case, I do know that it’s his classes. In this situation, he is taking five classes, which is a pretty big load for him because he’s also been diagnosed with ADHD.

Looking at the direct relationship between previous sessions and the most recent session was a quick and efficient way to monitor the progress the client made. This was helpful because all of the clinical mental health counseling practicum students were in training and often described difficulty gauging their clients’ progress during counseling. Elisabeth described how the feedback impacted her ability to learn to track client’s progress better:

For me I think it’s kind of difficult to see it [the client’s progress], I think I would have rather had them state it, so that it’s really clear to me. Personally to just observe it [the client change on the feedback measure], without that I don’t think I would have noticed it as well, so the feedback helps out a lot for me.

Kitty described a similar feeling as Elisabeth; she reported uncertainty in some situations where she was unclear about how well her treatment was working for the client. Kitty described the difficulty of gauging her clients’ progress especially when her clients appeared to plateau with their progress in session. Kitty expressed relief that all
the work she and her client did in session was represented, even if that work was unobservable at times in session. Kitty described this:

> It’s actually been really helpful, especially with this particular client because I was going in there thinking I’m not doing anything with her because we’re kind of stagnant, so seeing visually on the chart that something is working even if it’s just her [the client] coming in and spilling it; it’s kind of helping me see that even though I feel like I’m not doing something, something is happening. So it’s been really helpful and positive to see it graphed out and actually in writing.

Another area the participants reported as helpful was the red warning feedback messages. These messages arrived when clients scored in a way that was significantly higher, more distressed, than previous sessions. The red feedback signaled that the client had deteriorated during counseling and needed immediate attention before the client discontinued counseling services.

**Red warning flags.** These messages would be given out based upon the feedback algorithms incorporated in the OQ Analyst software. The participants received red feedback if their client completed the OQ 45 and had a score that was exceedingly high related to their previous session scores. Only two participants had clients during this study that received red feedback during a session. Kitty had a client who received red feedback twice, and Jane had a client who received red feedback once. In all three of these cases, the researcher, after he scored the client’s OQ 45 measure, called both participants, each time, to tell them that one of their clients needed their attention immediately, and that they should consult with their practicum instructor before seeing
the client again. Kitty described her experience of receiving a red feedback warning for one of her male clients:

With [male client’s name], after I got the feedback I expected feedback that was going to be high, but I was like, that’s really high. I didn’t expect it that high. So it allowed me to see what the severity of it was, which was nice. So the next session I went in I was like, Okay, [client’s name] we need to talk about this, and he was very aware of what he had put down. He even came in and said, yeah, I was thinking all week, I knew you guys would be wanting to talk to me about this since I said some really extreme things. He explained that it was how he was feeling that day . . . After this we processed what he was feeling that day, because those thoughts were coming up.

Kitty explored her experience in supervision with the client who received the red feedback warning. Kitty explained that in supervision she asked:

What should I do? Where do I need to go? What do I need to check on besides suicide ideation? What are some other things I can do or bring up that would be helpful? So it was nice to discuss the red feedback in supervision.

Jane described the same experience of being surprised when she got the phone call from the researcher, but reported feeling relieved because she knew that her client was in such high distress, and because it gave her time to prepare for the next session. Jane discussed that she knew the client was very upset and stressed the previous session because she used the complete session to process through a traumatic experience she had the week of the session. Jane reported that following the red feedback spike that her
client returned to her normal range, and continued to make subsequent improvement in session. The client’s statement was validated by her client’s continued decreasing scores on the OQ 45 during counseling. The next area the participants described utilizing was the area on the feedback named critical item status. This feedback mechanism reported the client’s response to questions that pertained to suicidal ideation, substance abuse, and work violence.

**Critical item status area.** The participants reported that the area of the feedback form named critical item status was particularly helpful in assessing the likelihood of suicidal ideation, homicidal ideation, and substance abuse concerns in their clientele. The participants reported that this area was not used to substitute for any clinical assessment, but instead acted to reassure the counselor if these concerns were present or not. Jane detailed that she thought it valuable not only for herself but also to the client. Jane reported:

> I think it’s helpful because it’s easier [for the client] to mark on paper sometimes if they are one of those things [suicidal or substance abuse], then it is to tell someone one of those things face to face. So I think it is a good thing for our clients to have.

Kitty shared the same opinion as Jane did on the usefulness of the most recent critical item status areas. Kitty explored her thoughts on the benefits from the critical item areas stating:

> The critical item status brings it right up in my face. Even though in session they might not be talking about it, verbalizing it, it’s still on their mind. So this [the
critical item status] has shown that. Even though they’re not saying it out loud, those thoughts are still there. Sometimes clients are like, I have thoughts but I’ve never done anything. So they’re not going to bring up the thoughts that they have. So it shows that they’re having thoughts. They might not think it’s a big deal to bring them up to me, but maybe I should touch on that with them during the next session.

Caroline spoke to the benefit of the critical item status areas because she had two clients in her practicum experience that had been referred out for suicidal ideation. Caroline described wanting to be sure that she could identify critical items like suicide and substance abuse in all of her clients. Caroline described her thoughts about the critical item areas as:

I have had two clients that we referred out because their concerns were so great that they needed 72 hour monitoring. So that is something as a counselor I want to be able to see, and I want to be able to see it immediately. This gives me that opportunity to do that. Because then that sets the stage and tells me I need to be on top of it. I need to be prepared, not that I wouldn’t be prepared. But it tells me how to be prepared.

The clinical mental health counseling practicum students discussed that the critical item status areas helped them in their treatment planning and monitoring of the clients’ progress towards their goals. This was especially true if the goals identified aspects related to the critical item status areas like alcohol or drug abuse, or reduction of suicidal ideation. Elisabeth explained:
I think it is useful [points to the upper most recent critical item status areas on the feedback form], because they are really simple to read. I think that knowing all of that stuff [points again to the boxes], it’s really easy to incorporate it, or leave it out, if it is not a problem, while doing the treatment plan. I think that has been the most helpful, because I think, treatment plans are difficult for me. So having that help, whatever amount it does, even if its just a little it, it makes it more clear in the treatment plan.

A reoccurring point that emerged from many of the clinical mental health counseling practicum students was their view that the items on the OQ 45 feedback form, such as the red flags, most recent critical item status areas, and the graph area, represented helpful tools that aided in their practice of counseling. The participants suggested that the OQ 45 feedback served as a quick reminder of key tasks and progress indictors that related directly to their client’s weekly sessions. The tool also gave the clinical mental health counseling practicum students an additional level of assurance that related to their ability to track the effectiveness of what they were doing in session. This benefit, especially for beginning counselors, was helpful because it allowed the clinical mental health counseling practicum students to make direct connections between what actions they took during their counseling sessions, what their client was doing, and how the relationship was forming. The subtheme that explored this area was titled quality assurance.

**Quality assurance.** This subtheme explored the clinical mental health counseling practicum students’ reactions to tracking their effectiveness with their clients. Tracking
their effectiveness entailed looking through the client’s progress in session routinely, and making sure the client was gaining an observable benefit from counseling. If the clinical mental health counseling practicum students found that clients were not progressing, a requirement of quality assurance entailed checking in with clients about their progress, or reworking treatment plans and intervention strategies. Kitty described her reactions to being able to track the progress of her client as:

I think definitely doing this has given me the confidence that yes; I’m doing something right. So it’s been good feedback, not just for my clients but also for me. Hey, I am doing something. If something comes up on the form, it like hey, maybe I should pay attention to this. I’m more comfortable to ask it, to get the feedback I want from the clients, getting the information I want without prying or trying to get them to talk about things they don’t necessarily want to. But I would say, “Hey, I noticed on your feedback form that you’re getting better,” the feedback is a helpful way to bring up things.

The benefit from seeing that her interventions were helpful encouraged her to continue to seek out what was working with the client, so she could discuss how to do it more to increase the client’s benefit from counseling. Kitty described how before she often had little evidence to suggest the client was improving or was gaining benefit from counseling at all. Relying on only verbal self-report in session may not have demonstrated as clearly, or operationally, if and how much a client was gaining benefit from counseling. Kitty described this process as:
It’s not a stab in the dark. So you might have a feeling that something’s going on, but without having evidence behind it, it’s harder to go for it. So I guess this is my evidence. Hey, there’s something going on, let’s talk about it.

Fitzwilliam described his use of the measure as quality assurance, which was beneficial to the client. Continuous improvement from the perspective of a counselor trainee was beneficial, because it gave him an avenue to evaluate per session what had been helpful and other things that had not been. This ability to tie outcome in counseling into a more direct feedback loop helped him isolate effective aspects of his counseling style. Fitzwilliam described this as:

I think that as a clinician in a training facility . . . we might think like what are we doing in session, what are we supposed to do with these clients? So honestly that’s one of the things I thought about when his [the client] score had went up [on the OQ 45, this suggests worsening symptomology], but when I was able to talk to the client and he was able to think about what actually went on during that session. He [the client] stressed that he had several midterms during that week. Fitzwilliam discussed that he was able to give that feedback to the client, of observing how his [the client’s] stress increased over the midterms. Fitzwilliam went on to describe how he felt picking up on these little things in session, like the midterms the client discussed, as essential moments that should not be missed, because they allow for therapeutic growth. He spoke about the quality assurance piece of the measure:

As clinicians we have to take responsibility and we have to do our best in these sessions so that we don’t leave the session thinking that there’s something we
could’ve done better, even though there may have been areas where we could have. When we look back at the feedback, we say I could’ve did this better, I could have did that better. I think the feedback might allow us to go into each session, giving it our best.

Caroline described her process of quality assurance similarly because it made her aware of what wasn’t working and encouraged her to try new directions:

I think, here again, it’s another opportunity to say, gee, this is really working; or maybe, perhaps, I need to review the treatment plan that I’ve prepared for the client; or, perhaps, even, I may need to even move into a different direction to even achieve what is going to be best for them.

The participants described themselves as having the ability to receive feedback and to integrate it into their practices of counseling. Caroline discussed that her past career utilized satisfaction surveys with students, and that she complied the results and gave the information over to her boss. Caroline reported that:

I understood the concept [the process of assessment and feedback] early on; it was just getting back into the business of it all. I feel I took it and ran with it [using feedback during counseling]. My paradigm shifted years ago, I believe I mentioned to you, in terms of quality, and to be honest with you, that’s something I’m going to miss, I’ve really learned to become adaptive with feedback, and grab hold of that and run with it. And I’m going to miss the feedback. I think it’s very effective.
Jane reported that she felt comfortable early on while getting feedback and relating it to her practice. She said, “I have always been open to feedback, especially like something that is going to help me become better.” Elisabeth discussed her early fear of the feedback and what it might say, and how later she learned to adapt to it.

I guess how I respond to feedback, sometimes I don’t like it. I do think it could be helpful absolutely. I think the feedback that I have gotten in practicum has been helpful, absolutely. I feel like I have also noticed it myself, like oh I need to focus on this more, focus less on this. I think I am open to it absolutely, even if I might not always want to hear it.

During Elisabeth’s final interview she commented, “I think as time has gone by, I have become a little bit more accepting of feedback. Like I want that feedback rather than, oh gosh what is it going to say.” Elisabeth felt more comfortable integrating the feedback and described looking forward to the results after each client session. The participants’ view of the feedback as helpful in tracking their effectiveness wavered on several assumptions; first, the participants had to be open to receive feedback, without getting overly anxious. Second, the participants had to value what the feedback was saying and see it as relatable to treatment. Lastly, the participants had to be able to relate what they saw on the form to how they perceived their client during session. For example, the participants who observed their client as very distressed and miserable during session, and then received feedback that suggested the client was well and was not distressed at all, often had considerable questions as to the measure’s validity, or to how truthful the
client was being in session. The participants described this phenomenon several times during the study; these instances became the next subtheme titled discrepant feedback.

**Themes 4 and 5**

These themes were important and frequently discussed during the interviews; however during coding had few analogues to accompany them. Theme 4 explored instances when the clinical mental health counseling practicum students found that the results they received back on the OQ 45 feedback form were much different from what the perceived the client would likely answer. The clinical mental health counseling practicum students described that they believed their clients were either under representing how symptomatic they felt in session to the counselor and then reporting more symptomology on the OQ 45 feedback, or vice versa. Theme 5 described suggestions the clinical mental health counseling practicum students and the practicum instructor gave the researcher about how they would like to see the feedback program improved. A representation of Themes 4 and 5 can be seen in Figure 4.

*Figure 4. Themes 4 and 5: Discrepant Feedback and Suggestion for Improvement*
Theme 4: Discrepant feedback. This theme describes instances when the OQ 45 feedback was dissimilar to what the participants observed in session. Often this created confusion about what source of information might be more telling or accurate. Jane described a scenario when this took place. “This one client kind of gave me a different result than what she portrayed in session. In session she’s really upbeat, but it [the OQ 45] showed that she was really down on herself.” Jane further explored how she learned to compensate for some of these discrepancies:

I think it [the OQ 45] is useful, but I think that you can’t put like 100% of your clinical decisions in it, like based upon its face validity it would be easy for someone to kind of like misrepresent their scores, like if I say I am depressed I could sit here and I could check all these and say like I’m very depressed and I needed attention right now; however, I think it does add to session if someone is being honest, it seems to be accurate.

Kitty had a similar experience with the score on the OQ 45 feedback coming back different than what she had expected from session described instances where she knew that what the client put down on the OQ 45 might be significantly more severe than what she was actually feeling. She reported that:

I guess with [a female client] she is where she would be the most of the time, but sometimes her self-appraisal of what’s going on in her life, she does blow it out of proportion. But I’ve noticed she is feeling that distress, she just doesn’t talk about it. She masks it, and when we try to get at it, she just pushes it away. So that’s what I’ve noticed about her. So she might really be feeling this way, she’s just
not letting on. So this instrument has been helpful with that. Obviously, something is going on and she [the client] is not telling me. So we’re just going to keep at it, and she finally has opened up, so it’s been helpful for me with that.

Discussing discrepancies in session became a large subtheme closely linked with giving the client feedback. Clinical mental health counseling practicum students described that when they had discrepant feedback on the OQ 45 at first they were confused and unsure about the client’s presentation in session. However as time went on and the clinical mental health counseling practicum students began to feel more comfortable using the instrument they described that they would actively seek out the source of the discrepancy in the way the client filled out the OQ 45 during their next counseling session. Fitzwilliam, who was most consistent upon giving the client feedback about their OQ 45 scores, reported that when he first began using the feedback, he observed discrepancies on the OQ 45 feedback that encouraged him to bring the feedback to the client, to gain more clarity. This often led the client to open up more about their presenting concern. Fitzwilliam expressed that he believed that this allowed the client to observe how they might be incongruent in the way that they present their concerns during counseling, and about how they actually feel about them.

Even though discrepancies appeared between what the client reported during counseling and what they endorsed on the OQ 45 measure, the clinical mental health counseling practicum student reported that most of their clients had accurate assessments that coincided with what they had observed in session. Most clinical mental health counseling practicum students described that they had learned how to compensate for the
face validity of the measure, and learned to take into account the openness and honesty of the client in session, when reviewing the feedback.

**Theme 5: Suggestions for improvement.** This theme described the participants’ suggestions on how to improve the feedback program after a semester of routine use. The clinical mental health counseling practicum students and the practicum instructors gave the researcher many suggestions on how improve the feedback system. Caroline described that she thought the inclusion of a section that allowed the client to rate how well the counselor had been in servicing the client’s need might benefit the overall feedback loop. Caroline stated, “Something possibly, and this could be a bit too invasive, but something in terms of some kind of acknowledgment as to how successful the counselor has been in terms of serving the client with some kind of a response.” Adding a place for the client to rate the counselor’s effectiveness or as Caroline went on to explore the client perception of the strength of the relationship.

Elisabeth added that she thought that on the feedback form itself, the counselor should be able to add his or her comments. She explained, “I don’t know, maybe just a few lines for the counselor to put their impressions of the session.” Elisabeth discussed that she could place these comments on the case note, but that often in this study the feedback did not arrive directly after the session when she often did her case notes. Immediate feedback delivered through a computer in session may have allowed this type of commenting or documentation about the feedback to flow more fluidly between sessions.
Kitty added that she believed that she benefited from the critical item status areas most, and that she wished she could see more information besides suicide and substance abuse that detailed specifically if any changes had occurred between sessions. Kitty explained:

I guess it’s hard for my one client; she really struggles with balancing her mood. I guess it would be nice to see something about how that continuum is for her, that day. And I know that’s not a real critical item question like suicide, substance use, or work violence, but to her it’s very critical, her mood stabilization. How she’s feeling, because she was diagnosed with bipolar and she accepts that. But she needs help stabilizing that. So having a visual or some feedback on how she is stabilizing that would be helpful for me to work directly with her.

Kitty called for a more specific type of feedback based upon chosen symptomology marker like depression, mania, or anxiety. Charles, the practicum instructor of four of the six participants, discussed a similar suggestion. He described:

This might overly complicate things, but if you have someone [a client] come in and if you have their overall score, their presenting concern both in session and on the assessment is all about anxiety. Will there be a way to pull the anxiety responses and track those separately over time? So regardless of what’s going on in their life overall, you also get sort of a vision as to how they see their presenting concerns being managed.
Being able to track the overall progress of the clients through session and on their presenting problem might benefit counselors by opening up a macro and micro view of the client’s progress during counseling. Unfortunately, during the time of this study the researcher had no way to unpack particular item responses using the OQ Analyst software that scored the OQ 45 measure. Fitzwilliam shared his suggestions to include a response on the feedback that would suggest the client was answering honestly or perhaps faking good or bad. He suggested:

I like the feedback program because it keeps the client updated with what they’re doing. However one thing that I wonder about on the assessment could they fake their responses and if their scores are going up [suggesting worsening symptoms], then they [the client] may wonder if the counselor’s going to look at them like something is severely wrong, so that may impact the way they answer their questions the next time they take the measure.

Fitzwilliam described how he perceived clients answering truthfully most often when he would share their responses with them, during the next session. He suggested that giving the scores back in the correct context made the clients much less anxious, and helped them understand what higher scores really suggested.

**Summary**

This chapter reviewed the findings from this quantitative and qualitative analysis of the investigation on how clinical mental health counseling practicum students and practicum instructor used per session assessment and feedback provided by the OQ 45. The quantitative analysis of the counseling center clientele showed that the clients left
counseling significantly less symptomology than when they appeared, \( t(18) = 2.52, p = .017 \). The qualitative analysis of the clinical mental health counseling practicum students and practicum instructors revealed the following themes: (a) perception of feedback, which included the subthemes of uncertainty, integration, and client’s experience of feedback; (b) application and use, which included the subthemes of process of using feedback, treatment planning, supervision; (c) feedback mechanisms, which included the subthemes of visual cue of client performance, red warning flags, critical item status areas, tracking effectiveness; (d) discrepant feedback; and (e) suggestions for improvement.

The next chapter explores these themes, and relates them to the existing literature and on the benefits and limitations of using per session assessment and feedback. This research study’s limitations are also presented. The researcher concludes with the implications that per session assessment and feedback has to the field of counselor education, clinical supervision, and clinical practice.
CHAPTER IV

Discussion

This study examined how clinical mental health counseling practicum students and practicum instructors used per session assessment and feedback, and how using it influenced their treatment approach and their ability to monitor client performance, and assisted in the evaluation of the clinical mental health counseling practicum student’s skill development. The research questions were

1. How do clinical mental health counseling practicum students use per session assessment and feedback from the OQ 45?

2. How do practicum instructors use per session assessment and feedback from the OQ 45 provided to their students?

Summary of Results

The quantitative analysis of the counseling center clientele showed that the clients left counseling with significantly less symptomology then when they appeared, measured by the pre counseling to post counseling OQ 45 scores. This finding suggested that clients at the counseling center found the counseling they received by the clinical mental health counseling practicum students to be effective. The qualitative analysis of the interview data collected from the clinical mental health counseling practicum students and practicum instructors revealed the following themes: (a) perception of feedback, which included the sub themes of uncertainty, integration, and clients’ experience of feedback; (b) application and use, which included the subthemes of process of using feedback, treatment planning, and supervision; (c) feedback mechanisms, which included
the sub themes of visual cue of client performance, red warning flags, critical item status areas, and tracking effectiveness; (d) discrepant feedback; and (e) suggestions for improvement.

This chapter explores these themes, and relates them to the existing literature and on the benefits and limitations of using per session assessment and feedback. The researcher concludes this chapter with implications for clinical mental health counseling practicum students, practicum instructors and supervisors, and professional counselors, directions for future research, limitations encountered during the study, and a summary.

Interpretation of the Findings

The findings of this study suggest that clinical mental health counseling practicum students and the practicum instructors used the feedback program to augment the services they provided to clients. In the case of the clinical mental health counseling practicum students, the feedback program helped them during treatment planning and supervision, and by creating a feedback loop that allowed them to improve their counseling interventions. The practicum instructors used the feedback as an aid during supervision that helped them track how well their supervisees were doing, helped focus their attention to cases that needed their attention before ones that did not, and helped them add richer context and description to what was occurring in their supervisees’ clients. Outlined below is an interpretation of the meaning of the five themes.

Theme 1: Perception of Feedback

This theme explored the initial adaptation of the OQ 45 program by all the clinical mental health counseling practicum students and the practicum instructors. The theme
contained descriptions about how the clinical mental health counseling practicum students began the study uncertain about tracking their sessions using the feedback program, followed by descriptions about how the clinical mental health counseling practicum students began to utilize the feedback program. The last subtheme contained a description of how the clinical mental health counseling practicum students viewed their clients’ perceptions of using the feedback program. At first the clinical mental health counseling practicum students expressed anxiety about what the feedback might say about their counseling ability. As the clinical mental health counseling practicum students became more familiar with the feedback program, they expressed that they gradually learned to value its use weekly with their clients, and that it added to their confidence, showing that what they were doing in session with their clients was working. The clinical mental health counseling practicum students also expressed that they observed their clients valuing the feedback program as well, describing that it helped give the client a better perspective on their own progress in session.

The clinical mental health counseling practicum students’ report of anxiety and uncertainty when first using the feedback may have been due to the belief that the feedback program might somehow document their ineffectiveness as counselors. Daniels and Larson (2001) described that counseling trainees’ levels of anxiety and belief in their own self-efficacy as counselors fluctuate dramatically during their training. The anticipation of performance feedback during training, not knowing if feedback will be positive or negative, often raises counselor trainees’ anxiety and lowers their counseling self-efficacy. Schauer, Seymour, and Green (1985) explored the effect that observing a
counselor trainee’s session had on his or her anxiety level. They speculated that the use of live supervision or videotaping increases trainee’s current anxiety. This increase in anxiety can be detrimental to the trainee’s ability because it can reduce his or her ability to receive instruction, by not being open to suggestions, as well as decreases the trainee’s empathy and sensitivity in session. Schauer et al. suggested the anxiety might arise from thoughts of not doing well, anticipation of criticism, and perceived threats to self-esteem. The clinical mental health counseling practicum students may have experienced these same thoughts as they prepared for the study. These anxious thoughts listed by Schauer et al. might also explain the difficulty the researcher had in recruiting potential participants to engage in this study.

Even though the clinical mental health counseling practicum students described uncertainty about the use of the feedback program at first, all the participants later described it as useful during their routine counseling activities. These activities included administering treatment, treatment planning, and supervision. For instance Elisabeth stated that “I was worried it was going to show how horrible of a counselor I was, like if I harmed the client or anything like that, so that was my first concern.” Later, however, she reported, “It helped to see the first graph and the first print out of it . . . the clients that I saw, they had good progress, and I do feel more comfortable with it now definitely.” Schauer et al. (1985) described that when trainees begin to see success on a given task they begin to feel less anxious and more confident. The clinical mental health counseling practicum students began to adapt to using the measure when they saw that it provided information that what they were doing in session was productive. This ability to observe
their effectiveness with clients led to a greater willingness to use the feedback and to trust its results.

As the clinical mental health counseling practicum student used the feedback program more during their sessions, they all stated that it increased their confidence with clients. This increased confidence could refer to an increase in their counseling self-efficacy. Daniels and Larson (2001) stated that counseling self-efficacy could be increased through mastery experiences. These mastery experiences are periods when trainees observe that their behaviors bring them closer to their behavioral goal. The behavioral goal for the clinical mental health counseling practicum student was to be an effective counselor with each of his or her clients. Daniels and Larson described that once trainees can reduce their anxiety related to their performance and increase their self-efficacy, they can begin to focus on technique and personal style, rather than continually monitor how they believe they performed during the session. This developmental shift relates directly to the transition between stage 1 and stage 2 of the Integrated Developmental Model of Supervision (Stoltenberg & McNeil, 1998). During this transition period between stages 1 and 2, counselor trainees begin to decrease their anxiety levels in session, and shift from a preoccupation with what they are doing in session, to a focus on the client.

This shift towards stage 2 development was evidenced through the clinical mental health counseling practicum students beginning to describe more instances of how they were working with their clients, and more reports on what was occurring in their clients’ lives. When describing how they integrated the feedback program, the clinical mental
health counseling practicum students gave specific examples of how they used the per session assessment and feedback to benefit their routine practice. For instance Kitty described that the feedback program helped her with her treatment decision making; Jane described that it allowed her to check if her counseling was efficacious; and Fitzwilliam described that he used it to engage his clients more actively during treatment. While it can not be said for certain, by the methods employed in this study, it appeared that the feedback program was able to help the clinical mental health counseling practicum students reduce much of their anxiety by providing them with a window into their performance as a counselor, providing them with more mastery experiences, such as, seeing that what they did during counseling was efficacious.

The benefit of implementing a feedback program in training facilities was evidenced by the feedback program being used as a tool in counselor preparation that aided in reducing trainees’ anxieties, and providing them with specific examples of counseling mastery that helps to increase their self-efficacy. As counseling is often a nebulous process to begin with, the OQ 45 assessment and feedback might add an opportunity for trainees to reflect upon what they did correctly and focus more intensely on instances in which their interventions did not produce effects. Theme 2 explored this area more fully as it described detailed instances of how the clinical mental health counseling practicum students and their practicum instructors used the feedback program.

**Theme 2: Application and Use**

This theme explored how the clinical mental health counseling practicum students and the practicum instructors used the feedback program in their routine clinical practice
and supervision. The clinical mental health counseling practicum students discussed that they used the feedback system during their treatment planning and supervision. George and Charles (practicum instructors) described how they utilized the feedback the clinical mental health counseling practicum students received and how they used it to influence their supervision processes.

No study, to date, has explored how experienced counselors, counselor trainees, supervisors, or educators have used per session assessment and feedback during routine mental health services. Researchers of client focused research have focused on the pre-to post-test difference of clients’ scores, and the differences in client outcomes between counselors who use the per session assessment and feedback system and counselors who did not use the system. These researchers have found several examples of how counselors who use the per session assessment and feedback have overall greater outcomes with their clients than counselors who do not (Shimokawa et al., 2010). Lambert (2010) has focused heavily upon how per session assessment and feedback systems can serve as early identification systems that track clients as non-responders versus responders to psychotherapy. He suggested that, based upon overwhelming evidence that suggests counselors have poor predictive validity in assessing clients who do well in treatment against ones who do not, an assessment and feedback system can help improve a counselor’s ability to monitor the overall improvement of clients on the case load (Hannan et al., 2005). However, these studies are limited in their efforts to address broader benefits from using per session assessment and feedback because they only focus on quantitative methodologies. By using detailed observation and qualitative
interviewing, this study was able to capture a more detailed account of the experiences of users of per session assessment and feedback. Before this study it was uncertain how clinicians used per session assessment and feedback.

However, the results of this study showed specific ways that clinical mental health counseling practicum students and practicum instructors used the feedback program inside and outside of their counseling sessions. Most surprising was the use of the feedback during treatment planning and supervision. During treatment planning the clinical mental health counseling practicum students described using the feedback program not only to create goals and objectives, but to also track the clients’ progress towards them. Falvey (2001) described treatment planning as a process that flows from intake to discharge and includes activities such as gathering case information, analyzing that information, formulating case hypotheses, and enacting treatment decisions. Other common treatment planning activities involve understanding the client’s presenting problem, identifying treatment goals and underlying objectives, and planning specific interventions to address the presenting concern. Given complexity of most clients presenting concerns and the vast quantity of ambiguous information often makes treatment planning a challenging process (Falvey, 2001).

Researchers like Garb (2005) have attempted to understanding the cognitive process that clinicians use when treatment planning. He suggested that clinicians selectively screen information about a client, picking out what he or she attenuates to first and most often. Clinicians then make a general hypothesis about the client’s concerns based upon the information they initially screened. Depending on the cognitive
complexity and experience levels of the clinician, the hypothesis may have varying levels of fit and depth. Garb (1998) suggested that when presenting information is ambiguous clinicians engage in the use of cognitive heuristics like the availability bias, the most recent information is recalled first, or the representativeness bias, which suggests that judgments are made based upon how much the present case represents prior cases. These biases and the experience level of counselors can often reduce the accuracy of a clinical judgment. There exists several differences in the treatment planning process between counselor trainees and counselors with more experience. More experienced counselors tend to look at less data or information presented to them, but identify the relevant data more easily; whereas counselor trainees might contemplate more data, but have a harder time identifying the relevant aspects of it (Falvey & Herbert, 1992). Because the participants in this study were counseling trainees, the assessment and feedback system may have provided assistance in their treatment planning in the following ways. Having a measure like the OQ 45 that examined the client’s report of symptomology every session may have provided additional relevant client information from which the clinical mental health counseling practicum student were able to compare their personal assessments. The per session assessment and feedback may have also provided a safety net for the clinical mental health counseling practicum student who might have missed out on relevant information in session. Treatment planning was a collaborative effort at the counseling center between the clinical mental health counseling practicum student and the client. This allowed the clinical mental health counseling practicum student to bring the feedback to the clients allowing them to see the counselor’s perception of their
presenting concern. Bringing the feedback into the session can help create a triangulation effect during treatment planning based upon the client’s voiced concerns, the clinical mental health counseling practicum student’s perception of the client’s concerns, and the OQ 45 assessment of what types of symptomology the client presented with.

During treatment planning the continual inclusion of the feedback system during every session created a negative feedback loop that allowed the client and counselor to continually monitor the effectiveness of the treatment, or in cases when it was not effective the feedback loop created an avenue to change directions. This changing of direction during treatment planning included reassessing new information from the client and collaboratively planning new strategies to reach the new treatment goals.

The clinical mental health counseling practicum students endorsed that the use of the per session assessment and feedback system during supervision was helpful. The clinical mental health counseling practicum students explained that they often brought the clients’ feedback forms into supervision, checking in with their practicum instructors on clients who they saw were doing well. The clinical mental health counseling practicum students also discussed that they would bring up clients who they saw as being stagnant, not making any gains in treatment, or deteriorating, getting worse as treatment continued. The clinical mental health counseling practicum students described that using the feedback system allowed them to triage their clients in order of which ones needed attention in order of their severity of symptoms. The two practicum instructors in the study expressed similarly that the feedback program allowed them to note which clients to attend to first, and which clients to spend more time with during supervision, and in
During the study it was noted that as the clinical mental health counseling practicum students began to become more acquainted with the feedback program, they had less questions in supervision regarding what this feedback might mean, and more statements in supervision such as: this is how this client is doing after we discussed this in session. This may possibly point to the clinical mental health counseling practicum students beginning to utilize the per session assessment as a performance indicator of their interventions.

Supervision is an activity of routine clinical practice that encourages learning, self-reflection, and professional and personal growth. Borders and Brown (2005) described that feedback during supervision is an essential development tool. The authors suggested that regular and consistent feedback is the most effective, because it allows counselor trainees to become acquainted with feedback as an expected experience that trainees eventually grow to welcome. Having a continuous negative feedback loop allowed the clinical mental health counseling practicum student in the study to become more engaged in the reflection of their counseling ability. As most per session feedback in the study suggested, the clients were improving as expected; the clinical mental health counseling practicum student began to feel more comfortable that they were performing well in sessions, and they became more welcoming of feedback when it was suggested the client was not progressing as expected. The practicum instructors also discussed that they could use the per session assessment and feedback in classroom discussion because it added additional context and depth to conceptualizing the client’s cases. This finding is important because the Association of Counselor Education and Supervision has
recently released (April 11th 2011) a Best Practices in Clinical Supervision Guide that will help supervisors determine how to set and maintain high standards for the supervision of counselors. These standards represent the suggestions or recommendations of some of the leading experts of clinical supervision in the Counselor Education community. A specific standard that relates well to per session assessment and feedback is Standard 3ci. This standard suggests that while giving feedback:

The supervisor helps the supervisee gather performance feedback from multiple sources (e.g., clients, peers, supervisors) using both informal methods (e.g., observation of clients’ non verbal responses) and formal methods (e.g., standardized assessments completed by the clients on a regular basis).

The standards suggest that performance feedback should be incorporated into routine supervision practices because it allows the supervisor to give feedback that incorporates multiple perspectives, mainly the supervisors, the clients, and an outside assessment.

Even though there is not yet direct research on the effect of performance feedback in supervision, Worthen and Lambert (2007) recommended the use of feedback during supervision, based upon their previous experiences of using it. The authors’ impressions of the use of per session assessment and feedback during supervision were as follows: (a) feedback provides a standard feedback mechanism that is beneficial to training, (b) feedback curbs overestimated benefits of therapy and helps predict client deterioration better than intuition alone, (c) feedback may provide information about the client that might be otherwise missed; supervisors can keep track of this information on clients from a second source, (d) the additional information the feedback program provides may help
supervisors and counselor make better decisions about treatment progress and direction than pure clinical intuition alone. The experiences of the practicum instructors and the clinical mental health counseling practicum student during this study showed that these recommendations were accurate and that per session assessment and feedback can be used to benefit the supervision process.

**Theme 3: Feedback Mechanisms**

The feedback mechanisms the clinical mental health counseling practicum students and practicum instructors reported were the visual cues of the clients’ performance, the red warning flags associated with clients who were deteriorating during treatment, the critical item status areas, and the ability to gauge quality assurance during counseling. As described earlier, the OQ 45 assessment and per session feedback provided a negative feedback loop that the clinical mental health counseling practicum students and practicum instructors could use during their routine practice. Feedback loops are based upon the tenets of control theory (Carver & Scheier, 1982). The negative feedback loop can be thought of a closed system, the end product of the system bleeds into the beginning of the system to continually assess the operator’s progress towards a specified goal. For instance, a common negative feedback loop is a thermostat. An operator desires a specified goal of a hotter room temperature. The operator turns the thermostat dial for a desired increase of 10 degrees. By turning the dial the operator turns on a furnace that blasts hotter air inside the room. Inside the thermostat is a thermometer that is linked to the control system. This thermometer measures the output of the furnace and compares its current temperature to the desired end point set by the operator.
Continual monitoring by the thermometer will show a gradual increase in room temperature; at the specified temperature, set by the operator, the system will shut off. This example best illustrates a negative feedback system where a continuous uniform effort by the furnace will produce the desired goal. During a negative feedback loop there can also be events that cause more changes in the original system. For instance in the above example if a door was opened and cold air blew into the room, the thermometer might read a decrease in temperature when it was expecting a continued increase. The thermometer might send a signal to the thermostat that the temperature is not increasing but decreasing and that more power to the furnace will be needed to reach the specified goal (Cianci, Schaubroeck, & McGill, 2010).

The feedback mechanisms associated with the OQ 45 assessment and feedback system worked similarly to the closed loop system of the thermostat. The client at the counseling center was the operator. The client set a goal during counseling to address his or her presenting concerns eventually leading to less symptomology. The clinical mental health counseling practicum student and the interventions used with the client can be thought of as the furnace. The OQ 45 per session assessment and feedback is the thermometer, as it continually assessed the progress the client was making towards his or her goal of less symptomology, and the per session assessment and feedback can be thought of as the loop that stretches back to the clinical mental health counseling practicum student to give them information based upon how much of the client’s symptomology has reduced during counseling. Figure 5 illustrates this negative feedback loop system.
Figure 5. The OQ 45 Feedback Mechanics: Negative Feedback Loop

Figure 5 shows that continuous evaluation of the client performance and the effectiveness of the clinical mental health counseling practicum student were conducted on a per session basis. The last subtheme, quality assurance, highlighted the benefits the clinical mental health counseling practicum student saw from doing this cycle every session. Most often clients had decreasing symptoms or stayed rather consistent
compared to their previous scores. However, several clinical mental health counseling practicum students had clients who triggered either yellow or red feedback on the OQ 45 suggesting they were approaching deterioration or had worsening symptomology based upon their previous session. In these situations the red warning flag was similar to an unexpected event to which the feedback loop would have to adjust. In the three cases during this study that clients received red feedback, their counselors were notified immediately to allow them ample time to prepare for the next session. Due to the immediate response from the clinical mental health counseling practicum students in each red waning flag situation, all three clients returned to their previous decreasing symptomology curve, making excellent progress by the end of treatment. Just like in the thermostat example the feedback messages provided the clinical mental health counseling practicum students with information needed to alter their current behavior to continue to reach the system’s specified goal.

Kluger and DeNisi (1996) suggested that in a negative feedback loop, when the assessment of progress made towards specified goal is determined to be incongruent, or in the case of the red warning flags, treatment was not progressing as expected, there will arise anxiety in the operator that will propel them to reduce this incongruence. In this study this process appeared as the clinical mental health counseling practicum students took extra steps to help their clients, when they received feedback that suggested their client was deteriorating, was stagnant, or was not making the types of improvement on the feedback the clinical mental health counseling practicum students expected. This incongruence between what the clinical mental health counseling practicum students
expected and what was occurring in session resulted either in increased motivation to try new or differing approaches during counseling, or led to the doubting of the OQ 45 assessment’s accuracy and clinical relevance. Theme 4, Discrepant Feedback, explored this doubting of the usefulness of the OQ 45 system in depth.

**Theme 4: Discrepant Feedback**

This theme described instances when the OQ 45 feedback was dissimilar to what the participants observed in session. Often this created confusion about what source of information might be more telling or accurate. This confusion often led the clinical mental health counseling practicum students to check in with their client to gain another source of information about his or her progress in counseling. The clients would often clarify what they meant on the feedback and that extra source of feedback would help the clinical mental health counseling practicum students to determine their continued course during counseling. During the study the clinical mental health counseling practicum students became aware of the face validity of the OQ 45 measure and how clients might over or under represent their symptomology. This phenomenon of discrepant feedback underscored the importance of clinical judgment when determining treatment decisions with any client. Unlike the thermostat example from earlier, the assessment of symptomology from a feedback measure like the OQ 45 is subject to bias and errors. Riemer et al. (2005) noted that effective performance feedback must (a) draw recipients into paying attention to it, (b) the recipients must accept the feedback, (c) recipients should be aware of its validity and reliability, (d) feedback should coincide with the recipient’s motivation to improve his or her task performance, and (e) the recipient must
be able to observe that the actions he or she is taking in performing the task are not consistent with reaching performance goals. When the feedback was in direct contrast to what the clinical mental health counseling practicum students saw, they began to alter their expectation of the validity of the feedback programs use. During this study the researcher chose to use the OQ 45 measure, this choice was made in large part because of the success the measure has had in other feedback studies, and because of its sound psychometric data. Even though there were a few occasions when the clinical mental health counseling practicum students experienced discrepant feedback, mostly they reported receiving fairly accurate accounts of their client’s progress. It appeared as if the clinical mental health counseling practicum students trusted the measure and the feedback program, because none of them ever stated that they entirely disregarded the feedback, rather they took steps in session to clarify the discrepant results. Checking in with the clients often yielded much more information about the state the client was in when filling out the OQ 45. The findings in this theme further confirm the characteristics of effective performance feedback, and give future researchers evidence that they should use well tested and validated measures in feedback programs if they hope to encourage their participant’s acceptance of the feedback program.

**Theme 5: Suggestions for Improvement**

This theme described the clinical mental health counseling practicum students and the practicum instructor’s suggestions on how to improve the feedback program after a semester of routine use. After routine use of the feedback program the participants had
several suggestions on how to improve the feedback program. Most notable were the following suggestions:

1. Add a rating scale for the client to give specific feedback on how well the clinical mental health counseling practicum student was meeting his or her needs as a client.

2. Add a rating scale that would give feedback upon the client’s perceived strength of the relationship between the client and the counselor.

3. Add a section on the feedback form where the counselor could estimate the accuracy of the feedback and their thoughts on it.

4. Include specific symptom related areas, which could be controlled by the user of the feedback, dependent on the client’s reported concern. For instance, a brief overview of the client’s anxious or depressed symptomology could be graphed on each feedback form.

5. Add a validity scale that could determine if the client was either over or under representing his or her symptomology.

These suggestions might be possible areas of study in the future, as new researchers begin the challenge of integrating feedback programs into routine mental health.

**Implications for the Counseling Community**

The results of this study and their links to the existing research point to new ways that per session assessment and feedback can be used with not only routine counseling, but also in training centers such as the one in which the study was conducted. The implications of the use of per session assessment and feedback were examined across the
following populations of the counseling community: clinical mental health counseling practicum students, practicum instructors and supervisors, and professional counselors.

**Clinical Mental Health Counseling Practicum Students**

The use of per session assessment and feedback offers a training advantage for clinical mental health counseling practicum students. When beginning to see clients for this first time clinical mental health counseling practicum students often have very little opportunities for feedback outside of supervision. This study suggested that the inclusion of the feedback program into the clinical mental health counseling practicum students’ training helped them gain confidence, decrease uncertainty about their effectiveness as a counselor, and helped them build collaborative relationships with their clients by sharing the per session assessment and feedback. The negative feedback loop was an essential element to the training features of the feedback program. Cianci et al. (2010) and Kluger and DeNisi (1996) argued that negative feedback loops are key ingredients in learning, as the loops provide continuous monitoring of performance and suggestions for improvement as recipients of the feedback alter their behavior to match their specified goals. This type of learning is helpful in a practicum class as students are encouraged to start learning more about their personal styles of counseling relying more upon the integration of the counseling skills they have learned.

**Practicum Instructors and Supervisors**

This study demonstrated that per session assessment and feedback contributed to the supervision process in the following ways: (a) allowed the clinical mental health counseling practicum students to triage their case load depending on which client may
have needed the most attention first, (b) allowed the supervisor to have an outside objective source of their supervisee’s clients progress during counseling, (c) allowed practicum instructors to easily identify what client sessions might need to be watched, provided that the supervisor had access to the session taping, and (d) allowed the practicum instructors to provide specific feedback to their supervisees based upon an objective measure.

This last contribution is important because according to the Association for Counselor Educators and Supervision Best Practices of Clinical Supervision task force, supervisors are encouraged to provide performance feedback to their supervisees based upon informal and formal methods of client evaluation.

**Professional Counselors**

This study’s findings are in support of implementing more per session assessment and feedback programs throughout the field of mental health counseling (Bickman, 2008). Bickman (2008) noted that in routine mental health counseling 90% of clinicians rely solely upon their clinical judgment of a client’s performance in counseling, even when an assessment of the performance was taken. A typical assessment of a client’s performance in routine mental health counseling offers little information to counselors, and mostly only reflects pre- and post-test score differences at intake and discharge. With systems in place that provide counselors with useful information within appropriate time windows, Bickman (2008) argued that to rely solely on clinical judgments of client performance, which studies have shown to have poor validity (Hannan et al., 2005), is a disservice to the field. Bickman (2008) suggested that if mental health providers utilized
more per session assessment and feedback programs, the gains would outweigh the possible costs of implementation.

**Limitations**

A limitation of this study may have been the face validity of the OQ 45. Clients may have misrepresented accurate profiles of themselves to the counselors. The clinical mental health counseling practicum students reported in the discrepant feedback theme that their clients often had scores on the OQ 45 that they perceived as incongruent to how the client was in session. While the amount of bias that clients may have had is largely unknown, the self-referral status of the clients may have lessened their desire to present overly good or bad.

Another limitation encountered in the study was the diversity of the types of counseling center clients who enrolled in the study. The study took no provisions to ensure that clients were new to the counseling center. Clients who were returning members to the university counseling center were free to participate in the study. Participants who were already actively engaged in treatment before entering the study were recorded in their current session number. The OQ Analyst is able to formulate accurate feedback messages based upon the number of sessions that the client has had. The researcher did not control for counseling center clients who may have differing levels of psychological disturbance and varying psychiatric disorders. The OQ 45 and the OQ Analyst are sensitive enough to account for ranges of psychopathology that present in the routine clinical practice of the average clinician (Lambert et al., 1996).
Another limitation was that the researcher did not enforce the clinical mental health counseling practicum students or the practicum instructors to use the feedback in their treatment or during supervision. The participants were free to use the feedback as they desired. To add to the possibility that feedback was integrated into routine treatment planning, the researcher described the per session assessment and feedback as a clinical support tool that was to be used to aid in the treatment decisions that counselors make in treatment planning, rather than a form that influences treatment nullifying the counselor’s and supervisor’s clinical decision making.

The sample size of the clinical mental health counseling practicum students and the practicum instructors was low. There were eight clinical mental health counseling practicum students who began the study; however, one was asked to discontinue half way through the study. The decision was mutual between the researcher and the participant, and was in regard to a family issue that arose in the participant’s life. The original research design called for the inclusion of doctoral supervisors as participants. The two doctoral supervisors who were available for inclusion declined the invitation to participate.

**Recommendations for Future Research**

This study was the first to have explored, using qualitative interviewing, how per session assessment and feedback was used by clinical mental health counseling practicum students and practicum instructors. Because this study was the first of its kind, it revealed several areas for future research. The researcher identified the following recommendations for future research involving per session assessment and feedback.
1. Replicate the above study interviewing more clinical mental health counseling practicum students to add to the credibility of the above findings. Previous studies on per session assessment and feedback have incorporated the feedback program as a routine treatment service, rather than just identifying a few eligible participants to use the feedback program. Future research might incorporate the counseling center using the OQ 45 feedback program for every client who seeks services. This would add to the overall amount of time that the feedback system is used, and provide more data entries with the OQ 45.

2. Include a measure at the beginning and end of the study that examines the clinical mental health counseling practicum students’ counseling efficacy and self-reports of their counseling ability. Daniels and Larson (2001) found that feedback had the ability to influence levels of anxiety and self-efficacy in counseling students enrolled in a basic skills course. The relationship between per session assessment and feedback is largely unknown. A feedback program may have the potential to decrease anxiety and raise self-efficacy during routine use.

3. Create a feedback measure to use in the feedback program that can isolate specific symptomology with which the clinical mental health counseling practicum student’s clients present. This might allow clinical mental health counseling practicum students to isolate the effects of their counseling interventions on targeted diagnostic symptoms.

4. Add a self-report measure that allows the client to rate aspects of the counseling relationship and how well the clinical mental health counseling practicum
student has attended to his or her needs. The ability for the counselor trainee to observe not only outcome ratings but also process data about the counseling session might further his or her development as a counselor. Counseling is often as much about the outcome as it is about the process, and allowing counselors in training to observe both could have impactful pedagogical implications.

The use of per session assessment and feedback is still an emerging tool in routine counseling practice. Continued testing in the future will help to distinguish its benefits and correct upon its limitations.

**Conclusion**

The purpose of this study was to explore, in depth, how per session assessment and feedback impacted the routine practice of clinical mental health counseling practicum students and practicum instructors inside of a university counseling center. This study included rich description about how these participants incorporated the use of the feedback system and found that per session assessment and feedback has a beneficial impact on practice. It was discovered that the use of the feedback program impacted treatment planning, and supervision positively, and created a negative feedback loop that appeared to help decrease anxiety and increase counselor self-efficacy in the clinical mental health counseling practicum students. While much further research is needed to validate these findings, it appears that per session assessment and feedback practices benefits far outweigh the cost and time of implementing such programs.
APPENDICES
APPENDIX A
PROCEDURE FOR CLINICAL MENTAL HEALTH COUNSELING
PRACTICUM STUDENT
Appendix A

Procedure for Clinical Mental Health Counseling Practicum Student

Initial non-intake session with client

1. Prior to session retrieve the informed consent documentation and the blank Outcome Questionnaire 45 and bring it to session.

2. Begin session by introducing yourself.

3. Complete the client session.

4. While finishing the session, instruct the client to complete the Outcome Questionnaire 45 in the room assigned for completing the OQ 45 by the researcher, and ask them to hand it into the Counseling and Human Development Centers front desk staff before leaving. If the client has any questions, please ask them about their questions now. If you do not know the answer please tell them to wait until next week to fill out the OQ 45 when you will have an answer to their question. Contact the researcher immediately following session to learn the solution to the client’s question about the measure.

5. Complete your case note for the client session.

Prior to session 2 and subsequent sessions

1. Consult the per session feedback packet included on top of your case note during in time before your supervision and before you see your client again.

2. If the per session feedback form identifies your client with either:

   Red: The client is not making any progress during counseling, consider altering treatment dramatically, reformulating the plan of action, intensifying treatment, or seek a referral for a psychiatric evaluation. The client may be at a higher risk for dropping out of treatment or at risk for having a negative treatment outcome.

   Or

   Yellow Feedback code: The rate of change the client is making is less than expected, compared to normative data on clients who have been in treatment for this period of time before. Consider altering or intensifying the client’s treatment, or the client may make no significant improvement during counseling.

   Notify your practicum instructors in person, or through the phone located within the Counseling and Human Development Center. Do not report any identifiable
information about the client over the phone; ask to set up a meeting with your practicum instructors to discuss the current client.

3. Discuss the per session feedback of every client in supervision.

**During session 2 and subsequent sessions**

1. Bring into session the client feedback messages form provided in your client’s chart.

2. Bring into session the new blank Outcome Questionnaire 45 provided in your client’s clinical record.

3. During the beginning of session explore the provided *client feedback messages form* included in your client’s per session feedback packet. You can explore this form with the client by bringing the form into session, however please place the *client feedback messages form* back in your client’s clinical record.

4. Proceed with the rest of the session.

At the end of the session give the client the new blank Outcome Questionnaire 45 instructing them to complete it, in the room assigned for completing the OQ 45 by the researcher, and then ask the client to drop it off with the Counseling and Human Development Centers front desk staff before leaving. If the client has any questions please ask them about their questions now. If you do not know the answer please tell them to wait until next week to fill out the OQ 45 when you will have an answer to their question. Contact the researcher immediately following session to learn the solution to the client’s question about the measure.
APPENDIX B
PROCEDURE FOR PRACTICUM INSTRUCTORS
Appendix B

Procedure for Practicum Instructors

**Weekly supervision session**

1. Prior to your weekly class time review the list of clients on your student’s caseload, who have received either a red or yellow feedback message. This list will be provided to you weekly in a printout that contains the names of the clients your student served that week, the client’s progress during counseling, and the color coded feedback message they received.

2. Review any client who may need direct attention during class as identified by the feedback system. Red or Yellow color coded feedback messages may suggest direct attention.
APPENDIX C
PROCEDURE FOR COUNSELING AND HUMAN DEVELOPMENT CENTER CLIENTS
Appendix C

Procedure for Counseling and Human Development Center Clients

First non-intake session

1. Please review the rationale for the current study and sign the informed consent to participate.

2. Continue with your regular session with your counselor.

3. Please take the Outcome Questionnaire 45 that your counselor hands to you post session and complete it in the room assigned to you. Complete the OQ 45 by the researcher, and then hand the completed OQ 45 into the Kent State University Counseling and Human Development Center (CHDC) front lobby window, before leaving.

4. Once the measure is complete please take it to the front desk staff member of the CHDC and hand it to them.

5. If you have any questions on the OQ45 please complete as much of the measure as possible, then turn it into the CHDC staff. Ask your counselor the question you had about the measure the following week in your next session.

Session 2 and subsequent sessions

1. Review your previous sessions corresponding feedback message with your counselor.

2. Continue with your regular session with your counselor.

3. Please take the Outcome Questionnaire 45 that your counselor hands to you following session and complete it in the room assigned to you. Complete the OQ 45 by the researcher, and then hand the completed OQ 45 into the Kent State University Counseling and Human Development Center (CHDC) front lobby window, before leaving.

4. Once the measure is complete please take it to the front desk staff member of the CHDC and hand it to them.
5. If you have any questions on the OQ45 please complete as much of the measure as possible, then turn it in to the CHDC staff. Ask your counselor the question you had about the measure the following week in your next session.
APPENDIX D
PROCEDURE FOR COUNSELING AND HUMAN AND DEVELOPMENT CENTER STAFF
Appendix D

Procedure for Counseling and Human Development Center Staff

Following the sessions of the practicum student participants

1. Following every participant’s session their client will be instructed to complete the Outcome Questionnaire 45 in the lobby of the Counseling and Human Development Center.

2. Once the client has finished the measure please instruct them to hand it in to you.

3. Place the completed measure in the filing cabinet folder labeled completed OQ 45’s.

4. If the client needs another measure due to a mistake, please take a new OQ 45 from the file labeled new OQ 45’s and instruct them to fill it out. Shred the old OQ 45 on which the client made a mistake.

5. If the client has any question regarding the OQ 45 please tell them to complete as much of it as they can and then to turn it in. Instruct them to ask their assigned counseling practicum student about the question during their next counseling session.
APPENDIX E
INTERVIEW QUESTIONS FOR CLINICAL MENTAL HEALTH COUNSELING PRACTICUM STUDENT
Appendix E

Interview Questions for Clinical Mental Health Counseling Practicum Student

1. What are your thoughts and feelings about using the feedback program?
2. How accurate would you describe the feedback is in assessing your clients?
3. How has the feedback program influenced your treatment planning?
4. Please describe step by step, in detail, how you use the per session assessment and feedback?

During the second interview the questions are repeated with one additional question

5. Since the last time we talked during the first interview, have you noticed any changes or had any new ideas regarding the feedback program?
APPENDIX F
INTERVIEW QUESTIONS FOR PRACTICUM INSTRUCTORS
Appendix F

Interview Questions for Practicum Instructors

1. What are your thoughts and feelings about using the feedback program?

2. How accurate would you describe the feedback in assessing your student’s clients?

3. How has the feedback program influenced the process of treatment planning with you and your supervisee?

4. Please describe step by step, in detail, how you use the per session assessment and feedback to inform your supervision practices.

5. Please describe how receiving weekly feedback logs on your student’s clients helped inform your classroom instruction.

6. Did your class have any in class discussions about the per session assessment and feedback program; if so what were these discussions about?
APPENDIX G
RESEARCH SCHEDULE
Appendix G

Research Schedule

Semester Interview, Member Checking and Transcription schedule

<table>
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<tr>
<th>Week</th>
<th>1 Jan 9th</th>
<th>2 Jan 16th</th>
<th>3 Jan 23rd</th>
<th>4 Jan 30th</th>
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Research to begin upon IRB approval on January 25, 2011
### Outcome Questionnaire (OQ®-45.2)

**Instructions:** Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth. Please do not make any marks in the shaded areas.

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APPENDIX I
SAMPLE OQ ANALYST INTERPRETATION WITH WHITE FEEDBACK
Appendix I

Sample OQ Analyst Interpretation With White Feedback

OQA: OQ Clinician Feedback Report

Name: An, Adult ID: 24059
Session Date: 5/7/2005 Session: 6
Clinician: Clinician, Clinic: South
Diagnosis: Depression
Algorithm: Empirical

Alert Status: White
Secondary Alert Status: Blue
Most Recent Score: 55
Initial Score: 88
Change From Initial: Recovery
Current Distress Level: Low

Most Recent Critical Item Status:
8. Suicide - I have thought of ending my life. Rarely
11. Substance Abuse - After heavy drinking, I need a drink the next morning to get going. Never
26. Substance Abuse - I feel annoyed by people who criticize my drinking. Rarely
32. Substance Abuse - I have trouble at work/school because of drinking or drug use. Rarely
44. Work Violence - I feel angry enough at work/school to do something I might regret. Rarely

Subscales Current Outpat. Comm. Norm Norm
Symptom Distress: 28 49 25
Interpersonal Relations: 16 20 10
Social Role: 11 14 10
Total: 55 83 45

Feedback Message:
The patient is functioning in the normal range. Consider termination. This patient is having an unusually rapid, positive treatment response and is expected to end treatment as markedly improved and maintain treatment gains for at least six months.

Graph Label Legend:
(R) = Red: High chance of negative outcome (Y) = Yellow: Some chance of negative outcome
(G) = Green: Making expected progress (W) = White: Functioning in normal range


5/17/2005
APPENDIX J
CLINICAL MENTAL HEALTH COUNSELING PRACTICUM STUDENT
INFORMED CONSENT
Appendix J

Clinical Mental Health Counseling Practicum Student Informed Consent

Kent State University
Institutional Review Board
Informed Consent to Participate in a Research Study
Clinical Mental Health Counseling Practicum Student

Study Title: The Use of Per Session Clinical Assessment with Clients in a Mental Health Delivery System: An Investigation into How Counseling Practicum Students, Clinical Supervisors, and Practicum Instructors Use Routine Client Progress Feedback.

Principal Investigator: Chad Yates M.A.

You are being invited to participate in a research study. This consent form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Your participation is voluntary. Please read this form carefully. It is important that you ask questions and fully understand the research in order to make an informed decision. You will receive a copy of this document to take with you.

Purpose:

The purpose of this study is to investigate how counseling practicum students, clinical supervisors, and clinical mental health practicum instructors use per session feedback provided to clients, by a psychological symptom measure such as the Outcome Questionnaire 45 (OQ 45) (Lambert et al., 1996). Per session feedback to counselors about their clients has been shown to increase expected therapeutic outcome, and decrease the rate of premature dropout in clients who are progressing poorly during counseling (Lambert et al., 2001) This study will investigate how Counseling Practicum Students, Clinical Supervisors, and Clinical Mental Practicum Instructors use per session feedback to influence their, monitoring, treatment planning, and interventions with clients.

Procedures

If you agree to participate in this study you will be expected to use the study's feedback program during your counseling practicum. The feedback program consists of you handing out a weekly OQ 45, following your individual sessions with your clients, and instructing the client to answer the OQ 45, and then hand it in to the Kent State University Counseling and Human Development Centers front desk staff. You will provide the OQ 45 to every student you see during the semester, beginning at the first session after intake. Following sessions you will receive a weekly message, on top of the corresponding case note, regarding the specific clients progress in counseling. Your clinical supervisor and your practicum instructor will receive a weekly printout that contains the overall progress your clients are making during counseling with their corresponding color coded feedback messages. During supervision you will be expected to review all your clients weekly progress provided by the OQ 45 assessment.

School of Lifespan Development and Educational Sciences
Counseling and Human Development Services • Educational Psychology • Gerontology
Human Development and Family Studies • Instructional Technology
Rehabilitation Counseling • School Psychology • Special Education
P.O. Box 5190 • Kent, Ohio 44242-0001
330-672-2294 • Fax: 330-672-2512 • www.ehhs.kent.edu/ldes/
At any time if one of your clients receives a red color coded feedback message, suggesting that they are deteriorating during counseling. You are to contact your supervisor in person or by the phone located at the Counseling and Human Development Center. Please tell your supervisor that one of your clients has received a red color coded feedback message, and that you wish to discuss this client in more detail before the next session with this client.

If you agree to participate in this study you will attend a training session scheduled in a time by the researcher and you. This will explain how to administer the Outcome Questionnaire 45, how to interpret its results. This training will last approximately one hour. You will engage in two one hour interviews, one during the 8th week of class and one on the 13th week of class. These interviews will be audio recorded. You will also engage in a one hour meeting on the 15th week, to review the transcriptions and the main themes and key statements of the interviews to ensure for accuracy. In week sixteen you will complete an exit survey that explores your experience with the study.

Audio Video Recording

This study will utilize audio recordings during the two one hour interviews. The audio recording will be fully transcribed during the study so that the researcher can access key statements and themes across interview periods and between the participants in the study.

Benefits

The potential benefits of participating in this study may include increased training in the use of routine client assessment, an opportunity to follow your clients progress through session, a possible increase in the amount of change your client may make during counseling, and a possible decreases in the premature drop out of your clients during treatment This study may also help you identify poorly responding clients early during treatment, so you may direct your attention towards these non responding clients. Your participation in the study will also help the researcher better understand how feedback programs work to influence counselor and supervisor choice when, monitoring client progress, during treatment planning, and intervention implementation. It may also increase the usability and effectiveness of future feedback programs.

Risks and Discomforts

This study will necessitate a time commitment on the part of the participant. You will be asked to attend the one hour training the second week of class and fulfill two one-hour interviews on the 5th and 10th week of the semester, as well as two one hour meetings in which the interview transcripts will be reviewed with the you for accuracy. You will also be asked to review the per session feedback, which may take 2-3 minutes per client a week, before sessions, during supervision, and in practicum class. You will also spend time handing out the OQ 45 during each of your sessions, every week.

During the two interviews if some of the questions the researcher asks are upsetting, or you may feel uncomfortable answering them; you may skip it and ask to go on to the next question. Participation in this study is completely voluntary; you may discontinue your participation in this study at any time with no penalty or negative consequences.
It is possible that per session feedback may reveal that one or more of your clients are not making significant progress during counseling. This revelation can be upsetting to counseling practicum students who wish for the best results for their clients. The feedback may also be in direct opposition to your personal assessment and judgment of the client’s progress. It is important to note that the OQ 45 per session assessment is to act as an aid for counselors, supervisors, and instructors when tracking the progress of their clients. No clinical decision should ever be made on the interpretation of a measure alone. Counseling practicum students have the discretion to use the per session assessment in a fashion that fits their best view of practice.

The per session feedback printout that will be given to your instructor will in no way be used as an evaluation of your counseling ability. Per session feedback assesses clients progress, and given that clients progress through counseling in several ways. The per session feedback assessment of clients may help your instructor, supervisor and you isolate clients who are poorly responding during counseling, providing essential time to alter treatment planning and interventions.

Privacy and Confidentiality

Your signed consent form and demographic data will be kept separate in a different file from your other study related information, and your responses will not be linked to you. Your study related information will be kept confidential within the limits of the law. The signed consent form, audio taping consent form, demographic data, digital audio recording from your individual interview, the transcriptions, and exit surveys will be kept in a secure location in a locked filing cabinet within Dr. McGlothlin’s office in White Hall room 310. Pseudonyms will be used in all transcriptions to further protect your confidentiality. Research participants will not be identified in any publication or presentation of research results; only aggregate data will be used.

Your research information may, in certain circumstances, be disclosed to the Institutional Review Board (IRB), which oversees research at Kent State University, or to certain federal agencies. Confidentiality may not be maintained if you indicate that you may do harm to yourself or others.

Voluntary Participation

Taking part in this research study is entirely up to you. Participating or not will not affect your course grade. You may choose not to participate or you may discontinue your participation at any time without penalty. You will be informed of any new, relevant information that may affect your health, welfare, or willingness to continue your study participation.

Any participant who is failing the practicum course or has violated any of the policies and rules outlined in the Kent State University Counseling and Human Development Centers handbook, will be asked to leave the study so that they may focus upon passing their practicum course or following any remediation plan outlined by their advisors in response to their policy or rule violation.

Contact Information

If you have any questions or concerns about this research, you may contact Chad Yates at (419) 290-8589 (cyates6@kent.edu), Dr. Betsy Page at (330) 0996 (bpage@kent.edu) or Dr. Jason McGlothlin at (330) 672-0716 (jmcgloth@kent.edu). This project has been approved by the Kent State
University Institutional Review Board. If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at (330) 672.2704.

**Consent Statement and Signature**

I have read this consent form and have had the opportunity to have my questions answered to my satisfaction. I voluntarily agree to participate in this study. I understand that a copy of this consent will be provided to me for future reference.

---

Participant Signature  

Date
APPENDIX K
CLINICAL MENTAL HEALTH COUNSELING PRACTICUM STUDENT
CONSENT TO BE AUDIO TAPE
Appendix K

Clinical Mental Health Counseling Practicum Student Consent to be Audio Taped

KENT STATE UNIVERSITY

AUDIOTAPE/VIDEO CONSENT FORM

The Use of Per Session Clinical Assessment with Clients in a Mental Health Delivery System: An Investigation into How Counseling Practicum Students, Clinical Supervisors, and Practicum Instructors Use Routine Client Progress Feedback.

Counseling Practicum Student Consent Form

Chad Yates M.A.

I agree to participate in an audio-taped interview about my use of the per session feedback program as part of the project and for the purposes of data analysis. I agree that Chad Yates may audio-tape this interview. The date, time and place of the interview will be mutually agreed upon.

__________________________
Signature

__________________________
Date

I have been told that I have the right to listen to the recording of the interview before it is used. I have decided that I:

___ want to listen to the recording

___ do not want to listen to the recording

Sign now below if you do not want to listen to the recording. If you want to listen to the recording, you will be asked to sign after listening to them.

Chad Yates may / may not (circle one) use the audio-tapes made of me. The original tapes or copies may be used for:

___ this research project

___ publication

___ presentation at professional meetings

__________________________
Signature

__________________________
Date

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Appendix L

Practicum Instructor Informed Consent

Kent State University
Institutional Review Board
Informed Consent to Participate in a Research Study
Clinical Mental Health Practicum Instructors.

Study Title: The Use of Per Session Clinical Assessment with Clients in a Mental Health Delivery System: An Investigation into How Counseling Practicum Students, Clinical Supervisors, and Practicum Instructors Use Routine Client Progress Feedback.

Principal Investigator: Chad Yates M.A.

You are being invited to participate in a research study. This consent form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Your participation is voluntary. Please read this form carefully. It is important that you ask questions and fully understand the research in order to make an informed decision. You will receive a copy of this document to take with you.

Purpose:
The purpose of this study is to investigate how counseling practicum students, clinical supervisors, and clinical mental health practicum instructors use per session feedback provided to clients, by a psychological symptom measure such as the Outcome Questionnaire 45 (OOQ 45) (Lambert et al., 1996). Per session feedback to counselors about their clients has been shown to increase expected therapeutic outcome, and decrease the rate of premature dropout in clients who are progressing poorly during counseling (Lambert et al., 2001). This study will investigate how Counseling Practicum Students, Clinical Supervisors, and Clinical Mental Practicum Instructors use per session feedback to influence their, monitoring, treatment planning, and interventions with clients.

Procedures
If you agree to participate in this study in this study you will teach and supervise master level practicum students who are using the study's feedback program during their counseling practicum, during your practicum two course. The feedback program consists of your counseling practicum students handing out a weekly OOQ 45, following their individual sessions with their clients, and instructing the client to answer the Outcome Questionnaire 45 and then hand it in to the Kent State University Counseling and Human Development Centers front desk staff. The practicum student will provide the Outcome Questionnaire 45 to every student they see during the semester, beginning at the first session after intake. Following sessions they will receive a weekly message on top of the corresponding case note, regarding the specific clients progress in counseling. Every week you will receive a printout from the researcher that provides a list of the overall progress your counseling practicum student’s clients made during that week, along with their color coded feedback messages.

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If you agree to participate in this study you will attend a training session scheduled in a time by the researcher and you. This will explain how to use the Outcome Questionnaire 45, and how to interpret its results. This training will last approximately one hour. You will engage in a one hour interview during the 10th week of class. This interview will be audio recorded. You will also engage in a one hour meeting, on the 14th week of the semester to review the transcription of your interview to ensure for accuracy. In week sixteen you will complete an exit survey that explores your experience with the study.

**Audio Recording**

This study will utilize audio recordings during the one hour interview. The audio recording will be fully transcribed during the study so that the researcher can access key statements and themes across interview periods and between the participants in the study.

**Benefits**

The potential benefits of participating in this study may include increased training in the use of routine client assessment, an opportunity to follow a client’s progress through session, a possible increase in the amount of change the client may make during counseling, and a possible decreases in the premature drop rates for your counseling practicum students clients during treatment This study may also help you identify poorly responding clients early on during treatment so you may direct your counseling practicum students attention towards these non responding clients. Your participation in the study will also help the researcher better understand how feedback programs work to influence counselor, supervisor, and instructor’s choices when, monitoring client’s progress, doing treatment planning, and implementing interventions. It may also increase the usability and effectiveness of future feedback programs.

**Risks and Discomforts**

This study will necessitate a time commitment on the part of the participant. You will be asked to attend the one hour training on the second week of class and attend a one hour interview on the 14th of the semester, as well as a one hour meeting on the 16th week of the semester in which your transcript will be reviewed with the you for accuracy. You will also be asked to review the per session feedback in the counseling practicum student’s clients clinical records, which may take 2-3 minutes per client a week. You will also be asked to review the weekly per session feedback with your counseling practicum students during class, and discuss during class any clients who receive a red color coded feedback messages, which suggests they are not responding to counseling.

During the interview if some of the questions the researcher asks are upsetting, or you may feel uncomfortable answering them; you may skip it and ask to go on to the next question. Participation in this study is completely voluntary; you may discontinue your participation in this study at any time with no penalty or negative consequences.

It is possible that per session feedback may reveal that one or more of your counseling practicum students clients are not making significant progress during counseling. This revelation can be upsetting to practicum instructors and to counseling practicum students who wish the best results for their clients. The feedback may also be in direct opposition to your personal assessment and judgment of the client’s progress. It is important to note that the OQ 45 per session assessment is to act as an aid for counselors, supervisors, and instructors when tracking the progress of their clients.
No clinical decision should ever be made on the interpretation of a measure alone. Practicum instructors, clinical supervisors, and counseling practicum students have the discretion to use the per session assessment in a fashion that fits their best view of practice.

**Privacy and Confidentiality**

Your signed consent form and demographic data will be kept separate in a different file from your other study related information, and your responses will not be linked to you. Your study related information will be kept confidential within the limits of the law. The signed consent form, audio taping consent form, demographic data, digital audio recording from your individual interview, the transcriptions, and exit surveys will be kept in a secure location in a locked filing cabinet within Dr. McGlothlin's office in White Hall room 310. Pseudonyms will be used in all transcriptions to further protect your confidentiality. Research participants will not be identified in any publication or presentation of research results; only aggregate data will be used.

Your research information may, in certain circumstances, be disclosed to the Institutional Review Board (IRB), which oversees research at Kent State University, or to certain federal agencies. Confidentiality may not be maintained if you indicate that you may do harm to yourself or others.

**Voluntary Participation**

Taking part in this research study is entirely up to you. You may choose not to participate or you may discontinue your participation at any time without penalty. You will be informed of any new, relevant information that may affect your health, welfare, or willingness to continue your study participation.

**Contact Information**

If you have any questions or concerns about this research, you may contact Chad Yates at (419) 290-8589 (cyates6@kent.edu), Dr. Betsy Page at (330) 672-0696 (bpage@kent.edu) or Dr. Jason McGlothlin at (330) 672-0716 (jmcgloth@kent.edu). This project has been approved by the Kent State
University Institutional Review Board. If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at (330) 672.2704.

**Consent Statement and Signature**
I have read this consent form and have had the opportunity to have my questions answered to my satisfaction. I voluntarily agree to participate in this study. I understand that a copy of this consent will be provided to me for future reference.

Participant Signature ___________________ Date __________
APPENDIX M
PRACTICUM INSTRUCTOR CONSENT TO BE AUDIO TAPE
Appendix M

Practicum Instructor Consent to be Audio Taped

KENT STATE UNIVERSITY

AUDIOTAPE/VIDEO CONSENT FORM

The Use of Per Session Clinical Assessment with Clients in a Mental Health Delivery System:
An Investigation into How Counseling Practicum Students, Clinical Supervisors, and
Practicum Instructors Use Routine Client Progress Feedback.

Clinical Mental Health Practicum Instructor Consent Form
Chad Yates M.A.

I agree to participate in an audio-taped interview about my use of the per session feedback program as part of
this project and for the purposes of data analysis. I agree that Chad Yates may audio-tape this interview. The
date, time and place of the interview will be mutually agreed upon.

_________________________________________  __________________________
Signature                                               Date

I have been told that I have the right to listen to the recording of the interview before it is used. I have decided
that I:

_____ want to listen to the recording  _____ do not want to listen to the recording

Sign now below if you do not want to listen to the recording. If you want to listen to the recording, you will be
asked to sign after listening to them.

Chad Yates may / may not (circle one) use the audio-tapes made of me. The original tapes or copies may be
used for:

_____ this research project  _____ publication  _____ presentation at professional meetings

_________________________________________  __________________________
Signature                                               Date

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Appendix N

Counseling and Human Development Center Client Informed Consent

Kent State University
Institutional Review Board
Informed Consent to Participate in a Research Study
Counseling and Human Development Center Clients

Study Title: The Use of Per Session Clinical Assessment with Clients in a Mental Health Delivery System: An Investigation into How Counseling Practicum Students, Clinical Supervisors, and Practicum Instructors Use Routine Client Progress Feedback.

Principal Investigator: Chad Yates M.A.

You are being invited to participate in a research study. This consent form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Your participation is voluntary. Please read this form carefully. It is important that you ask questions and fully understand the research in order to make an informed decision. You will receive a copy of this document to take with you.

Purpose:

The purpose of this study is to investigate how counseling practicum students, clinical supervisors, and clinical mental health practicum instructors use per session feedback provided to clients, by a psychological symptom measure such as the Outcome Questionnaire 45 (OQ 45) (Lambert et al., 1996). Per session feedback to counselors about their clients has been shown to increase expected therapeutic outcome, and decrease the rate of premature dropout in clients who are progressing poorly during counseling (Lambert et al., 2001) This study will investigate how Counseling Practicum Students, Clinical Supervisors, and Clinical Mental Practicum Instructors use per session feedback to influence their, monitoring, treatment planning, and interventions with clients.

Procedures:

If you agree to participate in this study in this study you will be expected to engage in the study’s feedback program during your counseling sessions. The feedback program consists of giving you a weekly OQ 45, following your individual session with your counselor. Once you have completed the measure following your session, please hand it in to the Kent State University Counseling and Human Development Centers front desk staff before leaving. You will be provided with an OQ 45 every session beginning with your first session after intake. During the beginning of every counseling session following the first time you took the OQ 45 you will receive a weekly feedback message summarizing your result on the measure, and on how you are progressing during counseling.

Benefits:

The potential benefits of participating in this study may include the benefit of being able to track your per session progress during your treatment in counseling. Other clients who have participated in per session feedback have achieved better outcomes during counseling, and were
less likely to have left counseling prematurely. Your participation in the study will also help the researcher better understand how feedback programs work to influence counselor and supervisor choice during, monitoring client progress, treatment planning, and intervention implementation. It may also increase the usability and effectiveness of future feedback programs.

**Risks and Discomforts**
The risks that you may encounter are that you may discover unknown aspects about yourself through the per session assessment. In some cases these aspects might make you upset or uncomfortable, however these aspects can also be therapeutic and essential to your success in counseling. The time demands for the study include asking you to complete the Outcome Questionnaire 45 weekly, which take roughly 3-5 minutes. During the time of answering the questions on the Outcome Questionnaire 45 if some of the questions the measure asks are upsetting, or you may feel uncomfortable answering them; you may skip them and go on to the next question. If you have any question while completing the measure, please direct these questions to your assigned counseling practicum student. Participation in this study is completely voluntary; you may discontinue your participation in this study at any time with no penalty or negative consequences.

**Privacy and Confidentiality**
Your signed consent form will be kept separate from your study data, and your responses will not be linked to you. All records of your participation in the study, your weekly OQ 45 interpretation and your informed consent will be kept private and secure. Your informed consent will be stored within a locked filing cabinet inside the office Dr. McGothin in Room 310 of White Hall. Your OQ 45 interpretation will be stored within your clinical record at the Kent State University Counseling and Human Development Center. These files are kept on record for 7 years in a locked filing cabinet, and are then shredded. Your specific results will not be identified in any publication or presentation of research results; only aggregate data will be used.

Your research information may, in certain circumstances, be disclosed to the Institutional Review Board (IRB), which oversees research at Kent State University, or to certain federal agencies. Confidentiality may not be maintained if you indicate that you may do harm to yourself or others.

**Voluntary Participation**
Taking part in this research study is entirely up to you. Participating or not will not affect your counseling services. You may choose not to participate or you may discontinue your participation at any time without penalty. You will be informed of any new, relevant information that may affect your health, welfare, or willingness to continue your study participation.

**Contact Information**
If you have any questions or concerns about this research, you may contact Chad Yates at (cyates6@kent.edu), Dr. Betsy Page at (bpage@kent.edu) or Dr. Jason McGothin at (jmcgothin@kent.edu). You may call the Kent State Counseling and Human Development Center (CHDC) at any time to be put in touch with the researcher; the CHDC telephone number is (330) 672-2208. This project has been approved by the Kent State
University Institutional Review Board. If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at (330) 672.2704.

Consent Statement and Signature
I have read this consent form and have had the opportunity to have my questions answered to my satisfaction. I voluntarily agree to participate in this study. I understand that a copy of this consent will be provided to me for future reference.

Participant Signature __________________________ Date ________________
Appendix O
Clinical Mental Health Counseling Practicum Student Demographic Form

Demographic Form

Clinical Mental Health Practicum Student

Gender: ___Female   ___Male    ___Transgender
Age __________

Marital Status: ___Single   ___Married   ___Separated/Divorced
___Lives with Partner   ___Widowed   ___Other

Race/Ethnicity: ___African American/Black   ___Asian/Pacific Islander
___Hispanic   ___White/Non-Hispanic   ___Native American
___Other   ___Unknown

How many hours have you earned during practicum one ______
Appendix P

Practicum Instructor Demographic Form

Demographic Form

Practicum Instructor

Gender: _____Female _____Male _____Transgender

Age __________

Marital Status: _____Single _____Married _____Separated/Divorced
_____Lives with Partner _____Widowed _____Other

Race/Ethnicity: _____African American/Black _____Asian/Pacific Islander
_____Hispanic _____White/Non-Hispanic _____Native American
_____Other _____Unknown

If you have supervised Clinical Mental Health Counseling Practicum Students before how many hours do you believe you have supervised for __________
Appendix Q

Training Booklet for Clinical Mental Health Counseling Practicum Students

Message to the counseling practicum student

The Outcome Questionnaire is a brief measure that your client will fill out, that will help them and you understand how much distress they are feeling and what specific areas in which you may need to focus on during session. It will also measure the progress your client makes during counseling. The researcher will place a new OQ 45 in your client’s clinical record for you to hand out to the client the next session.

The Outcome Questionnaire asks questions about how the client is doing and feeling. You will hand the client the OQ 45 after session and they will fill it out and hand it back to the Counseling Centers front desk staff. The researcher will score it quickly so that you can have the results back before your next session and share them with the client.

Looking at the results allows you and your practicum instructors to regularly think and talk about what is working and what is not working for the client during counseling. That allows you to tailor your care to the areas that need focus.

If you choose to participate during the study you will be interviewed once or twice for approximately an hour and will attend an hour-long meeting with the researcher to review the key statements and themes of your interview for accuracy.

Your participation in this study is voluntary. Your decision whether to participate in this study will not affect your grade in this class. We are asking you to participate and your students to participate so we can learn how practicum instructors, supervisors, and practicum students use the feedback provided by the OQ45 in clinical decision-making. If you have concerns or questions about it, please talk to the researcher Chad Yates or Drs. Betsy Page (330-672-0696) or Jason McGlothlin (330-672-0716). Chad Yates Cyates6@kent.edu
Procedure for Clinical Mental Health Counseling Practicum Student

Initial Non Intake Session with Client
1) Prior to session retrieve the blank Outcome Questionnaire 45 and bring it to session
2) Begin session by introducing yourself
3) Complete the client session
4) While finishing the session, instruct the client to complete the Outcome Questionnaire 45, and then hand it into the Counseling and Human Development Centers front desk staff
5) Complete your case note for the client session

Prior to Session 2 and Above
1) Consult the per session feedback packet included on top of your case note during supervision or before session
2) If the per session feedback form identifies your client with either the

Red Feedback code: The client is not making any progress during counseling, consider altering treatment dramatically and reformulating plan of action, intensifying treatment, or seek out medication. Client may be at higher risk for dropping out of treatment or at risk for having a negative treatment outcome.

Or

Yellow Feedback code: The rate of change the client is making is less than expected for clients who have been in treatment for this period of time before, consider altering the client’s treatment, intensifying treatment, or the client may make no significant improvement during counseling

Notify your practicum instructors in person, or through phone or email.

3) Discuss the per session feedback of every client in supervision

During Session 2 and Above
1) Bring into session the client feedback messages form provided in your client’s chart.
2) Bring into session the new blank Outcome Questionnaire 45 provided in your client’s chart.
3) During the beginning of session explore the provided client feedback messages form included in your client per session feedback packet. After processing the form with the client allow the client to take the form home.
4) Proceed with the rest of the session
5) At the end of the session give the client the new blank Outcome Questionnaire 45 instructing them to complete it then to drop it off with the Counseling and Human Development Centers front desk staff
### Outcome Questionnaire (OQ®-45.2)

**Instructions:** Looking back over the last week, including today, help us understand how you have been feeling. **Read each item carefully and mark the box under the category which best describes your current situation.** For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth. Please do not make any marks in the shaded areas.

<table>
<thead>
<tr>
<th>Session #</th>
<th>Date</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I get along well with others.</td>
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<td>2. I tire quickly.</td>
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<td>3. I feel no interest in things.</td>
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<td>4. I feel stressed at work/school.</td>
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<td>5. I am not myself for things.</td>
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<td>6. I feel irritable.</td>
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<td>7. I feel unhappy in my marriage/significant relationship.</td>
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<td>8. I have thoughts of ending my life.</td>
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<td>9. I feel weak.</td>
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<td>10. I feel sad/lowlife</td>
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<td>11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark “never”)</td>
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<td>12. I feel my work/school is satisfying.</td>
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<td>13. I am a happy person.</td>
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<td>14. I work/study too much.</td>
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<td>15. I feel worthless.</td>
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<td>16. I am concerned about family troubles.</td>
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<td>17. I have an unfulfilling sex life.</td>
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<td>18. I feel lonely.</td>
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<td>19. I have frequent arguments.</td>
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<td>20. I feel tired and wanted.</td>
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<td>21. I enjoy my spare time.</td>
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<td>22. I have difficulty concentrating.</td>
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<td>23. I feel hopeless about the future.</td>
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<td>24. I like myself.</td>
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<td>25. Disturbing thoughts come into my mind that I cannot get rid of.</td>
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<td>26. I feel annoyed by people who criticize my drinking (or drug use). (If not applicable, mark “never”)</td>
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<td>27. I have an upset stomach.</td>
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<td>28. I am not working as much as I used to.</td>
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<td>29. My heart beats too fast.</td>
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<td>30. I have trouble getting along with friends and close acquaintances.</td>
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<td>31. I am satisfied with my life.</td>
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<tr>
<td>32. I have trouble at work/school because of drinking or drug use. (If not applicable, mark “never”)</td>
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<td>33. I feel that something bad is going to happen.</td>
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<td>34. I have sore muscles.</td>
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<td>35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.</td>
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<td>36. I feel nervous.</td>
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<td>37. I feel my love relationships are full and complete.</td>
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<td>42. I feel shut off.</td>
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<td>43. I am satisfied with my relationships with others.</td>
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<td>44. I feel angry enough at work/school to do something I might regret.</td>
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<td>45. I have headaches.</td>
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**Total:**
Name: Adult, Bill, G  ID: ASDF0135
Session Date: 1/10/2005  Session: 1
Clinician: Clinician, Sue Clinic: South Clinic
Diagnosis: Dysthymia
Alert Status: NA
Most Recent Score: 78
Initial Score: 78
Change From Initial: No Reliable Change
Current Distress Level: Moderate

Most Recent Critical Item Status:
8. Suicide - I have thought of ending my life
   Never
11. Substance Abuse - After heavy drinking, I need a drink the next morning to get going.
   Frequently
26. Substance Abuse - I feel annoyed by people who criticize my drinking.
   Rarely
32. Substance Abuse - I have trouble at work/school because of drinking or drug use.
   Frequently
44. Work Violence - I feel angry enough at work/school to do something I might regret.
   Rarely

Subscales  Current  Outpat. Comm.  Norm  Norm
Symptom Distress: 39  49  25
Interpersonal Relations: 19  20  10
Social Role: 20  14  10
Total: 78  83  45

Feedback Message:
Scores in this range are typical of persons who enter outpatient psychosocial therapy. It can be anticipated that a reduction of the score by 14 points or more will occur within the first eight sessions of treatment. Most patients within this score range show a reliable benefit from treatment interventions. At the end of treatment that lasts about 18 sessions, the majority of clients with a score in this range will report distress that is within the normal range of functioning.

Normative Comparison Groups
Graph Legend:
- Inpatient (M=14)
- MH Center (M=40)
- MH (M=77)
- EAP (M=79)
- Community Sample (M=41)
- Current Score: 71

Principle Researcher Contact Form

Chad Yates
(###) ###-#### (Cell)
Cyates6@kent.edu (Email)

Fill in your Practicum Instructor’s Information

Name: __________________________

Phone Number: __________________

Email: __________________________
Appendix R

Training Booklet for Practicum Instructors

Message to practicum instructors before informed consent

The Outcome Questionnaire is a brief measure that your students clients fill out that will help them and you understand how much distress they are feeling and to what specific areas your student may need to focus. It will also measure the client’s progress during counseling.

The Outcome Questionnaire asks questions about how the client is doing and feeling. Clients fill it out after sessions and hand it back to the Counseling Centers front desk staff. The researcher will score it quickly so that your student can have the results back before their next session.

Looking at the results allows you and your student to regularly think and talk about what is working and what is not working for the client during counseling. That allows you and your student to tailor the care the client receives to the areas that need focus.

During this study you will receive a weekly feedback record, consisting of the clients your students see weekly OQ 45 Score and their feedback message. The feedback message will consist of a short paraphrase of the progress your student’s client is making during counseling.

If you choose to participate during the study you will be interviewed once for approximately an hour and will attend an hour-long meeting with the researcher to review the key statements and themes of your interview for accuracy.

Your participation in this study is voluntary. However, we are asking you to participate and your students to participate so we can learn how practicum instructors, supervisors, and practicum students use the feedback provided by the OQ45 in clinical decision-making. If you have concerns or questions about it, please talk to the researcher Chad Yates or Dr. Betsy Page (330-672-0696).

Chad Yates
Cyates6@kent.edu
Procedure for Practicum Instructors

**Weekly supervision session**
Prior to your weekly class time review the list of clients on your student’s caseload, who have received either a red or yellow feedback message. This list will be provided to you weekly in a printout that contains the names of the clients your student served that week, the client’s progress during counseling, and the color coded feedback message they received.

Review any client who may need direct attention during class as identified by the feedback system. Red or Yellow color coded feedback messages may suggest direct attention.
### Outcome Questionnaire (OQ®-45.2)

**Instructions:** Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth. Please do not make any marks in the shaded areas.

<table>
<thead>
<tr>
<th>Session #</th>
<th>Date</th>
<th>Name: ____________________</th>
<th>Age: ____ yrs.</th>
<th>Sex: M ○ F ○</th>
<th>ID#: ______</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Almost Always</th>
<th>SD</th>
<th>JR</th>
<th>SR</th>
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<tbody>
<tr>
<td>1. I get along well with others.</td>
<td>Date</td>
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<td>2. I tire quickly.</td>
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<td>3. I feel no interest in things.</td>
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<td>4. I feel stressed at work/school.</td>
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<td>5. I don't enjoy my work.</td>
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<td>6. I feel irritable.</td>
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<td>7. I feel unhappy in my marriage/significant relationship.</td>
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<td>8. I have thoughts of ending my life.</td>
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<td>9. I feel weak.</td>
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<td>10. I feel useless.</td>
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<td>11. Alcohol/drugs, I need a drink the next morning to get going (If you do not drink, mark &quot;never&quot;)</td>
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<td>12. I feel my work/school satisfying.</td>
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<td>13. I am a happy person.</td>
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<td>14. I work/study too much.</td>
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<td>15. I feel worthless.</td>
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<td>16. I am worried about family troubles.</td>
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<td>17. I have unfulfilling sex life.</td>
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<td>18. I feel lonely.</td>
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<td>19. I have frequent arguments.</td>
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<td>20. I feel USED and WANTED.</td>
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<td>21. I enjoy my spare time.</td>
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<td>22. I have difficulty concentrating.</td>
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<td>23. I feel hopeless about the future.</td>
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<td>24. I like myself.</td>
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<td>25. Disturbing thoughts come into my mind that I cannot get rid of.</td>
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<td>26. I feel annoyed by people who criticize my drinking or drug use. (If not applicable, mark &quot;never&quot;)</td>
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<td>27. I have an upset stomach.</td>
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<td>28. I am not working/studying as well as I used to.</td>
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<td>29. My heart beats too much.</td>
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<td>30. I have trouble getting along with friends and close acquaintances.</td>
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<td>31. I am satisfied with my life.</td>
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<td>32. I do not have trouble at work/school because of drinking or drug use. (If not applicable, mark &quot;never&quot;)</td>
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<td>33. I feel that something bad is going to happen.</td>
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<td>34. I have sore muscles.</td>
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<td>35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.</td>
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<td>36. I feel nervous.</td>
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<td>41. I have trouble falling asleep or staying asleep.</td>
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<td>42. I feel sick.</td>
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<td>43. I am satisfied with my relationships with others.</td>
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<td>44. I feel angry enough at work/school to do something I might regret.</td>
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<td>45. I have headaches.</td>
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**Total:**
OQA: OQ Clinician Feedback Report

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<tr>
<th>Name:</th>
<th>Adult, Bill G ID:</th>
<th>ASDF0135</th>
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<tbody>
<tr>
<td>Session Date:</td>
<td>1/10/2005</td>
<td>Session: 1</td>
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<tr>
<td>Clinician:</td>
<td>Clinician, Sue Clinic:</td>
<td>South Clinic</td>
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<td>Diagnosis:</td>
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<td>Dysthymia</td>
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<tr>
<th>Alert Status:</th>
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<tr>
<td>Most Recent Score:</td>
<td>78</td>
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<tr>
<td>Initial Score:</td>
<td>78</td>
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<tr>
<td>Change From Initial:</td>
<td>No Reliable Change</td>
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<tr>
<td>Current Distress Level:</td>
<td>Moderate</td>
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</table>

**Most Recent Critical Item Status:**

- **8. Suicide** - I have thoughts of ending my life: Never
- **11. Substance Abuse** - I have heavy drinking: Frequently
- **20. Substance Abuse** - I feel annoyed by people who criticize my drinking: Rarely
- **32. Substance Abuse** - I have trouble at work/school because of drinking or drug use: Frequently
- **44. Work Violence** - I feel angry enough at work/school to do something I might regret: Rarely

**Normative Comparison Groups**

- **Inpatient (M=54)**
- **MH Center (M=56)**
- **MBH (M=77)**
- **EAP (M=79)**
- **Community Sample (M=86)**

**Graph Legend:**
- **Inpatient** - Acute care settings with short stay
- **MH Center** - Outpatient settings such as community mental health centers
- **MBH** - Managed Behavioral Health company outpatient settings
- **EAP** - Employee Assistance Programs and students presenting at University Counseling Centers
- **Community Sample** - Individuals randomly drawn from the community

Feedback Message:

Scores in this range are typical of persons who enter outpatient psychotherapy. It can be anticipated that a reduction of the score by 14 points or more will occur within the first eight sessions of treatment. Most patients within this score range show a reliable benefit from treatment interventions. At the end of treatment that lasts about 18 sessions, the majority of clients with a score in this range will report distress that is within the normal range of functioning.

Note: This feedback is not to be used for clinical or professional evaluation. It is intended to provide guidance on the use of OQA and should be used in conjunction with clinical judgment. It should not replace professional judgment or consultations with experts in the field.

The Instructor Weekly Feedback Log example

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Appendix S

Exit Survey for Clinical Mental Health Counseling Practicum Students

Exit Survey: Clinical Mental Health Counseling Practicum Students
1. Strongly disagree
2. Disagree
3. Neither agree nor disagree
4. Agree
5. Strongly agree

1) I found the per session assessment and feedback helpful and informative

1___2___3___4___5

2) The per session assessment and feedback accurately reflected my client’s progress per session

1___2___3___4___5

3) The per session assessment and feedback influenced my treatment planning and interventions with my client

1___2___3___4___5

4) I would use the per session assessment and feedback again in my routine clinical practice

1___2___3___4___5

Please give any suggestions to how you might like to see the per session assessment and feedback differently in the future

______________________________________________________________________________

______________________________________________________________________________

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Appendix T

Exit Survey for Practicum Instructor

Exit Survey: Practicum Instructor

1. Strongly disagree
2. Disagree
3. Neither agree nor disagree
4. Agree
5. Strongly agree

1) I found the per session assessment and feedback helpful and informative during class supervision

   1____2____3____4____5

2) The per session assessment and feedback accurately reflected my counseling practicum student’s client’s progress per session

   1____2____3____4____5

3) The per session assessment and feedback influenced treatment planning and intervention choice for the client during class with my counseling practicum student

   1____2____3____4____5

4) I would use the per session assessment and feedback again in my teaching of a clinical mental health practicum course

   1____2____3____4____5

Please give any suggestion to how you might like to see the per session assessment and feedback differently in the future

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

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Appendix U

Data Analysis Flow Chart

Clinical Mental Health Practicum Students

Interviews

Interview 2 Practicum Students only

Transcribe the second interview

Transcribe the interviews

Open Coding Data Analysis

Peer reviewer examines open coding using Inter-Rater reliability technique

Axial Coding Data Analysis

Peer reviewer examines axial coding using Inter-Rater reliability technique

Triangulation using the OQ 45 Data

Selective Coding Data Analysis

Member Checking
REFERENCES
REFERENCES


Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that “everybody has won and all must have prizes”? *Archives of General Psychiatry, 32*, 995–1008.


