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Outcome-Informed Supervision: A Mixed Methods Investigation Of Counseling Supervisors' Utilization Of Feedback-Informed Treatment Data

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OUTCOME-INFORMED SUPERVISION: A MIXED METHODS INVESTIGATION OF COUNSELING SUPERVISORS' UTILIZATION OF FEEDBACK-INFORMED TREATMENT DATA

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DEDICATION

This dissertation is dedicated to my father, Mervin Lewis, who passed March 6th, 2020, and my mother, Elizabeth Lewis, who kept him safe the last several years. Without them both, I would not have the opportunity to take on a project like this.

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I would like to thank members of my family for their support and patience while I worked on this project. My wife, Krista, has been unwavering in keeping our family on track throughout this time. She has also given me wise counsel when things were difficult. My children, Lily and Onyx, have demonstrated considerable patience in enduring several discussions about research designs and statistical analysis. I am grateful for everything that they have done to help me finish this project.

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Finally, I wish to express my gratitude to my dissertation chair, Dr. Ken Engebretson, and other committee members, Dr. Angela Spiers and Dr. Charles Myers, for their guidance and encouragement throughout this project and in the coursework leading up to it. You have always been open to my ideas and found gentle ways to help me sort through which ones to work on now and which ones to save for later.

ABSTRACT

Routine clinical supervision is among the licensure expectations for the counseling profession, yet the connections of this tradition to evidence-based practices and client outcomes remain unclear. The utilization of feedback informed treatment (FIT) data in supervision represents a means to monitor treatment effectiveness and incorporate an evidence-based practice in supervision, but prior research has suggested that the adoption of FIT in practice is rare. The purpose of this study was to identify and clarify factors associated with the utilization of FIT data in the supervision of provisionally licensed counselors. An explanatory sequential mixed methods study design was used to explore what and how factors are related to supervisors' use of FIT data in supervision. In the first phase of the study exploring demographic, practice setting, and attitudinal factors, surveys were completed by 50 supervisors. In a second phase of the study, interviews were completed with 16 supervisors to clarify how factors are related to the use of FIT data in supervision. Results suggested that the use of FIT data in supervision is also rare but was more likely among supervisors who previously or currently work in community mental health centers. Attitudes towards the use of FIT data in supervision were favorable even among non-users, but barriers to use such as practical burdens and questions about validity of data were concerns for some supervisors. Findings indicated potential for expanded use of FIT data in supervision if future implementation accommodates supervisor expectations.

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CHAPTER ONE

INTRODUCTION

The effort to be effective in helping others can be understood as both simple and complex. Common sense suggests the best way to know if we are helping someone is to simply ask them. In a more complex sense, several assumptions are made about the act of helping and how to ask if it is effective. The following research involves the intersection of three concepts related to how the effectiveness of help is determined: clinical supervision, feedback informed treatment, and implementation science. Each concept is individually complicated by varied models and interpretations. As the intersections among the three concepts are the primary focus of the following study, common understanding of each of the concepts is critical. Feedback informed treatment (FIT) is an evidence-based practice that counselors use in practice. The data generated from FIT offers several potential benefits for clinical supervision if typical barriers to adoption are overcome.

Clinical Supervision

Clinical supervision is a shared tradition among the disciplines of psychotherapy in which core beliefs, practices, and responsibilities are passed on to future generations of professionals (Bernard & Goodyear, 2014). In a carefully considered definition of

clinical supervision synthesizing other proposed definitions and functions, Milne and Watkins (2014) provided the following for clinical supervision:

> The formal provision, by approved supervisors, of a relationship-based education and training that is work-focused, and which manages, supports, develops, and evaluates the work of colleague/s. It therefore differs from related activities, such as mentoring and therapy, by incorporating an evaluative component and by being obligatory. The main methods that supervisors use are corrective feedback on the supervisees' performance, teaching, and collaborative goal-setting. The objectives of supervision are "normative" (e.g., case management and quality control issues), "restorative" (e.g., encouraging emotional experiencing and processing, to aid coping and recovery), and "formative" (e.g., maintaining and facilitating the supervisees' competence, capability, and general effectiveness). These objectives could be measured by current instruments (e.g., Teachers' PETS; Milne, James, Keegan, & Dudley, 2002). (p. 4)

Routine clinical supervision is among the licensure expectations for the counseling profession (Gray & Erickson, 2013), yet the connections of this tradition to evidence-based practices and client outcomes remain unclear (Pilling & Roth, 2014). The counseling profession has pushed for the requirement for supervision of provisionally licensed counselors despite standards of extensive coursework and experiential learning in academic preparation. Although counseling supervision parallels aspects of counseling, supervisors are also expected to teach and evaluate the understanding and application of skills in psychotherapy using reviews of supervisee self-reporting, session recordings, live observation, and documentation of treatment.

Typical strategies for informing the supervision process have relied too heavily on supervisee intuition and limited direct observation by supervisors (Gray & Erickson, 2013). Supervisees' self-reports have many drawbacks rooted in natural bias and limited self-awareness of emerging professionals. Although more revealing, direct observations are time-intensive whether arranged as live observation or delayed through video or

audio recordings. Many counseling supervisors report barriers in securing authorizations for recorded sessions (Gray & Erickson, 2013). Even if supervisees are extraordinarily self-aware and generate observation opportunities, an overview of counseling effectiveness with all clients is missing. Preparing supervisees to collect client input through the process of feedback informed treatment (FIT) for the purposes of informing the supervision process represents a potential strategy for enhancing supervisee evaluation and development, by focusing attention in supervision on the reported experiences of clients.

Feedback Informed Treatment

The concept of routinely collecting client input about the quality and outcomes of treatment is identified by many terms throughout the literature. In what is often cited as the first article to discuss the concept, Howard, Moras, Brill, and Martinovich (1996) referred to "patient focused research" as a means of monitoring progress over the course of treatment and using this information as feedback to the therapist or supervisor. Ten years later, Duncan and Reese (2016) referred to systematic client feedback as "continuous monitoring of client perceptions of progress and the counseling alliance throughout the course of counseling" (p. 135). Examples of other terms used to refer to the process include routine outcome monitoring (ROM) (Boswell, Kraus, Miller, & Lambert, 2015), formal client feedback (Shaw & Murray, 2014), outcome measurement/outcomes management (Lambert, 2010), measurement feedback systems, and progress monitoring (Ionita & Fitzpatrick, 2014). Various combinations of the terms above are also used in literature, reflecting a wide range of purposes and applications. Many of the key figures associated with the development of specific

models for the process, such as Michael Lambert, Scott Miller, and Barry Duncan, have collaborated over the years in research and used the terms analogously.

Recent articles in the professional counseling literature influenced the decision to utilize the term feedback informed treatment in this study (Gentry, Baranowsky, & Rhoton, 2017; Shaw & Murray, 2015; Yates, Holmes, Smith & Nielson, 2016). Prior to the discontinuation of the National Registry of Evidence-based Programs and Practices in 2018 (Substance Abuse and Mental Health Services Administration, 2018), feedback informed treatment was also among the terminology used in the listing of the process as an evidence-based practice in the national registry (Substance Abuse and Mental Health Services Administration, 2017). Defining the concept in the counseling literature, Yates et al. (2016) described it as "continual assessment procedures that include weekly feedback about a client's current symptomology and perceptions of the therapeutic process in relation to previous counseling session scores" (p. 22-23). Although some authors (Shaw & Murray, 2015) have represented FIT as involving one specific model, this study is focused broadly on all models that systematically collect client feedback about treatment and utilize that feedback to shape ongoing treatment discussions and planning.

FIT is well-established as an evidence-based practice in psychotherapy associated with improved therapeutic outcomes, prevention of treatment failure, and enhanced therapeutic alliance (Anker, Duncan, & Sparks, 2009; Lambert 2010; Reese, Norsworthy, & Rowlands, 2009; Slade, Lambert, Harmon, Smart, & Bailey, 2008). Duncan and Reese (2016) provided an overview of how the use of feedback-informed treatment data improves outcomes for clients and accelerates counselor development.

Lambert (2010) noted intentions to address the failure of treatment to help some clients as a significant force in the development of FIT models. Trials have also demonstrated the potential benefits of using FIT data to inform supervision about treatment effectiveness and therapeutic alliance as a part of practicum and internship experiences for psychotherapists in training (Grossl, Reese, Norsworthy, & Hopkins, 2014; Minieri, Reese, Miserocchi, & Pascale-Hague, 2015; Murphy, Rashleigh, & Timulak, 2012; Reese, Norsworthy, & Rowlands, 2009; Yates, 2012).

Miller, Hubble, Chow, and Seidel (2015) have argued that "the true potential" is to "foster the professional development of each and every clinician" (p.455). Despite this potential, there is little evidence to suggest that many supervisors have integrated this strategy into supervision practice. Investigations into the utilization prevalence of feedback informed treatment among psychotherapists suggests it is not well-known or is rarely used (Hatfield & Ogles, 2004; Ionita & Fitzpatrick, 2014; Jensen-Doss et al., 2018; Overington, Fitzpatrick, Hunsley, & Drapeau, 2015).

Implementation Science

Even the best of innovations take time to transfer from the theoretical space to everyday interaction. Innovation in psychotherapy is much slower to spread than things in the technological arena. Implementation science theory illuminates several potential factors that are associated with the transmission of similar promising research-based interventions to practice settings (Aarons, Hurlburt, & Horwitz, 2011). Important factors identified from the theoretical perspective of implementation science have included practice selection, individual and organizational attitudes about changing practice, leadership, training methods, and the presence of ongoing support through

supervision and other accountability mechanisms (Aarons, Ehrhart, Farahnak, & Sklar, 2014). Prior research has indicated attitudes towards using evidence based practice as mixed, suggesting conflicts between motivations and barriers to adoption (Stewart, Stirman, & Chambless, 2012).

Prior studies on the prevalence of FIT adoption in psychotherapy have focused on demographic, practice setting, and attitudinal factors (Ionita & Fitzpatrick, 2014; Jensen-Doss et al., 2018; Overington, Fitzpatrick, Hunsley, & Drapeau, 2015). Jensen-Doss et al. (2018) found connections among workplace factors, attitudes, and adoption of FIT among psychotherapists but the limitations of the study design left unclear if positive attitudes towards FIT led to adoption or adoption of FIT led to positive attitudes towards FIT. Investigations into utilization prevalence of FIT among supervisors are lacking in the literature. How implementation factors are associated with supervisors' utilization of FIT data is similarly unclear.

Problem Statement: Knowledge Translation in Transition from Training to Practice

The true test of knowledge translation begins after the training period is over and counselors apply new skills in practice. In a survey of Canadian psychologists, Ionita and Fitzpatrick (2014) identified that many were not aware of FIT and even fewer were using it. This finding has been confirmed elsewhere by other researchers (Hatfield & Ogles, 2004; Jensen-Doss et al., 2018). In Kentucky, counseling professionals' exposure to and utilization of FIT is not known. But some degree of exposure and utilization is anticipated, because some community mental health centers in Kentucky

have undertaken efforts to implement FIT in recent years (Duncan, 2014; Better Outcomes Now, 2018).

Prior research has demonstrated the efficacy of using FIT to prevent treatment failure and positively influence the therapeutic alliance (Lambert, 2010). Trials have also demonstrated the potential benefits of using feedback in treatment data to inform supervision about treatment effectiveness and therapeutic alliance as a part of practicum and internship experiences for psychotherapists in training (Grossl et al., 2014; Minieri et al., 2015; Murphy, Rashleigh, & Timulak, 2012; Reese, Norsworthy, & Rowlands, 2009; Yates, 2012). Despite this evidence, counselor trainee exposure to EBPs such as FIT in their academic training may be growing but the prevalence of this is not well-known. Additionally, investigations of practicum and internship experience to understand attitudes and experiences with the use of feedback in treatment by counselors and supervisors are limited by academic semesters and workloads that are shaped to accommodate student levels of development. Counselor educators need a better understanding of the expectations of graduates when they enter the profession and the effects of their training on how graduates utilize EBPs.

Supervisors of provisionally licensed counselors, under the title Licensed Professional Counseling Associate (LPCA), may serve as effective indicators about the adoption of FIT among the profession across the state. At this stage, counselors, like other psychotherapy disciplines, continue development as professionals in the process of clinical supervision. The application of FIT, in terms of usage prevalence, as well as attitudes and experiences with it, will be better understood in the context of typical practice settings and longer supervisory relationships. Despite benefits available to

using FIT data in supervision (Duncan & Reese, 2016), there is little information about how supervisors are using it or if they are using it at all. Prior implementation efforts and studies published in the counseling literature may have raised awareness, however factors influencing adoption of FIT data in supervision are unclear.

Provisionally licensed counselors may receive limited training in EBPs, such as feedback informed treatment models, in their academic coursework but encounter expectations to use EBPs in many practice settings like community mental health centers. As agencies offering entry-level positions within the counseling profession, community mental health centers offer ongoing training opportunities in a variety of EBPs, but emerging counselors may experience obstacles to effective use. Freadling and Foss-Kelly (2014) identified various administrative stressors beyond working with clients that influence the experience of new professionals.

Once LPCAs start their first job, clinical supervisors serve a role in promoting and monitoring the adoption of EBPs and adherence to protocols, but training and preparation of supervisors for this purpose varies. Consumers and reimbursement entities, such as managed care and private insurance organizations, expect interventions that work, but the degree to which emerging counselors are prepared to deliver effective psychotherapy interventions is not well known. Upon entering the profession, counselors are confronted with hundreds of potential EBPs targeting a wide range of presenting problems or targeted populations and each requiring investment of time and money to achieve the expected competence level to use in their practice. The identification of the prevalence and attitudes about the use of feedback informed treatment models among supervisors of provisionally licensed counselors enhances

understanding of the potential successes and obstacles to EBP integration in the academic preparation of counselors and the continued adherence to EBP models in practice settings.

Purpose of the Study

The purpose of this study is to identify and clarify factors associated with the utilization of feedback informed treatment data in supervision of provisionally licensed counselors in Kentucky. An explanatory sequential mixed methods design was used that involved collecting quantitative data first and then explaining the quantitative results with in-depth qualitative data from selected respondents. In the first, quantitative phase of the study, survey data was collected from supervisors of provisionally licensed counselors as identified by Kentucky's Board of Licensed Professional Counselors (KBLPC) to explore factors associated with implementation science theory to assess whether utilization of FIT data in supervision relates to demographic, practice setting, and attitudinal factors. The second, qualitative phase was conducted as a follow-up to the quantitative results to help explain the directional relationships of implementation factors and utilization of FIT in supervision. In interviews with supervisors, what best explains the use of FIT data in supervision was explored. Interviews also investigated how factors identified in the quantitative data motivated adoption of FIT in supervision as well as any changes to supervision process or outcomes with selected supervisors who responded as users of FIT data in supervision or noted significant exposure to FIT models but had not used FIT data in supervision.

To identify supervisors with relevant information to share about their experiences with FIT, a case selection variant of explanatory sequential mixed methods

research design was utilized. Creswell and Plano Clark (2018) presented this approach to use an initial quantitative survey to select for participants with something to say about a research question in the subsequent qualitative investigation. The priority in this design is given to interviews with respondents to the initial survey who indicate experience with FIT in their practice.

Prior research (Grossl et al., 2014; Minieri et al., 2015; Reese et al., 2009; Yates et al., 2016) based in academic settings on the use of FIT has suggested that supervisors serve an important role in adoption of FIT and have an opportunity to enrich the supervision process. Researchers in the United Kingdom (Lucock et al., 2015; Unsworth, Cowie, & Green, 2012) also identified clinical supervision as being related to meaningful use of FIT models in practice settings. As prior research has explored the use of FIT among similar groups, this inquiry will increase understanding of how the use of FIT contributes to professional development and interacts with clinical supervision and other practice expectations.

Typical best practice recommendations for supervision focus on direct observation of supervisee work with clients to inform functions of gate-keeping for the profession and feedback on counseling skill development (Borders, 2014; Gray & Erickson, 2013). The effective integration of data associated with FIT represents an opportunity to broaden supervision focus further by informing the process with input from all clients about supervisee performance. The collection of data from the client perspective about response to treatment and quality of therapeutic alliance provides opportunities for client, counselor, and supervisor benefit if counselors take the initiative to adopt the practice. Counselor education programs and community mental

health agencies can incorporate insights from an inquiry into the factors associated with the use of FIT to further encourage its adoption.

Research Questions

Quantitative questions.

1. What factors are related to use of FIT data in supervision?

   1a. How prevalent is the use of feedback informed treatment (FIT) data in the supervision of provisionally licensed counselors in Kentucky?

   1b. What models and administration methods of FIT are most recognized by supervisors of provisionally licensed counselors in Kentucky?

Qualitative questions.

2. What do supervisors say about FIT as part of their practice and supervision?

   2a. How are supervision strategies and evaluation processes influenced by the collection of client feedback in treatment by supervisees?

   2b. How are supervisors explaining the decision to use FIT data in supervision?

Mixed methods questions.

3. How are factors related to the use of FIT data in supervision?

   3a. What results emerge from comparing the quantitative data about supervisor attitudes with explanatory qualitative data?

   3b. How are different models and administration methods related to adoption of FIT by counselors?

Hypotheses

Adoption of feedback informed treatment was anticipated to be low (under 25%) among supervisors of counselors based on prior findings about prevalence of FIT adoption within psychotherapy professions (Ionita & Fitzpatrick, 2014; Jensen-Doss et al., 2018). Among the models available for use, it was expected that the OQ-45 and PCOMS will be cited most frequently by respondents, because of status as EBPs according to the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices (2018). Based on recommendations by Boswell et al. (2015), factors anticipated to promote the use of FIT by provisionally-licensed counselors include agency requirements, prior academic training, and supervisor directives.

Defining Terms

Feedback informed treatment. The concept of routinely collecting client input about the quality and outcomes of treatment is identified by many terms throughout the literature. Duncan and Reese (2016) defined FIT as "continuous monitoring of client perceptions of progress and the counseling alliance throughout the course of counseling" (p. 135). Examples of other terms used to refer to the process include routine outcome monitoring (ROM) (Boswell et al., 2015), formal client feedback (Shaw & Murray, 2014), outcome measurement/outcomes management (Lambert, 2010), and progress monitoring (Ionita & Fitzpatrick, 2014).

Provisionally licensed counselors. Officially designated as Licensed Professional Counselor Associates (LPCAs) in Kentucky, provisionally licensed counselors may be identified with similar language in other states (lpc.ky.gov). This

group of counselors has completed graduate school training in counseling and applied to the state licensure board to begin practice as a counselor under the supervision of a fully licensed counselor. Magnuson, Norem, and Wilcoxon (2000) contrasted this group of counselors and counselors-in-training, noting that there are fewer layers of supervision for LPCAs and different agendas that pose challenges to direct observation, evaluation, and skill development.

Implementation science. Meyers, Durlak, and Wandersman (2012) described implementation science as the study and processes of translating knowledge determined from empirical findings into routine practice. Aarons et al. (2014) provided additional context about how EBP implementation is influenced by leadership and other organizational factors.

Clinical Supervision. Supervision is a commonly used term in a variety of contexts and professions, leading to some confusion of meaning in the literature. In a carefully considered definition of clinical supervision synthesizing other proposed definitions and functions, Milne and Watkins (2014) provided the following definition for clinical supervision:

> The formal provision, by approved supervisors, of a relationship-based education and training that is work-focussed [*sic*] and which manages, supports, develops, and evaluates the work of colleague/s. It therefore differs from related activities, such as mentoring and therapy, by incorporating an evaluative component and by being obligatory. The main methods that supervisors use are corrective feedback on the supervisees' performance, teaching, and collaborative goal-setting. The objectives of supervision are "normative" (e.g., case management and quality control issues), "restorative" (e.g., encouraging emotional experiencing and processing, to aid coping and recovery), and "formative" (e.g., maintaining and facilitating the supervisees' competence, capability, and general effectiveness). These objectives could be measured by current instruments (e.g., Teachers' PETS; Milne, James, Keegan, & Dudley, 2002). (p. 4)

Assumptions

In an effort for transparency in this inquiry, the following reflection is included to bracket the experience of this researcher as a counselor using FIT in practice. As a counselor beginning my career, I pulled from lived experience, optimism for change, and strengths in memory and charisma to promote treatment effectiveness in community mental health. Additionally, I was eager to integrate evidence-based practices that I had learned in training with ongoing work with adults, families, and children.

Through discussions with my clinical supervisors, I identified discrepancies in the observed outcomes and my expectations of therapeutic interventions. I lamented that the primary, objective indicator of treatment effects available to me at the time was the rate at which clients kept their appointments. Although we reasoned that unique individual factors were likely an influence on the outcomes, I insisted that if more relevant indicators of progress in the context of therapy were available, improvements in treatment would be possible.

Shortly after this realization, my agency provided a means to do this through the implementation of a feedback informed treatment system called the Partners for Change Outcome Management System (PCOMS). The process entails systematically collecting feedback from clients about treatment and then using that feedback to inform ongoing treatment process and decisions. I recognized benefits in the quality of my rapport with many clients immediately. The advantages of visualizing and partnering with clients about their feedback over the course of several sessions materialized later in my experience.

Despite the benefits that I was experiencing with the use of FIT, I listened to many colleagues who were frustrated, confused, or indifferent to it. From personal experience and observations from colleagues, the following assumptions are identified: (a) supervisors will report some awareness of FIT models, (b) supervisors will report obstacles to the use of FIT models in their practice, (c) supervisors will report benefits to the professional development of supervisees associated with the use of FIT.

To limit effects of researcher allegiance and the interaction of dual roles for the researcher in this inquiry, the identification of participants in the collection of qualitative data from a broad sample extending beyond personal relationships and convenient organizational affiliations was necessary. Otherwise, participants were likely to have had a prior relationship with this researcher as either colleagues in the same organization, trainees, supervisees, or students.

Conclusion

The counseling field has several benefits to gain from the adoption of FIT and the use of FIT data in supervision with both academic and practice settings. The ongoing collection of data about the effectiveness and relationship quality by many counselors strengthens the research capacity and integration of the profession in defining what works in psychotherapy. Supervision quality may also be improved through the routine review of client feedback in the dialogue between supervisor and supervisees. The overall findings about the effectiveness of counselors according to their clients may also be integrated into ongoing measurement of the effectiveness of academic training of professionals entering the field. Finally, counselors collecting client feedback become more deeply engaged in their professional development and the

quality of their counseling production, leading to improved morale and reduced incidence of burnout.

Although there are benefits for the profession, the review of FIT data by the supervisors of counselors is not being measured and findings from research among other professions suggest that the prevalence of its use is low. This mixed methods study was designed to identify current levels of FIT data use by the supervisors of LPCAs who have not been previously included in research about FIT adoption. A case selection variant of explanatory sequential mixed methods research design was used to identify supervisors with some exposure to or experience with using FIT data.

CHAPTER 2

LITERATURE REVIEW

The following review of literature presents the intersecting research literature connecting feedback informed treatment, implementation science, and clinical supervision as applicable in the counseling profession. First, considerations of therapy effectiveness research and the terminology of feedback informed treatment are reviewed. Next, different models associated with FIT are identified. Benefits cited in the literature about using FIT are presented. Applications for FIT as a mechanism in clinical supervision and counselor education are considered. Research about the prevalence of FIT adoption is also reviewed. Finally, using the framework of implementation science, barriers and facilitators associated with the adoption of FIT are identified and discussed.

Therapy Effectiveness Research

The effectiveness of psychotherapy has endured periods of skepticism in the past. Although skeptics existed in the public, Eysenck (1952/1992) questioned the assumptions about psychotherapy from within the psychotherapy community, drawing conclusions from a systematic review of outcome literature that suggested patients were likely to recover within two years with or without psychotherapy. This generated considerable controversy. Strupp (1963/2013) represented the resulting uproar among

contemporary researchers and practitioners over the discrepancy of their anecdotal experiences with psychotherapy benefits and Eysenck's conclusions, noting the anomalies generated by Eysenck's decisions to include or exclude studies in the analysis or compare outcomes among programs with very different expectations of outcome to the assumed control conditions. In outlining the limitations of how Eysenck proposed to evaluate psychotherapy effectiveness, Strupp highlighted the significance of ignoring client factors and the unique context of the therapeutic situation. This debate of how to measure the effectiveness of therapy has continued for decades.

Howard et al. (1996) categorized three main research questions to consider about treatment effectiveness: Does it work in special, experimental conditions? Does it work in practice settings? Is it working for a particular client? The first question is best answered by randomized clinical trials that the demonstrate effects of specific treatment actions that have been isolated from other influencing factors, while the second question must test the effects of treatment actions with the presence of those other factors. The measure of effectiveness for both questions relies on the average response of clients to treatment conditions. The final question, is it working for a particular client, represents a "critically important task of research… to provide valid methods for systematically evaluating a patient's condition in terms of ongoing response of that condition over the course of treatment" (p.1060). This question has driven researchers in the development of feedback informed treatment.

Traditional research of therapy effectiveness has focused on specific factors that distinguish theoretical orientations and interventions from one another (Wampold & Imel, 2015). Specific factors are the unique techniques and mechanisms that are tested

for effectiveness in research, while common factors refer to those aspects of psychotherapy that are shared by most interventions such as client presentation, anticipated benefits, and therapeutic alliance. Specific factors are easier to manipulate for the purposes of experimental research designs in randomized clinical trials. They are also promoted as proprietary methods that compete with similar specialized methods for research funding and licensing agreements with provider organizations. In the counseling literature specialized methods in psychotherapy may be referred to as evidence-based practices (EBPs), Patel, Hagedorn, and Bai (2013) defined EBPs as "counseling approaches that have been assessed for efficacy in treating psychological issues during randomized clinical trials" (p. 96).

Wampold & Imel (2015) reviewed a long tradition of investigating and advocating for common factors in the consideration of what accounts for effective therapy as an alternative to the extensive push for EBPs in psychotherapy. Duncan (2010) reviewed the initial emergence of the common factors' argument by Rosenzweig in 1936 and pushed further by the work of Sol Garfield and Jerome Frank. From these perspectives, the idea that the common elements between various approaches, styles, and techniques in psychotherapy must be understood as contributing value to outcomes in psychotherapy has grown in sophistication to include evidence of client and extratherapeutic factors, the use of models and techniques, the therapeutic alliance, and therapist factors. The intervention referred to in this study as feedback informed treatment has been developed from the theoretical perspective of that common factors account for the majority of effects of psychotherapy.

Terminology Shifts in Patient Focused Research

Howard et al. (1996) used the terminology of "patient focused research" to encompass efforts to better understand and evaluate therapeutic experiences at the level of specific clients. Lambert, Hansen, and Finch (2001) described this terminology as a new paradigm in connecting the term to their work on the development of the Outcomes Questionnaire as a brief measure to monitor treatment effectiveness and outcomes. Later, Anker, Duncan, and Sparks (2009) connected this terminology to what Barkham et al. (2001) called "practice-based evidence". Several others have also referred to the process as "practice-based evidence" (Barkham, Hardy, & Mellor-Clark, 2010; Lambert, 2010; Miller, Duncan, Sorrell, & Brown, 2005).

If the terms, patient focused research or practice based evidence, establish a broad scope of focus in the study of therapeutic experiences, outcome assessment, also referred to with variations of outcomes measurement or routine outcomes monitoring, could similarly include a wide range of practices for monitoring the effects of treatment (Lambert 2010). In an investigation of the use of outcome assessment, Hatfield and Ogles (2004) included a broad set of assessments, noting surprise over one example in which 125 instruments were used in outcome assessment by a single clinician. Many of these assessment instruments did not entail processing the data or reports with clients and would not be included as models of feedback informed treatment.

Building on the development of the Outcomes Questionnaire, which used a measure of psychological distress and a data report for therapists to use in session with clients (Lambert & Finch, 1999), Miller, Duncan, and Brown (2003) described the development of the Outcome Rating Scale which was then combined with the Session

Rating Scale (Duncan et al., 2003) in what became known as the Partners for Change Outcome Management System (Miller et al., 2005). Both models employ awareness of common factors such as client and life circumstances and therapeutic alliance in their approach to capturing and using practice-based evidence. From the development and testing of these instruments in psychotherapy, new terms emerged to highlight the distinction that the measures were used to employ client feedback in the therapeutic dialogue. The process was later referred to as "Client-Directed, Outcome-Informed" treatment (Bohanske & Franczak, 2014).

Bickman, Kelley, and Athay (2012) referred to measurement feedback systems as comprising two components: measures that are administered routinely during treatment to capture information about process and progress and also the presentation of the data to therapists. Overington et al.(2015) defined progress monitoring as:

> any tool that can be used to carry out continuous assessment of client change to give the clinician systematic feedback about treatment response…In contrast to pre-post assessments, PM measures are completed by the client on a routine basis and feedback is provided to the clinician throughout the therapeutic process. (p.204)

Other authors referred to this in-session clinical process using terms such as routine outcome monitoring (ROM) (Boswell et al., 2015), formal client feedback (Shaw & Murray, 2014), "systematic client feedback" (Duncan & Reese, 2015), feedback in treatment (FIT) (Tilsen & McNamee, 2015), and progress monitoring (Ionita & Fitzpatrick, 2014). Terminology has shifted over time even within the use of some important researchers of the concept. The terminology of feedback informed treatment (FIT) seemed to emerge from training material, publications, and video involving Scott Miller (Miller, 2011; Tilsen & Miller, 2011) and became the primary

terminology of a key purveyor of training materials for the process through the International Center for Clinical Excellence.

In the counseling literature, Yates et al. (2016) described FIT models as "continual assessment procedures that include weekly feedback about a client's current symptomology and perceptions of the therapeutic process in relation to previous counseling session scores" (pp. 22-23). This terminology is used in this study because of its prior use in the counseling literature and descriptive specificity. It should be noted that much of the research reviewed uses the alternative terms described above and may involve broader definitions such as routine outcome measurement or measurement feedback systems.

Models of FIT

The most well-known models of feedback informed treatment include the Clinical Outcomes in Routine Evaluation (CORE) system, the Partners for Change Outcome Management System (PCOMS), and the Outcomes Questionnaire (OQ) System (Macdonald & Mellor-Clark, 2015). Common examples of feedback informed treatment models considered in US counseling settings include: the Outcomes Questionnaire (OQ), the Partners for Change Outcome Management System (PCOMS), and the Counseling Center Assessment of Psychological Symptoms (CCAPS) (Yates et al., 2016). Another model, the Treatment Outcome Package (TOP) has also been developed for use in counseling (Boswell, Kraus, Castonguay, & Youn, 2015).

Although models may differ in number of items per measure or the timing and frequency of feedback reports, MacDonald and Mellor-Clark (2015) identified common ingredients in feedback informed treatment as the use of a common measure each

session to evaluate client perceptions of problem areas and engaging clients in discussing factors in therapy that may be affecting their progress. Feedback informed treatment represents the systematic effort to collect and use client feedback to answer an essential question in psychotherapy: “Is this treatment, however constructed, delivered by this particular provider, helpful to this client at this time?” (Boswell et al., 2015, p.7). Feedback informed treatment research dates back at least 20 years and is bolstered by numerous randomized clinical trials demonstrating its efficacy in reducing risk of client deterioration and enhancing effect sizes in treatment (Boswell et al., 2015).

Duncan and Reese (2015) described the evidence-base for the collection of client feedback as generated from two (the Outcomes Questionnaire [OQ] and Partners for Change Outcome Management System [PCOMS]) models supported by multiple randomized control trials and formerly listed in the Substance Abuse and Mental Health Administration’s national registry of evidence-based practices (EBP). Although the other models have established research as well, the EBP status of the OQ and PCOMS fulfills expectations of major stakeholders in the supervision process including professional disciplines, licensing boards, agencies, payor sources, supervisors, supervisees, and clients. The OQ (OQmeasures, 2019) has now developed into a variety of specific measures adapted for different ages, using a scoring and management software to facilitate utilization in busy clinical and training settings. PCOMS (BetterOutcomesNow, 2020) involves two brief measures the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS), targeting client reports of functioning or impairment and qualities of therapeutic alliance respectively.

The implementation of PCOMS, which has also been referred to as Client-Directed, Outcome-Informed (CDOI) treatment or simply as FIT in some contexts, has been popular with many large public mental health organizations including community mental health centers in Kentucky (Duncan, 2014). The brevity of the scales and open access to use paper versions has helped to establish its use in numerous contexts. Not only are shorter measures easier to score and understand, they are also less intimidating to therapists and clients without extensive training in assessment tools and interpretation. Although paper versions are available at the website for free, many organizations have opted to purchase access to software that facilitates scoring, storage, and analysis of client feedback data in a fitting way for organizations with many therapists, a large volume of therapy sessions, and expectations for data reporting for reimbursement purposes.

The Outcomes Questionnaire has evolved over two decades, relying on strong psychometric analysis and incorporating criticisms related to its length by offering shortened versions and electronic administration, scoring, and storage (Boswell et al., 2015). In the OQ system, therapists receive reports of client feedback data about outcome domains, therapeutic alliance, motivation, social supports, and recent life events. The clinical support tool associated with the OQ system includes data about therapeutic alliance and guidance on how to resolve issues that may be interfering with client treatment. Therapists who used the clinical support tool were noted as achieving superior outcomes than a control group providing treatment as usual.

The CORE system was developed as a non-proprietary client measure of psychological distress for use in the United Kingdom's public health care system

(Barkham, Mellor-Clark, Connell, & Cahill, 2006). The system originated through collaborative work in the 1990s and was influenced by similar research at the time in the US. The adoption of the system by practitioners overcame problems associated with the many privately designed or imported outcome measures, offering a common way to consider the effectiveness of psychotherapy in real practice settings. The original CORE outcome measure (CORE-OM) included 34 items framed on a 5-point Likert scale completed by clients on paper and then hand-scored by providers. Clinical scores are then evaluated based on statistically defined clinical cut-offs of severity of distress and a reliable change index. CORE has evolved over the years, incorporating feedback from users and research findings, to include an array of measures and electronic administration, storage, and processing of client feedback data (Unsworth, Cowie, & Green, 2012).

The CCAPS has been designed to fit the unique circumstances of university counseling centers in which a balance of clinical focus on specific population concerns and an educational training element for emerging professionals is needed (Martin, Hess, Ain, Nelson, & Locke, 2012). The system, which has 62 items in one version and 34 items in a condensed version, solicits client self-report to rate agreement with items on a 5-point Likert scale across several domains of distress. It has been embedded in an electronic record system called the Titanium Schedule software package which like other models is associated with reducing burdens on therapists to score, store, and interpret the data and focus more on using the report for meaningful dialogue with clients.

The Treatment Outcome Package (TOP) is a progress monitoring measure with multiple dimensions for use in routine practice settings (Kraus, Seligman, & Jordan, 2005). The TOP incorporates measurements of diagnostic symptoms, functioning, and satisfaction with treatment. Boswell, Kraus, Castonguay, and Youn (2015) reviewed the strong psychometric profile, research potential, and quality monitoring function of the TOP. The TOP is administered in three age-based versions; the adult version includes 58 items covering an expansive set of functioning and symptom report domains. Baxter et al. (2016) asserted the advantages of the TOP as the visualizations of change from multiple perspectives, analysis of conflicting views of progress, and alerts for significant risk factors like threats to self or others. Supervisors and counselor leaders of organizations may also find the aggregated data for individual or groups of therapists useful to assess supervision or organizational goals.

Benefits of FIT

As a starting point, feedback informed treatment has been associated generally with clients achieving better outcomes in treatment. In other professions, it has been suggested that even the process of asking for feedback may positively influence consumer choices and behaviors (Bone et al., 2017). In the literature of FIT, Shimokawa, Lambert, and Smart (2010) determined through a meta-analytic and mega-analytic approaches that feedback interventions effectively improved treatment outcomes, especially for those considered at risk for treatment failure. Each of the six trials examined in their analysis involved measuring the effectiveness of the Outcomes Questionnaire and randomized assignment to either use of feedback or treatment as usual. Some of the trials compared the collection of client feedback and different

strategies of using the data to shape the treatment process in what they called feedback interventions. Improved outcomes were described as increased rates of improved or recovered clients and reduced rates of deterioration. Although previous studies had indicated benefits to clients who were deemed at risk for treatment failure (Lambert et al., 2003), this study found the feedback interventions as beneficial for all clients.

De Jong, van Sluis, Nugter, Heiser, and Spinhoven (2012) were unable to reproduce the results reported by Shimokawa, Lambert, and Smart (2010) in a Dutch study of outpatient clinic clients. In this trial, clients were also randomly assigned to either feedback or treatment as usual conditions, but significant effects of the use of feedback were not found. In the post-hoc analysis, they noted that providing the client feedback results report to therapist did not necessarily mean that therapists would incorporate the feedback into their therapeutic discussion with clients or adjust their efforts with evidence that an approach was or was not working for the client. However, they noted that when therapists used the feedback report, clients who were deemed at risk for treatment failure did have significantly improved outcomes. Although this trial provided contrary evidence to the effectiveness of collecting client feedback to improve outcomes in any treatment circumstance, it exposed the importance of meaningful use of the data and the effect of therapist factors in outcomes.

In another international randomized clinical trial, Amble, Gude, Stubdal, Andersen, and Wampold (2015) found that feedback (Outcomes Questionnaire) improved service quality in routine psychiatric clinic care in Norway. They identified significant effects for using client feedback for clients deemed at risk of treatment failure but were unable to confirm significant effects for the general client population.

Their analysis also pointed to considerations about therapist effects; a surprisingly low number of therapists volunteered to participate in the study despite training and support available.

Anker, Duncan, and Sparks (2009) reported significantly higher rates of improvement for couples using client feedback than those experiencing treatment as usual in randomized clinical trial in an outpatient family counseling clinic in Norway. In the feedback condition, the Outcome Rating Scale (ORS) and Session Rating Scale (SRS) from PCOMS were used by therapists with couples, while in the control condition these scales were completed by clients but not given to therapists. The significant effects found for the feedback condition highlighted the mechanism of using client feedback data in discussion with clients about their treatment experiences and desired outcomes. Bickman, Kelley, and Athay (2012) asserted a specific benefit to client feedback data, noting that the potential for information provided from multiple perspectives in treatment would be useful in treatment for couples and families where differing opinions of problems and progress can be barriers to effective intervention.

Prevention of treatment failure.

Lambert (2010) provided a comprehensive guide about why treatment failure is a significant issue for psychotherapy and how the use of feedback informed treatment can mitigate the reality that not all clients experience benefit from therapy from a specific provider or treatment intervention. Feedback informed treatment has been lauded as the primary method for identifying clients not responding to treatment and as an effective tool for structuring discussion of what to do about it. Studies have demonstrated the accuracy of identifying clients who are at risk for negative outcomes

and usefulness of FIT in improving outcomes for these targeted clients (Ellsworth, Lambert, & Johnson, 2006; Whipple et al., 2003). Boswell et al. (2015) asserted that this ability to predict treatment failure or other negative outcomes is one of the primary benefits of using a FIT model.

Increased data available about treatment "puts research into the hands of the clinician" in real practice settings (Campbell & Hensley, 2009). Bickman, Kelley, and Athay (2012) suggested that feedback informed treatment can help therapists and organizations providing direct care to clients take part in the research of what works in therapy. This might restructure the traditional flow of research from elite institutions with significant resources focused on maintaining funding to a more grassroots-based research community from which innovations can sprout as they typically have from people who do the work.

Mellor Clark et al. (2016) pointed out the advantage of feedback informed treatment in a research context; capturing data in each session ensures that there will be final measures for all clients participating in at least one session. This advantage contributes to assertions that FIT will be useful for the evaluation of the implementation of other EBPs (Proctor et al., 2009; Weiz, Ng, & Bearman, 2014). Boswell et al. (2015) proposed that therapists using FIT data would be more aware of what works in their own therapy practice. This awareness of their data would also help them overcome faulty intuition about client response to treatment and be more inclusive of client factors in their treatment planning.

Quality monitoring.

Youn, Kraus, and Castonguay (2012) noted three important benefits of using feedback informed treatment: accountability associated with documenting changes, data-informed treatment planning, and enhanced therapeutic collaboration between therapists and their clients. Boswell et al. (2015) articulated the potential for feedback informed treatment systems to inform practice on a broad organizational or governmental scale through applications for client feedback in systems of care. However, they cautioned against exclusive reliance on any one measure or domain to inform decisions affecting complex treatment environments.

Douglas, Button, and Casey (2016) reviewed the uses of feedback informed treatment data for different levels of therapeutic organizations from the individual session level to treatment planning, supervision contexts, and broader agency level planning. Reese et al. (2014) applied feedback informed treatment as part of a quality improvement strategy for a large public behavioral organization, examining if treatment including the use of PCOMS was effective for 5,168 individuals at or below the poverty level who presented for therapy. Their findings supported the effectiveness of the organization and the utilization of feedback informed treatment as an adjunct to their treatment strategies for this population, noting results comparable to those of clinical trials for specific interventions for depressive disorders.

Other benefits.

FIT reassures clients with even modest improvements that treatment can be helpful and provides reassurance to those without progress that their therapist acknowledges and assumes responsibility for addressing the gap in expectations

(Boswell et al., 2015). Martin et al. (2012) also noted the potential for the discussion of progress or lack thereof between clients and their therapists as being beneficial to clients. They noted that clients were generally more favorable (over two-thirds reported their experience as positive) of completing and using the feedback data in sessions than their counselors. They reported that many clients described positive changes in how they thought of themselves.

Studies have shown that using FIT helps the therapeutic alliance. Following a systematic review of the international literature on routine outcome monitoring, Carlier et al. (2012) concluded that one of the significant effects of integrating client feedback into routine care was that clients and professionals communicated better by being more open and talking more frequently about the effects of treatment. Duncan and Reese (2015) cited effects on therapeutic alliance as one of the key predictors of treatment outcome that is woven into the method of feedback informed treatment. Student supervisees have also identified improved therapeutic alliance as a benefit of incorporating feedback informed treatment in their experiential coursework, noting even discussions of negative feedback from clients as strengthening the relationship (Esmiol-Wilson, Partridge, Brandon, Kollar, & Benning-Cho, 2017).

Gentry, Baranowsky, and Rhoton (2017) incorporated the effects of FIT on therapeutic relationship development and maintenance in a set of recommendations for competency in treating trauma. The researchers described the emergence of FIT as the most important development in the psychotherapy field in the past 10 years, highlighting its meaningful connection of the common factor of therapeutic relationship and measuring the effectiveness of treatment in real time. Unsworth, Cowie, and Green

(2012) described the way in which FIT enhances therapeutic alliance noting that it serves as validation of intuitive feelings, a means to start conversations, and a focal mechanism for sessions.

Recognition of FIT in Counselor Education

Yates et al (2016) and Schmidt (2014) specifically encouraged the adoption of client feedback informed treatment systems in counselor education programs. Feedback informed treatment represents a unique approach to EBP that aligns with the aims of the academic preparation and general perspectives of counselors as psychotherapists. The FIT process involves the routine collection of client input about their level of functioning or symptoms as well as response to participation in counseling interventions. Additionally, the collected data from client input is reviewed in the context of counseling through a partnership of counselor and client. Unlike many other EBPs, FIT is not restricted to a theoretical model or target population or disorder type, presenting an opportunity for counselors to broadly integrate the practice.

Shaw and Murray (2014) and Tilsen and McNamee (2015) utilized case vignettes to present the practical relevance of FIT use in common counseling exchanges with clients that are illustrative for counselor education. In an article advocating for adoption of feedback informed treatment among counselor education programs, Schmidt (2014) suggested strategies for incorporating feedback informed treatment among introductory coursework and the more advanced experiential coursework of practicum and internship. Introductory courses cover topics including professional orientation, counseling theories, and basic counseling techniques. In configuring syllabi and content for these courses to include feedback in treatment, faculty establish

emphasis on research-based practice, the counselor-client relationship, and reflection on feedback as foundational components of student perspectives about counseling. The integration of the practice in introductory coursework also contributes to the meaningful use of feedback in treatment in experiential courses that rely on client interaction and supervision for student learning and development. The advantages of integration of the feedback in treatment practice in the curriculum have the potential to align with accreditation standards and monitoring student learning outcomes.

The counseling profession has a leadership role to play in the implementation of effective practices. Counselors operate from a variety of leadership roles through professional associations such as the American Counseling Association (ACA) or accreditation entities such as the Council on Accreditation of Counseling and Related Educational Programs (CACREP). Counselors may also serve as administrators or supervisors in governmental institutions of health and human services, non-profit advocacy groups, community mental health centers, private clinics, or counselor education programs.

Although feedback informed treatment models fit logically into the mission of leaders in counseling, the steps to get started in changing practice vary based on unique local and personnel factors. Counselors must understand their specific readiness for changes to training and practice as well as the options presented by different models and implementation strategies. In their investigation of counselor educator attitudes towards EBPs, Patel et al. (2013) asserted that counselor educators would be most receptive to EBPs that emphasized the centrality of the therapeutic alliance. Feedback in treatment

models fit this mold through the deliberate and routine use of client input about the quality or outcome of therapy.

More importantly, Schmidt (2014) and Yates et al. (2016) described the meaningful integration of the practice within the curricula, building on careful selection of a feedback in treatment model that fits counselor education program aims for measuring and achieving multiple student learning outcomes. The two most frequently cited models PCOMS and the OQ-45 are good starting points for review, because both include mechanisms about therapeutic alliance and have strong evidence of utility. Alternatively, Martin et al. (2012) offered an example how the CCAPS system could be effective and convenient for both clinical and educational purposes in counseling programs that have an associated university counseling center. Although other models exist, research evaluating their utility to counselor education programs has not been conducted.

The experiential courses in counseling curriculum, practicum and internship, are strengthened by the inclusion of client feedback data in the measurement of student learning. Yates et al. (2016) exemplified potential links to specific accreditation standards through a case study describing how more than 10 student learning outcomes were addressed using feedback in treatment during the counseling internship through supervision. The narrative illustrating this example demonstrates how both comprehensive standards (Council for Accreditation of Counseling and Related Educational Programs, 2015) like the provision of formative and summative feedback in supervision (Section 3.C) and specific standards about counseling practice skills (Section 2.F.5.g) fit into the course design and measurement of student learning . The

potential fit of other standards of student learning and faculty measurement may also apply depending on plans of faculty and student site assignments, offering program faculty flexibility in monitoring a variety of student learning outcomes.

Graduates of counseling programs emerging as counselors in community mental health settings have advocated for more role-play and utilization of guest speakers to prepare students for the complex circumstances in the field (Freadling & Foss-Kelly, 2014). When faculty utilize the interactive and practical qualities of these instructive activities, the feedback in treatment concepts of data collection and discussion of treatment outcome are illustrated as practical tools to inform and enhance student growth as professionals. Role-play practice of collecting and discussing feedback from clients is vital to building an open dialogue about treatment outcomes and therapeutic alliance. Schmidt (2014) recommended this practice occur in basic counseling skill courses using the Session Rating Scale (SRS), a component of PCOMS, because students can share brief feedback with one another about qualities of therapeutic alliance. Students exposed to constructive feedback from peers at this level are not only able to adjust their behavior with this information but are also more receptive to constructive feedback from clients in subsequent experiential courses.

Feedback informed treatment has also been adopted in the academic training programs of other disciplines to meet a variety of professional standards. Although distinctions exist between these disciplines and the counseling profession, counselor educators share several values, responsibilities, and objectives which warrants attention on the reported benefits of using feedback in treatment to professionals representing those disciplines. Counseling psychologist and marriage and family therapist educators

have contributed to the literature about using systematic client feedback in their programs to meet initiatives for evidence-based practice integration, therapeutic skill development, and social justice (Grossl et al., 2014; Sparks et al., 2011). Grossl et al. (2014) identified standards of the American Psychological Association that were met through the implementation of feedback in treatment within the academic training of psychologists. Sparks et al. (2011) similarly noted that the effort to integrate feedback in treatment within the academic training of marriage and family therapist was linked to standards of the American Association of Marriage and Family Therapy.

Application of FIT as a mechanism in supervision

The use of client feedback was among the suggestions from supervision scholars (Goodyear et al., 2016) seeking to engage the international and interdisciplinary community of supervision researchers to increase accountability for practice of supervision. The group of authors concluded that the potential for feedback informed treatment to serve as an early warning signal to supervisors about supervisee difficulties and as a selection tool for further investigation with direct observation should be examined further. Supervisors engaged in the measurement of their own effects on supervisee performance may also use the data to track response to interventions in supervision or development of overall supervisee competence.

The accountability effort for supervision and FIT may be best described as working in both ways. Clinical supervision has been cited as an important component of the effective implementation of other EBPs (Schoenwald, Mehta, Frazier, & Shernoff, 2013). Unsworth, Cowie, and Green (2012) found supporting evidence that feedback informed treatment informs supervision about quality of treatment and supervision as

well as evidence that supervision supports the effective use of feedback informed treatment. Duncan and Reese (2016) also discussed this complex relationship between FIT model use and clinical supervision, suggesting that clinical supervision not only encourages the use of FIT, but is also enhanced by the availability of client input. They provided detailed instruction on how FIT can be incorporated in a thoughtful supervision approach which involves systematic ways for clients to select themselves for attention in supervision discussions as signals are flagged for clients with data suggesting potential for treatment failure.

Esmiol-Wilson et al. (2017) interviewed students using feedback informed treatment in their clinical practicum for marriage and family therapy. They identified positive changes in therapeutic delivery and therapist development. Students indicated benefits in their delivery of therapy such as learning to better match client needs, identifying a focus for sessions, collaborating with clients, and improving therapeutic alliance skills. There were also benefits noted for supervisees using client feedback including increased self-awareness and growth in empathy towards their clients from positive and negative feedback from clients as well as reflections on the data captured from client feedback over time.

Reese et al. (2009) described another potential advantage of using FIT data in supervision. The client feedback data leads to more efficient uses for supervision time, helping supervisors and supervisees to prioritize the limited time available to talk about key points for monitoring effectiveness of specific interventions and supervisee growth in identified areas. They acknowledge the challenge facing supervisors to oversee

discussions of large caseloads held by many supervisees and the considerable blind spots that are inevitable in the limited time dedicated to supervision.

Working professionals and their supervisors across many fields review best practice recommendations to assess and align practice with recent research and applications of effective techniques and new perspectives. Grossl et al. (2014) examined the use of client feedback data in supervision within the context of the best practice guidance within the psychology field. Feedback informed treatment data use in supervision offers a similar potential to support and enhance best practice standards in the counseling profession.

Best practice guidelines are not intended as minimum standards, nor are they prescriptive of particular methodologies (Association for Counselor Education and Supervision, 2011). As the Chairperson of the ACES Task Force that developed the *Best Practices in Clinical Supervision*, Borders (2014) provided an overview of the major content areas and themes associated with clinical supervision from the perspective of the counseling profession, noting the intentions of Task Force and potential for transdisciplinary efforts regarding clinical supervision. The major content areas represent the phases of supervision as well as legal, ethical, multicultural, and training processes. The sections include initiating supervision, goal setting, giving feedback, conducting supervision, supervisory relationships, diversity and advocacy considerations, ethical considerations, documentation, evaluation, supervision format, the supervisor, and supervisor preparation, training, and supervision of supervisors.

Traditional supervision strategies employed to fulfill minimum requirements and aspirational best practices involve live supervision, co-therapy supervision, review of

audio or video recordings, and case reviews based on documentation and supervisee self-report (Gray & Erickson, 2013). Among these supervision strategies and themes, supervisors encounter challenges posed by reluctance for audio or video recordings at many sites, setting up limited opportunities for observing supervisees directly in work with clients and framing the work of supervision through the faulty lens of supervisee self-report. Several authors (Duncan & Reese, 2015; Minieri et al., 2015; Reese et al., 2009; Sparks, Kisler, Adams, & Blumen, 2011; Swift et al., 2015; Yates et al., 2016) have proposed using continuous outcome measurements of client feedback in supervision to enhance evaluation and skill development strategies. Others (Minieri et al., 2015; Reese et al., 2009) exploring supervision from the perspective of counseling psychologists have tested hypotheses about implementing client feedback in supervision that investigated effects on client outcomes, social justice, supervisory relationship, satisfaction with supervision, and supervisee development.

Borders (2014) noted the critical nature of direct observation of supervisee work with clients as a means of promoting client welfare, monitoring treatment effectiveness, and evaluating supervisee development and disposition. Even when direct observation is available, the evaluation of treatment effectiveness and quality of therapeutic relationships remain narrowed to the interpretations of supervisee and supervisor interpretations. New strategies, such as using client feedback to inform supervision, provide both a broad view of supervisee practice and a specific client-framed view of effectiveness.

Although each section of the best practice guidelines may have some connection to the use of continuous client feedback, some sections relate more explicitly to

supervisor responsibilities of evaluation and development of supervisees. The utilization of client feedback in supervision as a strategy for supervisee skill development potentially aligns with several of the content areas. Supervisee skill development is a broad concept that many supervision strategies, such as live supervision or review of recorded sessions, are used to monitor and shape. As an additional strategy, the incorporation of client feedback addresses best practice expectations for how supervision is conducted, the supervisory relationship, diversity and advocacy considerations, documentation, supervision format, the supervisor, and supervisor preparation and training.

Beyond the initial point of setting goals, supervisors routinely and intentionally address and evaluate goals with supervisees. Using supervision strategies such as supervisee self-report and direct observation have roles to play in setting and monitoring goals, but do not offer supervisors much perspective about how supervisees are interacting with clients overall. Instead supervisees reveal that which is already known to them or show an isolated example in which direct observation was authorized. Swift et al. (2015) asserted the value of using client feedback data in supervision to attend to patterns in counseling competence and behavior across work with all clients, creating a means to develop and monitor a variety of goals in supervision. This broad picture of practice to measure progress towards supervisee goals is missing from the traditional supervision strategy emphasis on direct observation through recording or review framed by supervisee self-report on goals in supervision. This is not to say that client feedback information should replace direct observation, but instead be

incorporated to augment existing strategies of monitoring and addressing goals in supervision.

In terms of best practices of goal setting, Borders (2014) described expectations that goals help the therapeutic alliance and treatment effectiveness. Vignettes offered have demonstrated specific applications of the SRS of PCOMS to frame supervisory discussions of therapeutic alliance and monitor supervisee goal attainment in this skill (Duncan & Reese, 2015; Sparks et al., 2011; Yates et al., 2016). Client feedback in supervision indicated different degrees of supervisee effectiveness, presenting opportunities to point out strengths as well as weaknesses (Duncan & Reese, 2015). Client feedback systems have also been associated with helping supervisees increase effectiveness over the course of training. In a randomized trial of using client feedback in supervision, Reese et al. (2009) found that supervisees were twice as effective when using client feedback in treatment than when not. Despite even the best of scenarios, the realities of practice settings are that "not all clients benefit from services" and "no clinician serves all clients" (Duncan & Reese, 2015, p. 396). This understanding is best facilitated through an informed supervision process by thoughtful feedback and self-reflection.

In giving feedback, supervisors should seek to be constructive and specific while striking a balance of encouragement and challenge to supervisees (Borders, 2014). Direct observation is described as a best practice strategy from which feedback can be formed, providing a means to monitor supervisee behavior in session. Direct observation does not however provide adequate information to consider the therapeutic process over the course of multiple sessions or from the perspective of clients. Typical

supervision strategies may also present supervisors with challenges to giving critical feedback, because supervisory relationships parallel therapeutic relationships. Reese et al (2009) identified that supervisors reported that it was easier to give challenging feedback to supervisees when in the context of client feedback. The presence of client feedback offers outside information for the supervisory dyad to address, setting up both participants to assess what it means for supervisee development. Minieri et al (2015) highlighted this collaborative tone, noting that supervisees described being less defensive about receiving supervisory feedback in the context client feedback information.

Supervisors are responsible for routinely generating and sharing formative and summative evaluations of supervisees, preferably based on direct observation of work with clients (Borders, 2014). As a strategy used in conjunction with direct observations, routine review of client feedback in supervision has facilitated assessment of trainee development (Sparks et al., 2011). In settings in which consent for direct observations are limited, supervisors have an alternative for objectively monitoring and assessing skill (Reese et al., 2009). The broad patterns of information generated across multiple clients represent unique ways to evaluate the transfer of supervisee learning into practice (Duncan & Reese, 2015).

Although useful as one of many components of evaluation, the use of client feedback data should not be used to determine grades or promotion (Duncan & Reese, 2015; Sparks et al., 2011). Instead, its value rests in adding depth to the supervisory process, establishing habits of practice-based evidence, and fostering self-reflection. Multiple authors identified that collecting client feedback and incorporating it in

supervision promoted the development of supervisee self-reflection and evaluation (Duncan & Reese, 2015; Minieri et al., 2015; Reese et al., 2009; Sparks et al., 2011; Yates et al., 2016). Supervisors establish a foundation of evaluation and self-reflection through the encouragement of routinely collecting and reviewing client feedback. When supervisees move into independent practice, they will be equipped with an awareness of their ability to help clients achieve desired change and a means for monitoring this process in the future.

Finally, supervisors may consider a parallel process to systematic client feedback: systematically collecting student feedback in supervision or other coursework. Duncan and Reese (2016) identified interest among some professionals for the development and utilization of a system analogous to PCOMS based on the supervisory relationship. This potential supervisory strategy involves the collection of feedback from supervisees about the supervision process similarly to how feedback is gathered from clients about treatment. Although noting that the idea had merit, Duncan and Reese argued that the significant differences in the purposes of supervision and treatment warranted deeper reflection to clarify how the collection of feedback data would be used productively.

Upon analysis of the differences among supervision and psychotherapy, the constructs of impairment or distress as measured in the Outcome Rating Scale (ORS) of PCOMS might be more appropriately replaced when measuring supervision outcomes with construct items for counselor self-efficacy, engagement in counseling, supervision alliance, and overall satisfaction with supervision. Although benefits associated with modeling the collection and discussion of feedback may be assumed, additional

investigation is needed to understand the usefulness and validity of a parallel scale based on these constructs. Similarly, the teacher-student relationship represents another avenue for the use of a parallel process in systematically monitoring student outcomes. The collection of student feedback at beginning and end of courses is a common practice in higher education; prompting students for data within class meetings systematically and using the feedback to inform the teacher-student relationship is not well-understood.

Prevalence of FIT adoption

Despite research suggesting the effectiveness of feedback informed treatment (Duncan & Reese, 2015) and pressure to increase the integration of evidence-based practices in psychotherapy (Gioia & Dziadosz, 2008), many therapists report being unaware of feedback informed treatment and few adopt it in practice (Ionita & Fitzpatrick, 2014; Jensen-Doss et al., 2018). Most studies have focused on prevalence among psychologists (Hatfield & Ogles, 2004; Ionita & Fitzpatrick; Overington et al., 2015). Ionita and Fitzpatrick (2014) developed a survey tailored to collect specific information related to research questions about exposure to and adoption of feedback informed treatment among Canadian psychologists. Jensen-Doss et al. (2018) expanded the focus on adoption of FIT to include counselors, social workers, and marriage and family therapists.

In an early study of the use of routine outcome assessment, Hatfield and Ogles (2004) had shown higher rates of awareness and use, however this was framed around the broader term of outcome measurement which incorporates a wide range of assessment tools featuring self-report but does not typically specify ongoing feedback to

inform treatment planning decisions between client and therapist. Overington et al. (2015) and Peterson and Fagan (2017) found even higher levels of awareness and use of progress monitoring measures among doctoral psychology graduate trainees which may suggest increased attention on measuring outcomes in academic settings in the psychology profession. There were no studies found that focused on the prevalence of FIT data use in supervision.

Implementation Science of FIT

Even though there is significant pressure to increase evidence-based practices in routine psychotherapy from professional associations and reimbursement entities, professionals are slow to make changes in their practice (Boswell et al., 2015; Mellor-Clark, Cross, Macdonald, & Skjulsvik, 2016). Providers face a double bind of financial expectations to gain reimbursement through the use of evidence-based practices that they cannot afford to implement (Stewart et al., 2016). Several factors affect the research-practice gap, including the complexity of organizational contexts, applicability and appeal of research conclusions to client populations, and practitioner attitudes towards research and practice (Patel et al., 2013). Aarons et al. (2014) noted system, agency, and leadership contexts that can facilitate or impede the effective dissemination and implementation of scientific evidence into everyday practice. Ongoing efforts to increase the use of evidence-based practices (EBPs), those contextual activities supported with scientific proof of benefit, involve a broad spectrum of professions including counseling. Patel et al. (2013) found that counselor educators, at least those with Association for Counselor Education and Supervision (ACES) membership,

revealed openness to the integration of EBPs in the curriculum, despite past suggestions of resistance to changing the curriculum for this purpose.

Counselors in leadership roles influence the implementation of EBPs, contributing to either adoption or resistance to changes in practice. Leaders may take direct action to encourage adoption of a practice through establishing policies, outlining procedures, or incentivizing changes through reward systems (Aarons et al., 2014), yet these actions out of context with the overall style of leadership may not achieve desired results. Among the specific dynamics linked to leadership counseling, McKibben et al. (2017) noted connections to transformational leadership characteristics such as modeling, interpersonal influence, creativity/innovation, and mentorship qualities in the literature about counseling leadership. Transformational leadership characteristics may buffer the stresses of changing practice and encourage positive attitudes about EBPs; both viewed as keys to effective implementation (Aarons et al., 2014). Transformational leadership skills may be acquired through academic training or professional mentoring, but these capabilities must be combined with other conditions such as receptivity to EBPs among leadership and supportive organizational culture.

In the specific context of implementation of EBPs, Aarons et al. (2014) reviewed similar overlapping uses of the terms, organizational climate and culture, to describe the overt, covert, and implicit forces within organizations that shape how individuals interact with others in the group as well as the recipients of services and other stakeholders. Organizational culture, formed in the beliefs, traditions, and assumptions of workplaces, affects the adoption of EBPs through the transmission of

attitudes towards changes in practice, the quality of staff morale within the system, and the overall perception of support for an EBP.

As the evidence has developed, proponents of feedback informed treatment broadened the focus from proving efficacy of the concept to include investigations of the barriers and facilitators to implementation. Potential barriers or facilitators may include disciplinary training, theoretical orientations, financial factors, organizational culture, therapist characteristics, or types of practice settings among many others. Researchers have investigated some of these factors, finding for example, that therapist attitudes about collecting outcome feedback might serve as either facilitators or barriers to implementation in practice (de Jong & de Goede, 2015). Further investigation can be enhanced by review of how research methodologies differ and contribute knowledge to questions about effective implementation.

Barriers to FIT Implementation

Boswell et al. (2015) confirmed the importance of funding and supervisor support in a discussion of barriers and solutions to the implementation process of feedback informed treatment in organizations. The authors grouped additional factors such as time burden, staff turnover, and the general mistrust of oversight into practical and philosophical obstacles. Philosophical barriers described were the perception that outcome assessment is different from other assessment or that clients will refuse to cooperate with completing measures or doing so will interfere with forming a therapeutic alliance. There is also fear and mistrust of the intentions for the data – will this be used to question reimbursement, direct how treatment is planned, or establish competition with other therapists? There are also concerns for privacy and ethics in

managing the data. The implementation of FIT also challenges the intuition of therapists who tend to believe that their clinical judgment is sound.

Esmiol-Wilson et al. (2017) described some of the challenges to using FIT that might prevent some therapists from adopting the practice based on qualitative analysis with therapists in training. They identified feelings of vulnerability in the act of requesting, processing, and responding to client feedback. It was also challenging to establish an understanding with clients that they could provide negative feedback, especially with an awareness of "contextual issues of privilege and marginalization" (p. 28). Although it may be argued that therapists in training face similar challenges in their initial therapy experience regardless, these concerns are likely shared with licensed peers.

In a review of how feedback informed treatment is used in naturalistic practice settings, Youn et al. (2012) identified therapist concerns that clients will not complete measures or that imposing the measures on clients will impair the development of an effective therapeutic alliance. They also noted the potential fear that feedback data will reveal therapists as incompetent, a feeling that few therapists have revisited since their academic training. Okiishi et al. (2006) also noted that therapists avoided public comparisons of outcomes with their peers which is commonly mentioned as one of the potential uses of feedback informed treatment data. Therapists who were more aware of the use of FIT have also expressed more concern about the potential use of the data for evaluation (Overington et al., 2015).

Hatfield and Ogles (2004) organized concerns about FIT as consisting of either practical barriers or burdens involved with use and philosophical differences or attitudes

that influence resistance to adoption. Among the practical barriers, they noted concerns that FIT represents more paperwork and time spent on assessment as well as more expenses in the treatment process and distraction to the client. In the philosophical sense, therapists' attitudes shape perceptions that FIT is not helpful or relevant in the treatment process. There is also suspicion of the intentions for the data and concern about how the process might interfere with building a relationship or maintaining confidentiality.

Software packages such as the OQmeasures (2019) and BetterOutcomesNow (2020) have offered solutions to streamline collection and measurement of client feedback as well as analytic tools to facilitate interpretations by individual counselors and to organize data for convenient oversight by supervisors and other agency leaders. Although dedicated software holds promise as a solution to the burdens of time and technical understanding to effectively use client feedback in real time, problems have also been noted in this format of managing FIT data. Amble et al. (2015) described a barrier to effective use of feedback associated with administration of the FIT measure as temporary disruptions in internet access forced providers to troubleshoot with the older paper/pencil format for processing client feedback data which resulted in significant delays and extra work. Bickman et al. (2016) also reported unexpected frustrations with software glitches in their randomized clinical trial of a FIT system that emphasized the advantages of computer assisted collection and processing of client feedback data.

Unsworth, Cowie, and Green (2012) conducted interviews with individual clients and therapist focus groups to understand perspectives on the use of a computer-assisted version of the CORE featuring visual feedback to clients and therapists. By

narrowing the inquiry to perceptions of clients and therapists, the researchers focused on the depth of a smaller group of participants to extrapolate themes via inductive analysis of transcribed interviews. Therapists were concerned about being judged based on client feedback, citing a connection between this fear of judgment and questions about accuracy and expectations of the data. Clients reported more favorable attitudes to using feedback informed treatment than their therapists, suggesting further that the vulnerability of being judged influenced receptivity to FIT.

In a survey of psychology training clinics, Peterson and Fagan (2017) explored reasons for and against the use of feedback informed treatment data. They found a lack of resources and the attitudes of supervisors as the top reasons why feedback informed treatment was not being adopted in training clinics for psychologists. The authors reported the reasons training clinic directors cited for using feedback informed treatment as student skill development, treatment quality, and faculty responsibility. Supervisors attitudes that discouraged use of FIT as reported by trainees were a lack of familiarity with FIT, reluctance to switch to new methods, and little perceived value for it overall.

In a complex study design, de Jong and de Goede (2015) sought to understand the relationship of variables such as person-organization fit and regulatory focus on therapist attitudes to feedback and outcomes measured through feedback in treatment. They reviewed collected client feedback data from the OQ in addition to instruments measuring person-organization fit and regulatory focus, which were collected once, as well as attitudes about feedback, which was collected at the beginning of the study and 6 months later. They found that the degree to which therapists feel a strong fit within

their organization and their motivational approach to success and failure in work influence attitudes about using feedback informed treatment models.

Lucock et al. (2015) incorporated a mixed methods research design to investigate the effectiveness of feedback in treatment in terms of therapeutic goals as well as the feasibility and acceptability of the process among professionals in common practice settings. The researchers employed quantitative methods inherent to the feedback in treatment model, CORE, to determine treatment effectiveness and other questionnaires to measure acceptability and feasibility. The researchers also collected qualitative data through offering open-ended responses in the questionnaire system and hosting focus group meetings with therapists and patients.

Barriers and facilitators to the adoption and continued use of feedback informed treatment have been reported at the individual, administrative, and systemic levels (Duncan & Murray, 2012). Levels of understanding and confidence vary among professionals about the use of outcome data in practice. Organizational support and resources are also variables that can either facilitate the implementation of FIT or hinder it. Past implementation efforts offer guidance on how implementation can stall or succeed (Boswell et al., 2015).

Facilitators of FIT Implementation

Boswell et al. (2015) presented an account of the barriers and facilitators of implementing feedback in treatment by identifying themes from each of the authors' lived experiences as researchers, consultants, and practitioners in the process. Although their conclusions were well-informed and comprehensive, few researchers will have similar lived experiences to replicate this design in the context of implementing

feedback in treatment in counseling education settings at this stage of dissemination of the practice. They encouraged the development of a collection of case vignettes illustrating the application of feedback in treatment as potent facilitator for adoption in practice settings.

Demographic factors have previously been included in analysis of what influences FIT adoption in practice. De Jong et al. (2012) discovered that female therapists were significantly more likely to use the feedback in treatment discussions than their male counterparts, however they found no significant effect for other demographic categories such as years of experience or professional discipline. Jensen-Doss et al. (2018) found evidence that more years of experience was associated with a reduced likelihood of ever using a FIT model. Favorable attitudes about FIT were identified among therapists reporting a cognitive behavioral therapy theoretical orientation than their peers, however they also noted no significant relationship between attitudes favorable to FIT use and degree level, years of experience, or work with children and adolescents.

Publicly funded practice settings such as hospitals, universities, or community mental health centers have been identified as more likely to have counselors using FIT than independent or group private practice settings (Hatfield & Ogles, 2004). Possible explanations for this finding include the pressure for accountability from institutional funding through grants, government contracts, or managed care as well as the presence of supportive resources and administrative structure to facilitate the implementation effort. Jensen-Doss et al. (2018) presented findings of less use of FIT models in private practice settings. They also noted that there were more negative attitudes about the

practicality and treatment planning function of FIT in private practice settings than other settings.

Outspoken supporters of feedback informed treatment may be identified as local champions of the implementation effort, serving informally or formally to coordinate and support others in the training, coaching, and supervision of the practice (Boswell et al., 2015). The idea of local champions as aids to implementation has been documented in other EBP implementation efforts as well (Aarons et al., 2014). Supervisors function effectively as mentors of new practices like feedback informed treatment, encouraging close adherence to protocols and enhancing skills to integrate methods into routine practice (Carlson, Goscha, & Rapp, 2016).

Although attitudes of therapists towards FIT were identified as barriers by many, attitudes have also been described as shifting with direct training and experience (Esmiol-Wilson et al., 2017). Esmiol-Wilson et al. (2017) isolated shifting attitudes about using FIT among student supervisees resulting in "buy-in" to the use of FIT by 25 of the 26 student supervisees who participated in their study. Several others (Hatfield & Ogles, 2004; Jensen-Doss et al., 2018; Martin et al., 2012; Overington et al., 2015; Trauer, Callaly, & Herrman, 2009) have reported similar findings that attitudes become more favorable with more exposure or experience to FIT.

Conclusion

In seeking to further understanding factors associated with adoption of feedback informed treatment, future research should investigate the attitudes and behaviors of supervisors. Supervisors of provisionally licensed counselors in Kentucky represent a group of professionals not previously the subject of inquiry in the feedback informed

treatment literature. Despite being overlooked in previous inquiries, supervisors offer an opportunity to explore how academic training is being transferred to practice and how ongoing supervision requirements influence the use of EBPs such as feedback informed treatment. For the subjects of this inquiry, the incorporation of feedback informed treatment data in their supervision may serve as an alternative or adjunct to typical means of evaluating supervisee development and giving feedback. Incorporating the practice in supervision will also help supervisees embrace the demands of EBP integration by reimbursement groups and establish a sense of effectiveness as professionals that may sustain their careers. However, their exposure to and experience with feedback informed treatment may lead to very different conclusions.

To investigate what counseling supervisors in Kentucky have to say about feedback informed treatment, a mixed methods approach will be needed to overcome challenges in identifying participants with relevant knowledge and experience. To avoid limitations associated with a convenience sample or researcher allegiance to feedback informed treatment, a study designed so that the researcher will not serve in dual roles as instructor, trainer, or supervisor to participants. Creswell and Plano Clark (2018) described a case-selection variant of explanatory sequential design that presents a process for using quantitative data to identify relevant participants for further qualitative investigations. In this study design type, quantitative input is sought first to both obtain descriptive statistics on the adoption of feedback informed treatment data among supervisors and also select participants who can provide more explanation of how potential barriers or facilitators relate to their status as using or not using FIT.

CHAPTER 3

METHODS

The Mixed Methods Paradigm

The tradition of mixed methods research is based on the idea that both quantitative and qualitative inquiry may be necessary to deepen the understanding of research questions. This study was intended to identify how prevalent the use of FIT data is among supervisors of provisionally licensed counselors as well as their perspectives about it. To identify those supervisors with relevant perspectives about FIT use in practice settings, a case selection variant of mixed methods design was used. The explanatory sequential design involved collecting survey data before identifying participants for interviews.

The quantitative data collection and analysis were not only intended to identify participants for subsequent interviews, but also provided descriptive statistics about the prevalence of FIT data use in supervision, characteristics of supervisors using FIT data, and settings in which it has been used. This information is useful for policy decisions and tracking progress about the dissemination of the practice. Yet, survey data does not explain why or how FIT data is or is not being used in supervision. The additional sequence of collecting and analyzing qualitative data offered greater understanding of

why and how FIT data is or is not being incorporated into supervision of counselors at the beginning of their careers.

Research Design

Creswell and Plano Clark (2018) described an explanatory sequential design as consisting of both quantitative and qualitative phases. Differing from approaches to mixed methods study that intend to collect quantitative and qualitative data simultaneously, the sequential design, data collected in a planned sequence, most appropriately addresses the challenge of selecting participants with experiences of using FIT data in supervision. In the case selection variant of mixed methods explanatory sequential design, a researcher first collects and analyzes quantitative data. Next, cases or participants from the quantitative data are selected for further collection and analysis of qualitative data. The qualitative inquiry is prioritized in this variant because the resulting analysis helps explain the phenomenon of study, which in this study relates to the specific factors cited by supervisors as motivating their use of FIT data in supervision. Both quantitative and qualitative data sets offer important information to answer research questions in mixed method designs. The mixture of data strands also creates opportunities to explore complementary and discrepant findings from each step in the sequence.

The interview data collection targeted respondents identified from analysis of the survey results who fit representative groups reporting varying degrees of awareness of FIT or use of FIT data in supervision. Once interview data was collected and analyzed, data from the two phases were integrated. The sequence of quantitative and qualitative strands is illustrated in Figure 1 (Creswell & Plano Clark, 2018).

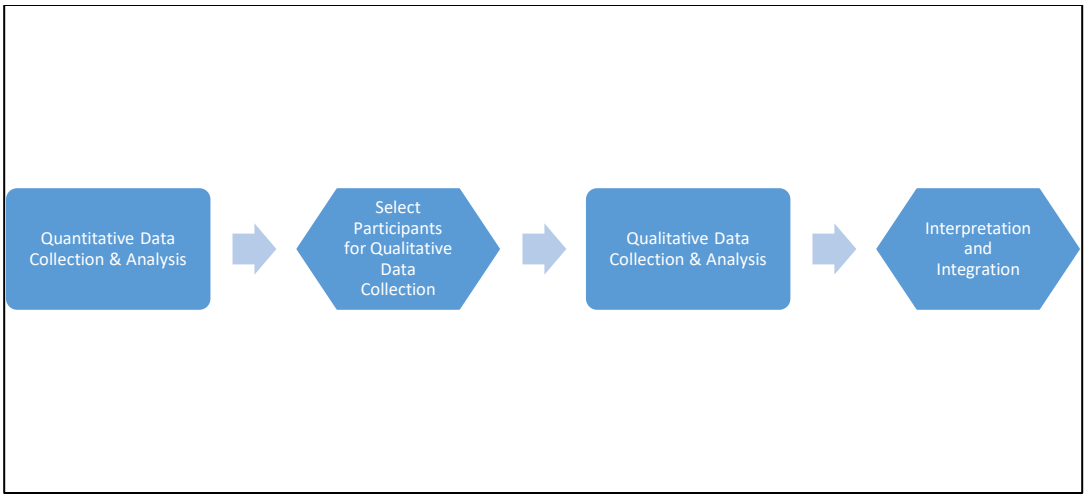

Figure 1: Design Flowchart

Source: Creswell, J. W., & Plano Clark, V. L. (2018). *Designing and conducting mixed methods research* (3rd ed.). Los Angeles, CA: SAGE.

Supervision, FIT, and Implementation Science in Mixed Methods Research

Lucock et al. (2015) offered an example of how this research paradigm has been used in the FIT literature in the past, but the scope of such complex studies is beyond what is feasible for a single researcher. The convergent mixed methods design utilized by this team of researchers was organized around a practice-oriented research paradigm fitting a specific implementation effort. Their findings confirmed the potential for implementation of FIT among complex therapy provider agencies, but also identified barriers to implementation such as adherence to model guidelines about using feedback in discussion with clients and in supervision.

In another study on the implementation of a FIT model, Gleacher et al. (2016) used a mixed methods design to better understand clinicians' experiences of using a FIT model in practice. In their findings, clinicians reported more implementation barriers, such as practical constraints of time and resources, than facilitators, such as leadership

and training support. Surprisingly, clinicians in clinics reporting more barriers to facilitators were also in the clinic demonstrating the highest degree of implementation.

Ethical Considerations

The primary ethical consideration associated with this research design was related to the linking of responses to personally identifying information. The case selection sequencing required that contact information from respondents was collected and maintained following the initial quantitative data collection step, so that participants who indicated agreement with the interview phase of the study would be later contacted for interviews. Although there were not any evaluative or other potentially harmful consequences linked to the inquiry, steps to inform and protect participants of any potential harm were considered for both data collection, analysis, storage, and reporting phases. A coding system was employed following the development of the distribution list to limit the instances in which personally identifying information was referenced in the data collection, analysis, and storage phases. Potentially identifying information in interviews such as names of colleagues or specific agencies were replaced with notes in transcriptions signaling that an identifier was cited by the interviewee.

Limitations of Mixed Methods Inquiry

Like all methods of research, mixed methods inquiry has limitations that should be acknowledged. The combination of methods may imply that the limitations of traditional quantitative or qualitative methods are somehow eliminated. However, barriers to effective quantitative research associated with sample sizes and validity of instruments remain as do challenges in interpreting the meaning of qualitative data.

Although the purpose of mixing methodology might include attention to overcoming limitations of one method, there is also potential for combining problems from both.

Creswell and Plano-Clark (2018) noted three main threats to validity in explanatory sequential variants of mixed methods research. The first two of these relate to not identifying worthwhile results to explain and not investigating surprising or contradictory results. The authors recommended considering all possible explanations and devising interview questions that clarify surprising or contradictory results. The final threat to validity mentioned is when the two strands of the research are not connected or integrated effectively. The authors encouraged purposeful selection of participants for the follow-up qualitative strand who can provide explanations related to the study questions.

Phase One: Quantitative/Case Selection

Participants.

Participants sought for this study included supervisors eligible to provide clinical supervision to licensed professional counselor associates (LPCAs) in the state of Kentucky. The geographic presentation of regions and distribution of participants in the state is featured in Figure 2. To obtain email addresses for eligible supervisors, an initial review of the state's counseling licensing board directory indicated 615 supervisors were eligible for 997 LPCAs (Department of Professional Licensing, Commonwealth of Kentucky, 2019). The LPCC Supervisor List contains names as well as mailing and business cities and zip codes. By cross-referencing locations of supervisors on the list with the seven region categories indicated in the Active License Directory, Table 3.1, a distribution of all eligible supervisors by region, was created as a

sole reference point for comparing the sample in this study with the population of eligible supervisors.

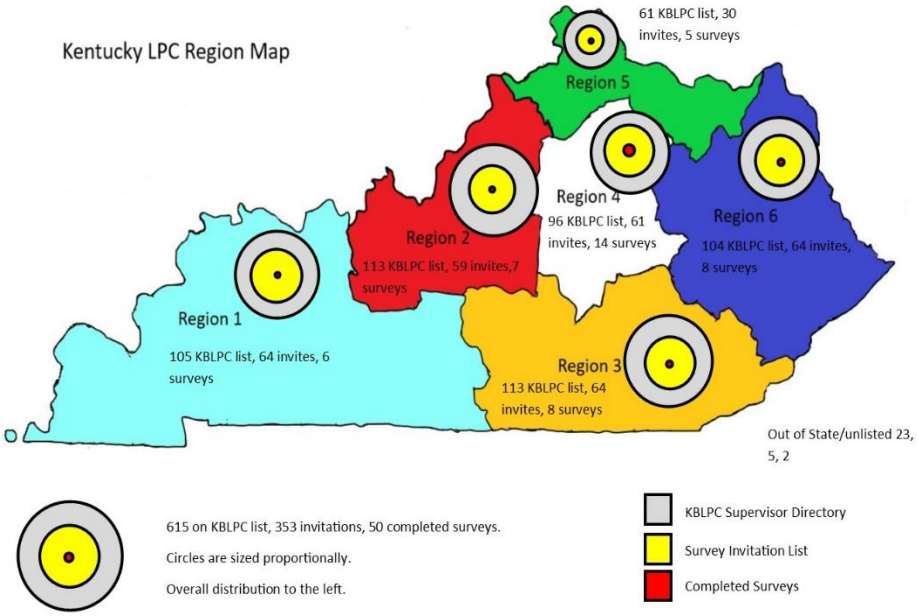

Figure 2: Kentucky LPC Region Map

Table 3.1

Eligible Supervisors by Region

LPC Region	LPCC #	LPCC %	LPCA #	LPCA % of KY total	Supervisors	Supervisor % of KY total	Ratio LPCA : Supervisor
1	315	18.6	165	16.5	105	17	1.57:1
2	433	25.6	214	21.4	113	18.3	1.89:1
3	265	15.6	207	20.7	113	18.3	1.83:1
4	301	17.8	188	18.8	96	15.6	1.95:1
5	170	10	67	6.7	61	9.9	1.13:1
6	206	12.1	156	15.6	104	16.9	1.5:1
OOS	191	11.2	52	5.2	23	3.7	2.2:1
Total	1690	100	997	100	615	100	1.62

As publicly available information shared at the discretion of individuals, contact information available from the state licensure website varies by entry (Department of Professional Licensing, Commonwealth of Kentucky, 2019). Additional cross-referencing of many entries was needed to establish an appropriately sized distribution list. Cross-referencing the Supervisor List with the broader Active License Directory of Licensed Professional Counselors led to identifying 190 supervisors who had publicly listed email contact information.

The remaining supervisors' contact information was not listed, so additional steps were taken to cross-reference professionals listed with other directories such as the Kentucky Counseling Association (KCA) website and the state Department of Behavioral Health mailing list for community mental health providers. Both the state licensure and KCA administrative staff were contacted about reaching out to the full list of supervisors, but neither group indicated that this request would be honored. Both entities noted that members were protective of their contact information and had not authorized releasing their contact information for this purpose.

Another 139 email addresses for supervisors were obtained through cross-referencing the eligible supervisor list with other publicly available mailing lists and web searches for practice websites. The distribution list for the survey at the beginning of the quantitative data collection reached 319 supervisors with contact information. Upon the establishment of a distribution list of more than half of the total population of listed supervisors in the state, a probabilistic sampling method was not considered. The final regional distribution of supervisors included in the survey distribution is presented in Table 3.2.

Table 3.2

Supervisor Response by Region

LPC Region	Total Supervisors by KBLPC	Supervisors on survey list	%Region Representation in survey distribution	%Region contribution to survey	Supervisors completed survey	%Sample Completed by region
1	105 (17%)	64	60.95	18.13	6	12
2	113 (18.3%)	59	52.21	16.71	7	14
3	113 (18.3%)	64	56.63	18.13	8	16
4	96 (15.6%)	64(-3)	66.67	18.13	14	28
5	61 (9.9%)	30	49.18	8.4	5	10
6	104 (16. 9%)	64	61.53	18.13	8	16
OOS	23 (3.7%)	5	21.73	1.41	2	4
Total	615	353			50	

Survey development.

In the collection of quantitative data, an electronically distributed survey was used. The questionnaire was developed for online distribution using Qualtrics, a web-based software toolkit for creating, distributing, and organizing surveys (Qualtrics, 2018). The questionnaire was pilot tested with the support of faculty on the dissertation committee and with doctoral student peers to gather feedback and adjust prior to broad distribution, resulting in 62 self-report items. The first item of the survey clarified agreement with the study instructions and overall consent information, while a final item presented the opportunity to participate in the second phase of the study through interview.

The survey incorporated similar content to that used in Ionita and Fitzpatrick's (2014) study of prevalence of FIT use, consisting of items about demographics,

theoretical orientation, clientele type, and setting type as well as items specifically addressing exposure to and use of feedback in treatment models. In the demographic category, eight items were included to collect information about age, gender, education experience, years of experience as a supervisor, and theoretical orientation. Nine questions were included in a category for practice conditions, seeking information about hours of direct time with clients per week, various practice characteristics, and the degree to which aspects of practice are mandated. Additionally, supervision conditions were explored with four items about the number of supervisees, the placement of supervisees, and ways in which supervisors seek continuing education experiences.

The survey also included the Monitoring and Feedback Attitudes Scale (MFA) and selected items from the Attitudes toward Standardized Assessment Scales-Monitoring and Feedback (ASA_MF) (Jensen-Doss et al., 2018). The Monitoring and Feedback Attitudes Scale measures therapist attitudes according to two factors: perceived benefit associated with monitoring and feedback and perceived harm in receiving negative feedback. Both factor subscales have demonstrated good internal consistency (MFA Benefit a=0.87, MFA Harm a=0.87). There were six items chosen from the ASA-MF, including two items for each of the three factors: clinical utility, treatment planning, and practicality.

There were no prior measurements of attitudes of supervisors about using FIT data identified in the literature, so a small number of items were developed to measure attitudes about using FIT data for evaluation and structuring feedback to supervisees about skill development. The 5-point Likert scale structure of the MFA and ASA-MF items was continued for the items developed to measure agreement with attitudes about

using FIT data in supervision. Themes suggested from review of the supervision literature focusing on responsibilities for evaluation and giving feedback to supervisees were developed into five items such as "Using client feedback data in supervision enhances the evaluation of treatment effectiveness."

The remainder of items in the survey related to exposure to and utilization of FIT whether in practice as a counselor or in supervision. In this final section, a brief definition of FIT was provided from Yates et al. (2016) to clarify for participants the specifics of the concepts and examples of the model. The display logic function of the survey software was utilized to direct participants to relevant follow-up items if they indicated awareness or use of FIT models. Participants noting awareness of FIT were asked to identify models known to them. In turn, participants noting use of FIT were also asked to identify models known to them as well as models that they had previously used. Participants noting use were also asked if they currently used FIT, how often they administer FIT, and how often they would prefer to use FIT in their practice. Participants were separately asked if they used FIT data in their work as supervisors, then if they indicated yes, how often and how often they preferred to review FIT data with supervisees.

Survey distribution analysis.

Saleh and Bista (2017) noted advantages and disadvantages of online surveys as a means of data collection. Researchers appreciated the faster response, low cost, and tools for managing follow-up communication to remind or thank participants about the survey. Although initial findings on online surveys suggested a high response rate, the response rate has been declining. Trespalacios and Perkins (2016) concluded that

combining strategies to pre-notify, incentivize, personalize, and send reminder messages was associated with a higher response rate to online surveys. The survey distribution plan included welcome messages that were personalized for each potential participant and included a notification of a continuing education unit opportunity available for free to all supervisors notified of the study. Reminder messages were also scheduled within the distribution plan.

In the initial sequence of quantitative data collection, analysis focused on determining the response patterns of supervisors. Although some supervisors responded promptly to the initial invitation to the study, issues emerged related to incorrect or outdated email contact information for many supervisors which either failed to reach any recipient or were never read. Other issues included over 30 invitations that were blocked by email server framework standards that prevent and reduce malware and spam messages. Alternative strategies recommended within Qualtrics support resources online were either not available to the researcher or had little effect in increasing participation, so a recruitment revision was developed with consultation from the doctoral committee.

Recruitment revision.

Upon the initial distribution of the welcome email, significant limitations were apparent in the accuracy of the identified contact information on the Kentucky Board of Licensed Professional Counselors (KBLPC) website. Of the 615 potential participants on the list, only 190 had an email address indicated on the KBLPC board website. Another 139 email addresses for participants were identified through web searches for businesses, other public mailing lists and networking tools for counselors. In evaluating

the response to the initial distribution, it was determined that many email addresses were not accurate or up to date, resulting in a significant reduction in participants who received the welcome message. After the first month of data collection, only 21 responses to the survey had been collected. The small number of responses to the survey were insufficient to resolve the study questions.

The researcher explored the issues using the troubleshooting tools within the Qualtrics software and learned that email servers might be blocking the invitation to the survey because of a technical issue in something called "Sender Protocol Framework" (SPF), which is a system to reduce spam and malware being sent through email. This issue suggested that even participants who seemingly received the welcome invitation may not be able to view it, because their email software had quarantined the message. There were several explanations of why the distribution was affected by this failure in the SPF, but the only one that could be addressed by the researcher was to adjust the recruitment strategy to include a more personalized method.

The researcher requested a revision to the recruitment strategies to employ a popular tool for professional networking called LinkedIn to contact potential participants on the KBLPC website list and clarify their email contact information. Specifically, this adjustment altered section 3.5 of the Institutional Review Board application with the addition describing how more email addresses would be identified by reaching out through LinkedIn to potential participants from the list of eligible supervisors on the KBLPC website.

The basic message sent to potential participants through LinkedIn used the following script: "I am trying to connect with counseling supervisors in my dissertation

research at EKU. I am hoping you will provide an email address so that I can send an invitation to study to you." The script was limited to a small number of characters based on the messaging system of LinkedIn.

Participants were free to ignore the invitation to connect or ask questions about participating within the messaging system of LinkedIn. They were also able to view the profile of the researcher to verify credentials for themselves. Upon receipt of an updated email address, the previously approved welcome invitation was sent to the participant for their review.

Data collection.

Following the revision to recruitment procedures, another 33 responses to the survey were collected from supervisors, resulting in a total of 54 survey responses. Four responses were incomplete and remained incomplete despite efforts to reach out to these supervisors to troubleshoot any barriers they encountered with the survey. Incomplete surveys were withheld from the quantitative analysis. Although Qualtrics software offers some functional analysis, survey data was organized and formatted in a database for use in the Statistical Package for the Social Sciences for further statistical analysis.

Case selection.

Following collection of survey responses, a basic analysis of the descriptive statistics was conducted to organize participants by responses to items about exposure to and use of FIT data in supervision. Because part of the purpose of sequencing quantitative data collection first was to identify participants for the subsequent qualitative data collection, participant responses were linked with identifying information. Many survey participants (38 of 50) indicated agreement with participating

in interviews, creating an opportunity to understand more context about the potential for implementing FIT data in supervision.

Interim Phase: Interview Protocol Development

Content for the interview protocol was tentative prior to the quantitative data collection. Potential prompts were related to explaining why some supervisors use FIT data and others do not as well as perceived benefits and challenges to the use of FIT in practice and supervision. As final reminders were issued to survey recipients, the interview protocol was developed in consultation with the dissertation chair. With a relatively small sample and quantitative data still incomplete, analysis of the survey results was only speculative in nature, but revealing 14 supervisors who reported being unaware of FIT, another 13 reported being aware but had not used it, and another 10 had reported using it.

The protocol was organized from preliminary review of the quantitative results that suggested three distinct groups within the sample with different levels of awareness and experience of FIT models. Group A was defined as those supervisors who indicated either no prior awareness of FIT or no more awareness than name recognition. Group B was defined as those supervisors who indicated some degree of awareness of FIT beyond name recognition but were not using FIT data in supervision. Group C was defined as those supervisors who indicated use of FIT data in supervision.

The interview protocol included open-ended questions about general supervision experience, prior knowledge about FIT, motivation to use FIT data, concerns about using FIT data, perspectives on evaluation and giving feedback in supervision, and what best explains their use of FIT data. Most prompts were posed to all interviewees, but

some were adjusted in wording to fit the experience of the group. For example, Group A interviewees were asked “What are your questions about the feedback informed treatment concept?”, while Groups B and C were asked “What would you like to tell me about the use of FIT models?”. Group A was presented a total of 8 main prompts from the interview protocol, while Groups B and C were presented with 9 and 10 prompts respectively.

The interview protocol was arranged to help explain the quantitative data results about various factors that influence the utilization of FIT data in supervision. The open-ended prompt about supervision experience was included to clarify how and why supervision practice variables such as the number of supervisees, years of experience as a supervisor, or types of supervision experience matter in the utilization of FIT data. The open-ended prompt for questions about the concept of FIT was intended to reveal common impressions of the practice by those who acknowledged limited awareness of FIT as a concept as well as help interviewees more clearly distinguish FIT as a concept for later prompts in the protocol. Groups B and C were asked generally what the supervisor wants to say about FIT so that more information about their experience with FIT could emerge. This also served as an opportunity to determine if survey responses that suggested awareness such as “read about it in books or articles” were adequate to classify as being aware enough to consider using FIT data in their supervision practice.

Phase Two: Qualitative/Interpretive

Participants.

Survey respondents who agreed to the interview phase were grouped according to response to the survey item indicating their use of FIT in supervision. For the group of respondents who had indicated not being aware of FIT and for whom the question of using FIT data in supervision was not presented (referred to as Group A), there were 12 who agreed to interviews. Five interviews were scheduled with those who responded to the email invitation. For the group of respondents who indicated some degree of awareness of FIT beyond simple name recognition but also indicated not using FIT data in supervision (referred to as Group B), there were 17 who agreed to interviews. Five interviews were scheduled with those who responded to the email invitation. For the group of respondents who had indicated using FIT data in supervision (referred to as Group C), all seven fitting this group at the initial quantitative analysis period agreed to the interview phase. In the final collection of surveys beyond the initial quantitative analysis used to inform the development of the interview protocol, another two respondents indicating use of FIT data in supervision and agreeing to the interview phase were identified. Nine email invitations were sent to Group C. Six interviews were scheduled and completed with this group.

Data collection and Transcription.

Follow-up communication was sent to supervisors who agreed to the interview phase of the study to recruit and schedule structured interviews. Interview settings were offered according to participant preferences to include face to face, web-conferencing, and telephonic formats. Specific options were presented for interviews by telephone or

web-conferencing, although participants were encouraged to suggest alternatives such as meeting in person or establishing a process for an online interview through a web chat service.

The structured interviews were scheduled and completed within the month of November of 2019. Five interviews were completed using the web-conferencing tool Zoom, while another 11 were completed telephonically. All interviews were electronically recorded and transcribed before being processed in the qualitative data analysis software Nvivo (version 12). Following the collection of interview data, the researcher transcribed audio recordings using a facilitative software program (Transcriptions, Version 1.2).

Data analysis and validation

Interview transcriptions were first coded according to categories based on prompts from the interview protocol using the qualitative data analysis software, Nvivo (version 12). Subsequent thematic coding organized common types of responses to specific prompts into themes associated with each category derived from the interview protocol. The subsequent thematic coding was later quantified according to the three case selection groups.

Qualitative coding is subjective by nature, contributing to concerns about validity and reliability. Many designs feature multiple coders to address these concerns as measuring inter-rater reliability can show to what degree that the themes were coded consistently. For this dissertation study, the research design did not include multiple qualitative raters because it was deemed not feasible in the study period. A code book

was developed to support multiple reviews and validity analysis in the future. It is included in the appendix for reference.

Integration of Study Phases

Following the completion of both phases of the study, results were integrated to generate the most accurate and relevant considerations for the study questions. First, a deeper analysis of the quantitative results was conducted. In the initial analysis of the survey data, a basic understanding of the sample, the prevalence of using FIT data in supervision, and hypothesized factors were evaluated to select cases for the next phase of the design and to formulate a more specific interview protocol. With both strands of data, the analysis integrated discrepant data about the use of FIT data in supervision and considered information not precisely measured in the survey that emerged in the interview analysis.

Summary

An explanatory sequential mixed methods research design was used to investigate the use of FIT data in supervision. In this design, supervisors were first surveyed, then participants within the survey sample were selected for follow-up interviews to provide further explanation about using FIT data in supervision. Data were analyzed according to the phase of the design and later integrated when both strands of the data were collected.

CHAPTER 4

QUANTITATIVE RESULTS AND CASE SELECTION

Fifty-four supervisors responded to the survey out of 353 invitations sent out to eligible supervisors in the KBLPC directory, resulting in a response rate of 15.3%. Four of the responses were incomplete and excluded from the analysis, resulting in a sample of 50 supervisors. Before presenting information about potential factors, results about awareness levels of the sample and prevalence results of FIT in practice and supervision are presented. Results of potential factors are analyzed next with frequencies and percentages among the sample presented before identification of any significant relationships with the use of FIT data in supervision.

Research Questions

The research questions that guided this phase of the study included the following:

1. What factors are related to use of FIT data in supervision?

   1a. How prevalent is the use of feedback informed treatment (FIT) data in the supervision of provisionally licensed counselors in Kentucky?

   1b. What models and administration methods of FIT are most popular in the supervision of provisionally licensed counselors in Kentucky?

FIT Awareness & Use

Supervisors were asked to identify which of the following best described their level of FIT awareness: never heard of it until now, recognized the name but not much else, read about it in books or articles, heard about it from colleagues, attended a conference presentation about it, attended training about using it, or used it in practice. Supervisors indicating awareness of FIT beyond simple name recognition were also asked if they used FIT data in supervision, establishing supervisors who use FIT data in supervision and those who do not. The results for awareness levels and distribution of FIT data use in supervision are displayed in Table 4.1.

Responses for either of the first two choices for FIT awareness level, never heard of it until now (28%) and recognized the name but not much else (14%), were categorized in a group as unaware supervisors (42%). Supervisors who reported using FIT in practice as counselors comprised 24% of the sample. The remaining third of supervisors, identified as being aware but not using FIT data in supervision, were split among “read about it in books or articles” (16%), “heard about it from colleagues” (8%), “attended training about using it” (6%), and “attended a conference presentation about it” (4%).

Supervisors reporting the use of FIT data in supervision increased as the level of awareness increased. Supervisors who had experience using FIT in practice were most likely to be using FIT data in supervision. Two-thirds of supervisors using FIT data in supervision had prior experience using it in practice, yet half of supervisors with experience using FIT do not use FIT data in supervision.

Table 4.1

Awareness Level of FIT and Use of FIT Data in Supervision

Item Response	Frequency	Percent	Using FIT in supervision	Not Using FIT in Supervision
Never heard of it until now	14	28.0	0	14
Recognized the name but not much else	7	14.0	0	7
Read about it in books or articles	8	16.0	0	8
Heard about it from colleagues	4	8.0	1	3
Attended a conference presentation about it	2	4.0	1	1
Attended training about using it	3	6.0	1	2
Used it in practice	12	24.0	6	6
Total	50	100.0	9	41

Supervisors who were categorized as being aware of FIT were also asked to identify specific models of which they were aware from options suggested in the literature. Two supervisors indicated awareness of FIT models other than those scripted in the survey, but both appeared to be in error with one stating in text entry "None; client's [*sic*] may not be truthful" and the other citing the "ORS/SRS" scales of the Partners for Change Outcome Management System (PCOMS) which was a listed option. Among models of FIT, supervisors reported awareness of PCOMS the most (18%) which was followed by the Outcomes Questionnaire (14%) and the Treatment Outcome Package System (6%).

Of the 12 supervisors who indicated experience using a FIT model, two-thirds indicated use of PCOMS, while another third indicated use of the Outcome Questionnaire. Three supervisors indicated use of other FIT models and indicated in text entry the use of "CANS, DLA-20", "Likert Scales re symptomology", and "TOPS". Only 8 of the supervisors who reported ever using FIT models in counseling practice indicated currently using a FIT model. Supervisors using FIT in their practice were more likely to use FIT data in supervision as depicted in Table 4.2. Supervisors reporting current use of FIT in counseling practice were more likely to also report use of FIT data in supervision than their peers who were unaware of FIT or aware but not using. Current use in practice and use of FIT data in supervision were related at a statistically significant level ($\chi^2 = 19.030$, $df = 4$, $p < .01$). This relationship was moderately strong between use in counseling practice and use of FIT data in supervision (*rho* = .565).

Table 4.2

Current Use of FIT Model in Practice & Use of FIT Data as a Supervisor

		Do you use Feedback Informed Treatment Data in your work as a supervisor?		
		Yes	No	Total
Do you currently use a Feedback Informed Treatment tool/process in your work as a counselor?	Yes	5	3	8
	No	1	3	4
	Total	6	6	12

Supervisors who reported currently using FIT in their counseling practice were also asked about the frequency of administering FIT with clients (see Table 4.3). Three

supervisors indicated use every session (37.5%) and another three indicated use once monthly (37.5%). Two supervisors indicated using FIT periodically but less often than monthly (25%). This group of FIT using supervisors were also asked about preferences for frequency of administering FIT with clients. Every session, every other session, and every few sessions each had one supervisor response representing a total of 37.5%. Another three supervisors reported preferences to administer FIT with clients once monthly, while the final two supervisors indicated preference for periodically but less than monthly. The reported frequency and preferences for frequency are closely linked, however fewer supervisors indicated preferences for administering FIT with clients every session.

Table 4.3

Frequency of FIT Administration with Clients & Preferred Frequency of FIT Administration with Clients

		How often would you prefer to administer FIT with clients?					
		Every session	Every other session	Every few sessions	Once monthly	Less than monthly	Total
How often do you administer FIT with clients?	Every session	1	1	0	0	1	3
	Once Monthly	0	0	1	2	0	3
	Less than monthly	0	0	0	1	1	2
	Total	1	1	1	3	2	8

Supervisors who indicated awareness of FIT (n = 29), meaning more awareness than name recognition, were also asked if they used FIT data in their work as supervisors. Supervisors who indicated that they used FIT data in supervision accounted for 18% of the survey sample, while those supervisors who indicated some degree of awareness of FIT beyond name recognition but were not using FIT data in their work as a supervisor accounted for 40% of the survey sample. Results related to supervisor use in supervision are provided in Table 4.4.

Table 4.4

Using FIT Data in Supervision

	Frequency	Percent
Yes	9	18.0
No	20	40.0
Total Aware of FIT	29	58.0
Unaware of FIT (Supervisors not asked)	21	42.0
Total	50	100.0

The group of supervisors who indicated use of FIT data in supervision were also asked about the frequency and preferences of frequency in which they used FIT data in supervision (see Table 4.5). In actual frequency of FIT use, periodically but less often than monthly was the most cited answer accounting for two-thirds of supervisors. This level of frequency does not match specific model instructions suggesting drift in model fidelity. The other three supervisors were split among every session, every few sessions, and once monthly. Supervisors indicated preferences for more frequent use of FIT data in supervision with four choosing once monthly, three choosing every few sessions, and the final two were split between every other session and every session.

Table 4.5

Frequency of Reviewing FIT Data & Preferred Frequency of Reviewing FIT Data

		How often would you prefer to review FIT data with supervisees?				
		Every session	Every other session	Every few sessions	Once Monthly	Total
How often do you review FIT data with supervisees?	Every session	1	0	0	0	1
	Every few sessions	0	0	1	0	1
	Once Monthly	0	0	0	1	1
	Less than monthly	0	1	2	3	6
	Total	1	1	3	4	9

Demographic Factors

Factors explored under the category of demographics in the survey included age, gender, and theoretical orientation. None of the demographic items were significantly related to use of FIT data in supervision. Each of the age ranges included in the survey were recorded, showing some diversity in the sample of supervisors.

Supervisors were asked in the survey to choose their age among 10-year ranges beginning at 21 years and grouping all supervisors 71 years or older into one response. More participants reported ages of 41-50 (n = 20) and 31-40 (n = 20) years old than ages of 51-60 (n = 5) and 61-70 (n = 3) which, in turn, were reported more than ages of 21-30 (n = 1) and 71 years or older (n = 1). The overall difference in age ranges was statistically significant at the .001 level (χ^2 = 50.32, df = 5).

More participants reported identifying as female (n = 30) than male (n = 20) in the survey. However, the difference was not statistically significant at the .05 level (χ^2 = .157, df = 1). Female supervisors were more likely to continue using FIT in counseling practice more than males if they reported ever using it. Table 4.6 provides a crosstabulation of age ranges and gender.

Table 4.6

Age Ranges & Gender

		To which gender identity do you most identify?		
		Male	Female	Total
Choose your age among the following ranges.	21-30 years	0	1	1
	31-40 years	4	16	20
	41-50 years	11	9	20
	51-60 years	1	4	5
	61-70 years	3	0	3
	71 years or older	1	0	1
	Total	20	30	50

Table 4.7 displays frequencies of theoretical orientation as reported by supervisors in the survey and the distribution of theories among supervisor groups designated by use of FIT data in supervision and awareness level. Supervisors were provided with seven options for describing theoretical orientation: Cognitive-Behavioral Therapy, Humanistic, Family Systems, Psychodynamic, Eclectic, Integrated (Multi-Modal), and Other. Integrated (36%) and Cognitive Behavioral Therapy (30%) were theoretical orientations most frequently indicated. Eclectic (18%), Humanistic (12%), and Other (4%) were indicated with less frequency. No supervisors indicated theoretical

orientation as Family Systems or Psychodynamic. FIT use was most common among supervisors using multiple theories in their practice whether indicated by choosing "integrated" or "eclectic" but theory choice was distributed proportionally in the sample with no significant relationship to using FIT data in supervision.

Table 4.7

Theoretical Orientation & FIT Data Use in Supervision

Theoretical Orientation			FIT Data Use in Supervision		
	Frequency	Percent	Using FIT in supervision	Not Using FIT in supervision	Unaware
Cognitive Behavioral Therapy	15	30.0	2	5	8
Humanistic	6	12.0	0	3	3
Eclectic	9	18.0	1	4	4
Integrated (Multi-Modal)	18	36.0	5	8	5
Other	2	4.0	1	0	1
Total	50	100.0	9	20	21

Educational Factors

Educational experience items were included in this category such as highest degree obtained, whether the degree was obtained within the state, the CACREP status of degree program, and the year in which the highest degree was completed. Table 4.8 displays the frequency counts split for each of these variables. There was not enough diversity among the variables to determine any relationship to the use of FIT data in supervision. If academic preparation has increased awareness of FIT or promoted the

use of FIT in practice, the survey results do not provide enough variety within degree level, location, or accreditation to determine it.

Table 4.8

Degree Level, In-state, and Accreditation Status

Educational Variables				Frequency
Highest	Masters	In Kentucky	Accredited	26
Degree			Not accredited	6
Attained			Not sure	1
		Not in Kentucky	Accredited	6
			Not accredited	1
			Not sure	0
	Doctorate	In Kentucky	Accredited	5
			Not accredited	1
			Not sure	0
		Not in Kentucky	Accredited	4
			Not accredited	0
			Not sure	0

More participants reported their highest degree attained as a masters (n = 40) than reported doctorate degrees (n =10) in the survey. The difference was statistically significant at the .001 level (χ^2 = 18.000, df = 1). More participants reported attaining their degrees in Kentucky (n = 39) than reported degrees from outside of Kentucky (n = 11) in the survey. The difference was statistically significant at the .001 level (χ^2 = 15.680, df = 1). More participants reported attaining their degrees at CACREP accredited programs (n = 41) than reported degrees at non-accredited programs (n = 8) or not being sure of accreditation status (n= 1) in the survey. The difference was statistically significant at the .001 level (χ^2 = 54.760, df = 2).

Another educational factor considered in the survey was related to required continuing education. Supervisors were asked to indicate all ways in which they seek continuing education or scholarship. Online continuing education systems (90%) were most frequently indicated. The next most frequently indicated ways were professional associations (72%), conference presentations (68%), and agency hosted training (50%). The least frequently indicated ways included reading academic journals (32%), other (18%), and research participation (14%). Associations between FIT data use in supervision and selected ways for continuing education are displayed in the crosstabulation in Table 4.9.

Table 4.9

Continuing Education Methods & FIT Data Use in Supervision

Crosstabs	Do you use Feedback Informed Treatment Data in your work as a supervisor?			
	Yes	No	Unaware	Total
Online Continuing Education Systems	8	18	19	45
Professional Associations	3	18	15	36
Conference Presentations	8	14	12	34
Agency-hosted Training	4	10	11	25
Reading Academic Journals	2	8	6	16
Other	3	3	3	9
Research Participation	5	2	0	7
Total	9	20	21	50

Practice Factors

Practice settings.

Several practice setting options were presented to supervisors including: Private Independent Practice, Private Group Practice, State Designated Community Mental Health Center, Other Outpatient Mental Health Agency, K-12 School, Higher Education, Hospital Setting, Day Treatment Facility, Residential or Group Home Facility, or General Medical Practice. Supervisors in the sample were spread among the settings with no one setting accounting for more than 20%. No supervisors reported Day Treatment Facility as their practice setting. The frequencies in order of rank included: Private Independent Practice (20%), Private Group Practice (18%), State Designated Community Mental Health Center (16%), Residential or Group Home Facility (16%), Other Outpatient Mental Health Agency (14%), Higher Education (8%), General Medical Practice (4%), K-12 School (2%), and Hospital Setting (2%). The distribution of practice settings is depicted in Figure 3.

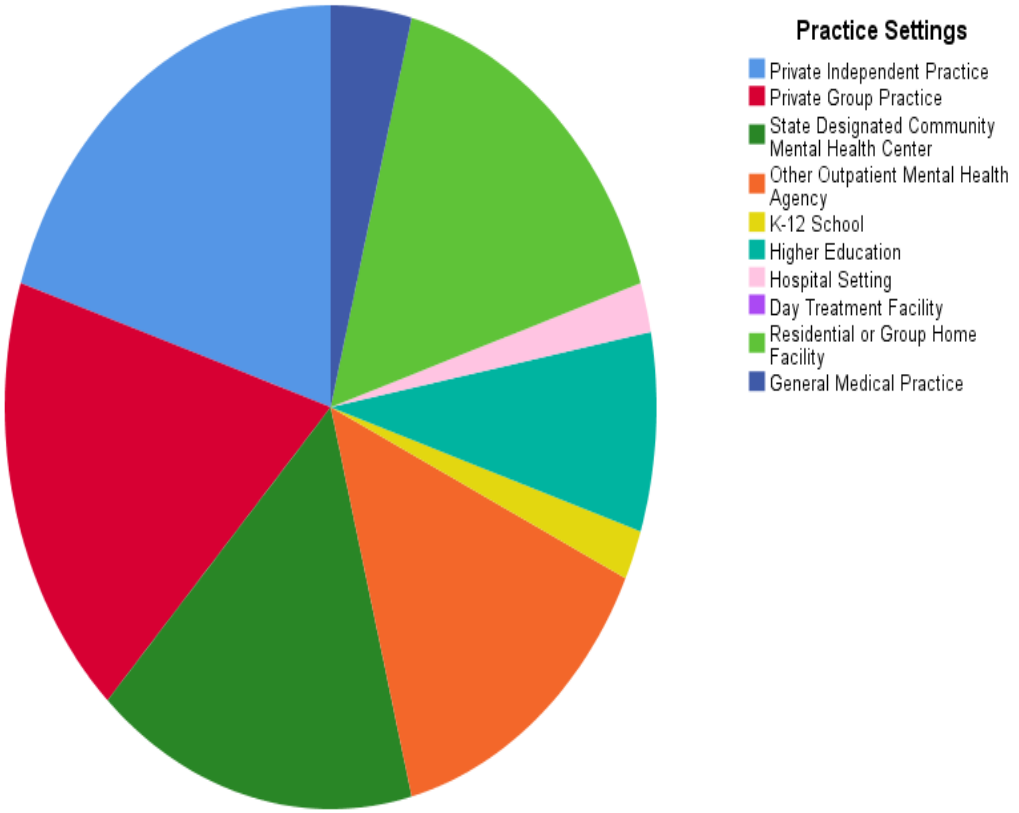

Figure 3 Practice Settings Pie Chart

Those supervisors reporting practice settings of community mental health center or higher education were most likely to have used in practice and half of supervisors in both groups reporting use of FIT data in supervision. Higher education was also most aware as a group as all supervisors in the category indicated awareness. Private Independent Practice and Other Outpatient Mental Health Agency settings had the most supervisors reporting being unaware. The Private Group Practice setting was split evenly in being unaware, aware but not having experience, and used in practice. Table 4.10 displays the distribution of FIT data use in supervision across practice settings.

Table 4.10

Practice Settings & FIT Data Use in Supervision

		Using FIT Data in Supervision			
		Yes	No	Unaware	Total
Practice Setting	Private Independent Practice	0	4	6	10
	Private Group Practice	2	4	3	9
	State Designated Community Mental Health Center	4	2	2	8
	Other Outpatient Mental Health Agency	0	2	5	7
	K-12 School	0	1	0	1
	Higher Education	2	2	0	4
	Hospital Setting	0	1	0	1
	Residential or Group Home Facility	1	3	4	8
	General Medical Practice	0	1	1	2
	Total	9	20	21	50

Practice size.

Agency size was measured by asking supervisors to estimate the number of clients engaged in treatment through their agency annually. Options were grouped as less than 100, 101-200, 201-300, 301-400, 401-500, and 501 or more. Nearly half of supervisors reported belonging to the largest agency size of 501 or more (46%). The smallest agency size, less than 100 (20%), was the next most frequent in the sample followed by 201-300 (14%), 101-200 (10%), 301-400 (8%), and 401-500 (2%).

The largest totals of supervisors who were unaware of FIT and had used FIT were from the most frequently reported and largest agency size. FIT data use in supervision was most reported in the largest agency size. There was no significant relationship apparent between agency size and awareness or agency size and use of FIT data in supervision as displayed in Table 4.11.

Table 4.11

Practice Size & FIT Data Use in Supervision

		Using FIT Data in Supervision			
		Yes	No	Unaware	Total
Estimated Clients Engaged in Treatment at Practice Agency	Less than 100	1	4	5	10
	101-200	1	2	2	5
	201-300	2	5	0	7
	301-400	0	0	4	4
	401-500	0	0	1	1
	501 or more	5	9	9	23
	Total	9	20	21	50

Payor source.

Supervisors were asked about payor sources most responsible for funding their practice including Medicaid Managed Care, Private Insurance, Government Agencies, Grant Funding, or Direct Client Payment-Fee for Service. Supervisors indicated Medicaid Managed Care (44%) as funding their practice more frequently than other sources with Private Insurance (26%), Direct Client Payment-Fee for Service (16%), Grant Funding (10%), and Government Agencies (4%).

Awareness patterns do not seem to be relate to payor sources. The two highest categories of use in practice were the two highest reported payor sources. Other payor sources were either evenly spread among awareness or of such a small number that a

relationship could not be determined (Government agency had only two supervisors, both of whom were unaware of FIT). The reported use of FIT data in supervision is proportionally distributed across payor sources as shown in Table 4.12.

Primary clientele.

Primary clientele of supervisors was limited to options for Adults, Children and Adolescents, or General. Supervisors indicated primary clientele of Adults (52%) more than Children and Adolescents (30%) or General (18%). Those supervisors working primarily with adults were more likely to be unaware of FIT than those supervisors working primarily with children and adolescents. FIT data use in supervision was proportionally distributed among clientele types as shown in Table 4.12.

Record system type.

Record systems used by supervisors were described as either Predominantly Paper-Based Record System or Predominantly Electronic Record System. By far, supervisors described their record systems as being electronic (86%) more than paper-based (14%). Record type responses also did not reveal a relationship to awareness level. 86% are using electronic health records. Awareness levels were distributed widely among the two record types, but FIT data use in supervision was only reported among supervisors who predominantly use electronic record systems (shown in Table 4.12).

Table 4.12

Payor Source, Primary Clientele, Record Type and FIT Data Use in Supervision

	Frequency	Percent	FIT Data Use in Supervision (n = 9)
Primary Payor Source			
Medicaid Managed Care	22	44.0	4
Private Insurance	13	26.0	2
Government Agencies	2	4.0	0
Grant Funding	5	10.0	1
Direct Client Payment- Fee for Service	8	16.0	2
Primary Clientele			
Adults	26	52.0	4
Children and Adolescents	15	30.0	3
General	9	18.0	2
Record Type			
Predominantly Paper-Based Record System	7	14.0	0
Predominantly Electronic Record System	43	86.0	9

Practice specialties.

Supervisors were able to indicate all claimed practice specialties in a multiple response item of the survey. Among available specialty choices, all were indicated by supervisors with Trauma (72%) and General (70%) as the specialties most frequently indicated. Severe Mental Illness (42%), Substance Use (34%), Couples/Families (34%), and Group Counseling (28%) followed in frequencies indicated. School Settings (24%) and Career and Lifestyle Counseling (24%) were the least frequently chosen by supervisors. Interestingly, half of supervisors reporting school settings as a practice specialty also reported use of FIT data in supervision as shown in Table 4.13.

Table 4.13

Practice Specialties and FIT Data Use in Supervision

	Frequency	Percent	FIT Data Use in Supervision (n = 9)
Trauma	36	72.0	7
General	35	70.0	8
Severe Mental Illness	21	42.0	6
Substance Use	17	34.0	4
Couples/Families	17	34.0	3
Group Counseling	14	28.0	3
School Settings	12	24.0	6
Career and Lifestyle Counseling	12	24.0	4

Mandated practice elements.

Supervisors were asked to rate the degree to which assessment procedures were mandated in their practice setting as not a lot, some, or a lot. Supervisors in the sample described higher degrees of mandated assessment procedures as more frequent with rankings of "a lot" (42%), "some" (36%), and "not a lot" (22%). Supervisors were also asked to rate the degree to which evidence-based practices were mandated in their practice setting as "not a lot", "some", or "a lot". In this item the strength of the mandate in their practice settings was even stronger as supervisors reported the degree as "a lot" (58%) more than "some" (28%) and "not a lot" (14%) combined. Crosstabulations of mandated practice elements and FIT data use in supervision are displayed in Tables 4.14 and 4.15. FIT data use in supervision was reported across all degrees of mandated practice elements. Frequency of FIT data use in supervision

increased as the degree of mandate increased but so did the report of all supervisors in the sample.

Table 4.14

Degree of Mandated Assessment and FIT Data Use in Supervision

		Using FIT Data in Supervision			
		Yes	No	Unaware	Total
Degree of Mandated Assessment Procedures	Not a lot	2	3	6	11
	Some	2	8	8	18
	A lot	5	9	7	21
	Total	9	20	21	50

Table 4.15

Degree of Mandated EBP and FIT Data Use in Supervision

		Using FIT Data in Supervision			
		Yes	No	Unaware	Total
Degree of Mandated Use of EBPs	Not a lot	1	3	3	7
	Some	3	5	6	14
	A lot	5	12	12	29
	Total	9	20	21	50

Direct hours with clients.

For the final item in the practice settings category of survey items, supervisors were asked to indicate a range of hours of direct therapy that they provided on average each week beginning at 0 hours and continuing in five-hour increments to 31 hours or more. The more hours supervisors dedicate to direct care for clients might mean less hours available for supervision or review of FIT data of supervisees. The sample revealed a wide distribution of average hours per week with clients in therapy. The least

frequent response “31 or more” was reported by 8% of supervisors, while the most frequent responses were “6-10” and “21-25” which were both reported by 18% of supervisors. No significant relationship between average direct hours of therapy per week and awareness level was detected as levels of awareness were distributed proportionally across the range of direct hours reported. Supervisors using FIT data in supervision were also spread across all ranges of direct hours reported except for the highest and least frequent option available “31 or above”.

Supervision Experience

Supervisors indicated their years of experience as supervisors for counselors by choosing among year ranges beginning at 0 to 3 years and ending at 18 years or more. Although each 3-year range presented was indicated at least twice, two-thirds of the sample indicated being supervisors for counselors 6 years or less as shown in Table 4.16. Two-thirds of supervisors who reported FIT data use in supervision had also reported years of experience as supervisors as 6 years or less. However, the relationship between years of experience as a supervisor and the use of FIT data in supervision was not statistically significant at the .05 level ($\chi^2 = 8.997$, $df = 10$).

Table 4.16

Supervisor Years of Experience & FIT Data in Supervision

		Using FIT Data in Supervision			
		Yes	No	Unaware	Total
Years of Supervision Experience for counselors or student counselors	0-3 years	2	9	7	18
	4-6 years	4	7	4	15
	7-9 years	2	1	4	7
	10-13 years	0	2	4	6
	14-17 years	1	0	1	2
	18 years or more	0	1	1	2
	Total	9	20	21	50

Because the research questions emphasized inquiry about supervision for LPCAs, supervision relationships were divided into separate items for the number of LPCA supervisees and students for whom each supervisor was responsible. Supervisors in the sample reported 102 LPCAs being supervised. The distribution of LPCA supervisees reported was moderately skewed. The mean number of LPCA supervisees reported was 2.04 (*mdn* = 2) with over a quarter of supervisors reporting no LPCA supervisees. Only two supervisors reported having more than five LPCA supervisees, the most being reported as eight. The mean reported number of LPCA supervisees among supervisors reporting use of FIT data in supervision (*m* = 2.67) were not significantly different from those aware but not using FIT (*m* = 2.00) or unaware of FIT (*m* = 1.81).

For student supervisees, the distribution of responses was highly skewed by an outlier reporting 24 student supervisees. The mean number of student supervisees reported was 2.56 (*mdn* = 2). Again, many supervisors, 16, reported having no student

supervisees. Five supervisors accounted for 37.5% of the 128 student supervisees reported in the sample. The mean reported number of student supervisees among supervisors reporting use of FIT data in supervision (m = 3.33) were not significantly different from those aware but not using FIT (m = 3.55) or unaware of FIT (m = 1.29).

Four supervisors reported having no LPCA or student supervisees. These supervisors also reported being unaware of FIT as a concept (only one reported recognizing the name). Three of these individuals reported holding doctoral degrees. None of these individuals participated in the interview process. Although three agreed in the survey, one declined the invitation once the interview phase began. The other two did not respond to the invitation. It is assumed that these supervisors would not be using FIT data in their supervision if they had supervisees given their lack of awareness of FIT as a concept. There were no supervisors that responded to the item about using FIT data in supervision who had no supervisees to supervise, meaning that all who answered the question had opportunity to use FIT data in supervision with a supervisee.

Supervisors were asked to categorize how many of their supervisees were employed within the same agency by choosing “All”, “Most”, “About half”, “Less than half”, or “None”. Supervisors and supervisees working within the same agency are likely to share other implementation influences such as organizational culture, leadership styles, or mandates from external payor sources. The two most frequent responses “None” (40%) and “All” (28%) reflected opposite ends of possible answers. Two-thirds of supervisors reporting the use of FIT data in supervision also reported that “all” or “most” of their supervisees were employed at the same agency. However, the

relationship between supervisees being employed at the same agency and the use of FIT data in supervision was not statistically significant at the .05 level ($\chi^2 = 11.313$, $df = 8$).

Attitudinal Factors

Attitudinal factors were measured using the Monitoring and Feedback Attitudes Scale (MFA), selected items from the Attitudes toward Standardized Assessment Scales-Monitoring and Feedback (ASA-MF), and similarly structured items framed around attitudes about the relation of FIT data to supervision responsibilities of evaluation and giving feedback. Overall supervisors in the sample reported attitudes favorable to the use of FIT in practice and in supervision. Analysis of supervisors' responses began with comparing the sample means for scales and individual items with prior research using the MFA and ASA-MF. Next scale and individual item means were compared between subgroups of unaware, aware but not using FIT data in supervision, and FIT data use in supervision.

Perceived benefit.

To calculate the variable perceived benefit, instructions from the MFA were followed. Ten items from the scale were averaged to compute a mean score for perceived benefit. The supervisors in the sample generally perceived FIT to be beneficial in practice. The mean score for perceived benefit from supervisors in the sample was higher than ($m = 4.36$) the mean ($m = 4.07$) reported in Jensen-Doss et al. (2018) at a statistically significant level ($p < .001$, $t = 3.847$, $df = 49$).

Participating supervisors who reported awareness of FIT but not using FIT data in supervision ($m = 4.165$, $sd = .591$) reported less perceived benefit than supervisors who use FIT data in supervision ($m = 4.7$, $sd = .324$). The difference between the two

means is statistically significant at the .05 level (t = 2.531, df = 27). There is a moderately strong relationship between perceived benefit scores and using FIT data in supervision (Spearman's *rho* = .541). The group of supervisors who were unaware of FIT had a mean (m = 4.4, sd = .479) of perceived benefit between those using FIT data in supervision and those aware but not using FIT.

Perceived harm.

Instructions from the MFA were also followed to calculate perceived harm. Four items from the scale were averaged to compute a mean score for perceived harm. Overall, the sample suggested disagreement with items asserting potential harm from using FIT in practice. The mean score for perceived harm between this sample (m = 2.315) and the mean reported in Jensen-Doss et al. (2018) (m = 2.45) was not significant at the .05 level (t = -1.421, df = 49).

Participating supervisors who reported use of FIT data in supervision (m = 2.22, sd = .592) and supervisors who were unaware of FIT (m = 2.22, sd .646) reported slightly stronger disagreement with perceived harm than supervisors who indicated awareness of FIT but not using FIT data in supervision (m = 2.45, sd = .737). The difference among the means was not statistically significant at the .05 level (F [2, 49] = .664).

Clinical utility.

Two items were pulled from the ASA-MF relating the variable of clinical utility. One of the items “standardized progress measures don’t tell me anything I can’t learn from just talking to clients” was reverse coded in the analysis according to instructions. Supervisors reported stronger disagreement with this item in the sample (m = 2.18) than

in the sample reported in Jensen-Doss (2018) (*m* = 2.79). The difference between the means was statistically significant at the .01 level (*t* = -4.212, *df* = 49). Supervisors using FIT data in supervision (*m* = 1.78, *sd* = 1.202) reported stronger disagreement with the item than their peers who were aware but not using FIT data (*m* = 2.45, *sd* = 1.099), however this difference was not statistically significant at the .05 level (*t* = -1.481, *df* = 27).

The other survey item related to clinical utility focused on having information available that might not "otherwise come up in session". Supervisors reported stronger agreement with this item in the sample (*m* = 4.16) than in the sample reported in Jensen-Doss (2018) (*m* = 3.68). The difference between the means was statistically significant at the .01 level (*t* = 4.984, *df* = 49). Supervisors using FIT data in supervision reported stronger agreement (*m* = 4.44, *sd* = .527) with this item about the clinical utility of FIT than their peers who were aware but not using FIT data (*m* = 3.90, *sd* = .718), however this difference was not significant at the .05 level (*t* = 2.033, *df* = 27).

Treatment planning.

Items related to treatment planning from the ASA-MF were also included. The first of these items was "standardized progress measures help identify when treatment is not going well". Supervisors reported stronger agreement with this item in the sample (*m* = 3.68) than in the sample reported in Jensen-Doss (2018) (*m* = 3.31). The difference between the means was statistically significant at the .01 level (*t* = 3.532, *df* = 49). Supervisors using FIT data in supervision reported stronger agreement (*m* = 4.00, *sd* = .707) than their peers who were aware but not using FIT (*m* = 3.70, *sd* .657), however this difference was not significant at the .05 level (*t* = 1.112, *df* = 27).

The second item relating to the treatment planning variable focused on how information from standardized assessment "helps planning for sessions". Supervisors reported stronger agreement with this item in the sample (m = 3.88) than in the sample reported in Jensen-Doss (2018) (m = 3.44). The difference between the means was statistically significant at the .01 level (t = 4.17, df = 49). Supervisors reporting use of FIT data in supervision reported stronger agreement with their peers who were unaware and aware but not using FIT data in supervision. The difference was statistically significant at the .01 level (F [2, 47] = 5.703).

Participating supervisors who reported awareness of FIT but not using FIT data in supervision (m = 3.6, sd = .66) agreed less with the overall value of standardized assessment in treatment planning than supervisors who use FIT data in supervision (m = 4.16, sd = .612). The difference between the two means is statistically significant at the .05 level (t = 2.182, df = 27).

Practicality.

Two items were included from the ASA-MF relating to the variable of Practicality. One of these items was reverse scored and focused on whether the information gathered from standardized assessment was worth time dedicated to it. Supervisors reported stronger disagreement with this item in the sample (m = 1.96) than in the sample reported in Jensen-Doss (2018) (m = 2.90). The difference between the means was statistically significant at the .001 level (t = -6.721, df = 49). Supervisors using FIT data in supervision reported somewhat stronger disagreement with this item (m = 2.00, sd = 1.581) than their peers who were aware but not using FIT data in

supervision (*m* = 2.30, *sd* = .865), but this difference was not significant at the .05 level (*t* = -.534, *df* = 10.219).

The other item related to Practicality asserted that standardized assessment "efficiently gathers information". Supervisors reported stronger agreement with this item in the sample (*m* = 4.1) than in the sample reported in Jensen-Doss (2018) (*m* = 3.52). The difference between the means was statistically significant at the .001 level (*t* = 5.378, *df* = 49). There was not a significant difference between supervisors using FIT data (*m* = 4.33, *sd* = .707) and those aware but not using FIT data (*m* = 4.00, *sd* = .795), despite a similar pattern of stronger agreement among supervisors using FIT data in supervision.

The relationship between supervisor attitudes about the usefulness of FIT data for clinical utility and practicality is moderately strong (*r* = .619). The relationships between clinical utility and treatment planning (*r* = .588), as well as practicality and treatment planning (*r* = .579) are moderately strong. Correlation is significant at the 0.01 level for each relationship.

Supervision utility.

Evaluation.

Three items were developed for the survey to measure attitudes about using FIT data in supervision to evaluate supervisee performance. The first of the items asserts that the use of FIT data in supervision enhances the evaluation of treatment effectiveness. The mean for this item was 4.24 in the overall sample (*sd* = .744). An ANOVA for this item revealed that supervisors using FIT data in supervision (*m* = 4.89, *sd* = .333) had stronger agreement than those unaware of FIT (*m* = 4.33, *sd* = .577) who

in turn also had stronger agreement than supervisors aware but not using FIT data in supervision (m = 3.85, sd = .813). The difference among the means was statistically significant at the .01 level (F [2, 47] = 8.199).

The second item related to how discussing FIT data in supervision encourages supervisee self-reflection. The overall sample had a mean of 4.3 (sd = .614). An ANOVA for this item also revealed that supervisors using FIT data in supervision (m = 4.89, sd = .333) had stronger agreement than those unaware of FIT (m = 4.24, sd = .625) and supervisors aware but not using FIT data in supervision (m = 4.10, sd = .553). The difference among the means was statistically significant at the .01 level (F [2, 47] = 6.486).

The final item in this category included an assertion that FIT data provides more accurate understanding of skill development in supervisees (m = 3.88, sd = .895). An ANOVA for this item also showed that supervisors using FIT data in supervision (m = 4.56, sd = .726) had stronger agreement than those unaware of FIT (m = 3.95, sd = .805) who in turn had stronger agreement than supervisors aware but not using FIT data in supervision (m = 3.50, sd = .889). The difference among the means was statistically significant at the .01 level (F [2, 47] = 5.190).

Participating supervisors who reported awareness of FIT but not using FIT data in supervision (m = 3.816, sd = .597) agreed less in all three items combined that FIT data is useful for evaluating supervisees than supervisors using FIT data in supervision (m = 4.777, sd = .44). The difference between the two means is statistically significant at the .001 level (t = 4.311, df = 27).

Giving feedback.

The first of two items in the survey about giving feedback to supervisees using FIT data focused on the idea that giving challenging feedback to supervisees was easier if informed by FIT data. The overall mean in the sample for this item was 3.84 (*sd* = .842). Although the pattern of stronger agreement with the item among supervisors who use FIT data in supervision (*m* = 4.33, *sd* = .707) than their peers in either group (Unaware *m* = 3.81, *sd* = .814) (Aware but not using *m* = 3.65, *sd* = .875) was present, the difference among the means was not statistically significant at the .05 level.

The second item was reverse-scored and related to the assertion that supervision sessions using FIT data lead to negative experiences for supervisees. The mean for this item in the sample was 2.10 (*sd* = .839). An ANOVA for this item indicated stronger disagreement among supervisors using FIT data in supervision (*m* = 1.78, *sd* = .833) than those unaware of FIT (*m* = 2.14, *sd* = .854) and supervisors aware but not using FIT data in supervision (*m* = 2.20, *sd* = .834). However, the difference among the means was not statistically significant at the .05 level.

Participating supervisors who reported awareness of FIT but not using FIT data in supervision (*m* = 3.725, *sd* = .617) agreed less that FIT data is useful over both items for giving feedback to supervisees than supervisors who use FIT data in supervision (*m* = 4.277, *sd* = .618). The difference between the two means is statistically significant at the .05 level (*t* = 2.23, *df* = 27). The relationship between supervisor attitudes about the usefulness of FIT data for evaluation and giving feedback is moderate (*r* = .490, *p* < .001).

Case Selection for Interviews

Three groups emerged from the preliminary analysis of the survey responses based upon level of awareness of FIT and the use of FIT in supervision. The first group consisted of supervisors reporting never hearing of FIT before or knowing nothing more than recognizing the name of it. The second group consisted of supervisors who indicated some awareness of FIT beyond name recognition but were not using FIT data in supervision. The final group consisted of those supervisors who indicated use of FIT data in supervision.

Summary

In this analysis, various factors with relationships to the use of FIT data in supervision were considered. It was determined that the use of FIT data in supervision increased along with the degree of awareness and experience using it in practice. Two-thirds of supervisors using FIT data in supervision reported experience using FIT in their counseling practice. Demographic and educational factors did not show any significant relationships to the use of FIT data in supervision. Supervisors reporting practice settings at state designated community mental health centers represented 44% of those using FIT data in supervision and half of the supervisors at this practice setting used FIT data in supervision which was significantly more than any other type of setting. None of the other practice or supervision factors indicated significant relationships to using FIT data in supervision.

Various attitudes towards the use of FIT models in general were related to using FIT data in supervision. Attitudes about the perceived benefit of using FIT had a moderately strong positive relationship with the use of FIT data in supervision. Other

attitudes such as about perceived harm, clinical utility, treatment planning, and practicality also followed a pattern in which supervisors using FIT data in supervision reported more favorable attitudes about FIT than their peers, however the statistical significances for these differences were not strong. One item related to treatment planning in which it was asserted that information from progress measures helps with planning sessions did have a statistically significant difference with FIT data using supervisors indicating stronger agreement than their peers. Attitudes about using FIT data in supervision specifically for evaluation was significantly stronger among those who use FIT data in supervision than their peers. However, how these attitudinal factors are related to use of FIT data in supervision is not clear from the results.

FIT data use in supervision was low in prevalence in the sample. Supervisors reporting use of FIT data in supervision accounted for only 18% of the sample and only 24 LPCAs claimed out of the overall sample total of 102 LPCAs (23.5%). Students claimed in supervision among the group of supervisors using FIT data in supervision had a similar percentage of 23.4%.

Majorities of supervisors aware (n = 9) and using FIT (n = 8) indicated PCOMS as the most recognized and used model. Two-thirds of those supervisors who reported experience using a FIT model cited PCOMS as the model. The Outcomes Questionnaire was the next most recognized (n = 7) and used model (n = 4). The only other FIT model that was cited for recognition or use in the sample was TOPS which had three supervisors note awareness of and one supervisor noting use of in practice.

CHAPTER 5

QUALITATIVE RESULTS AND MIXED METHODS INTEGRATION

Following the preliminary quantitative analysis, an interview protocol was prepared to further explain the use of FIT data by supervisors. From the 50 completed surveys, 38 supervisors indicated agreement to participating in follow-up interviews if selected. Invitations were sent to all supervisors who indicated agreement. Minimal targets were established to interview at least 5 supervisors for designated categories of previously FIT unaware supervisors (Group A), FIT-aware supervisors not using FIT data in supervision (Group B), and supervisors using FIT data in supervision (Group C). 16 supervisors responded to the invitations and completed interviews.

This chapter contains the results of the qualitative phase of the study and data integration with the quantitative phase of the study. The qualitative phase of the study explored the following research questions:

2. What do supervisors say about FIT in their own practice and in supervision?

    2a. How are supervision strategies and evaluation processes influenced by the collection of client feedback in treatment by supervisees?

    2b. How are supervisors explaining the decision to use FIT data in supervision?

The chapter also covers the integration of the quantitative results and the qualitative results to address the following question in the mixed methods analysis:

3. How are factors related to the use of FIT data in supervision?

    3a. What results emerge from comparing the quantitative data about supervisor attitudes with explanatory qualitative data?

    3b. How are different models and administration methods related to adoption of FIT by counselors?

Results

Semi-structured interviews were completed with 16 supervisors within one month. Results are presented according to the interview protocol structure and identified themes within the content of transcriptions. There were 15 broad categories coded in the qualitative analysis of supervisor responses to interview prompts. Most categories matched specific prompts in the interview protocol, but some were organized from responses to multiple prompts. Within categories, themes and subthemes were coded to reflect the variety of what supervisors had to say.

Early in interviews with two supervisors, responses to prompts in the interview protocol suggested discrepancies in supervisor knowledge and their assigned group in the case selection plan. One supervisor asked for a definition of FIT in response to the second prompt of the interview protocol. In hearing the specific model name of PCOMS, the supervisor remarked, “I use those. So that’s what we’re talking about. (A9)” This information resulted in an adjustment in the interview protocol for this supervisor to include the prompts for Group B instead of Group A. Another supervisor assigned to Group C clarified in response to the second prompt that they had been trained in PCOMS but did not use a specific FIT model in supervision. This supervisor had interpreted the concept of feedback informed treatment as an effort to informally

include client feedback in the treatment process but did not have FIT data available for supervision. The interview protocol provided for this supervisor was also adjusted to follow the prompts of Group B.

Experience

Supervisors were asked about their experience as supervisors of counselors in a broad open-ended first question. The open-ended nature of the question from the interview protocol sought to both orient the participant in the interview experience and provide supervisors the opportunity to determine what aspects of experience were most important for them to share. Supervisors responded with combinations of describing the length in time of being a supervisor, the positive or negative aspects of their experience, prior training as a supervisor, and varied types of supervision experience.

Supervisor responses characterizing years of experience were grouped into three qualities: relatively new, some experience, and extensive. Supervisors who reported experience of less than two years were coded as "relatively new" (n = 6), which was used to describe this range of supervision experience by one of the supervisors. Some experience was used as a theme for seven supervisors who described years of experience between two and ten years. Three supervisors responded by describing their experience as extensive, which was used for 10 years or more of experience as a supervisor. Supervisors also noted difficulties getting connected with supervisees to start their experience as supervisors.

Supervisors talked about other elements of their experience as supervisors. Most supervisors described varied types of supervision such as experiences in administrative supervision or in specific practices like play therapy. Equal numbers of supervisors

mentioned positive and negative aspects of experience as supervisors. One supervisor (C4) commenting on their experience revealed the following negative experience: “I've kind of had a lot of different experiences with people who don't show up. And then people who want me to see them way more than I probably need to.” The same supervisor also noted positive experiences as “other people have been fairly east to supervise.” A quantitative breakdown of responses about experience is listed in Table 5.1 according to assigned case selection groups.

Table 5.1

Supervision Experience

Theme	Group A	Group B	Group C
Interviewees	4	7	5
Years Experience			
Years Exp - New	2	4	2
Years Exp - Some	2	2	3
Years Exp - Long	1	1	1
Experience			
Positive Exp	2	1	1
Negative Exp	0	3	1
Academic Training	1	2	0
Varied Types	3	4	5
Other States	1	1	1

Knowledge about FIT

The interview protocol presented two versions of the question about what supervisors had to say about FIT. For supervisors who indicated no awareness of FIT beyond name recognition (Group A), the interview prompt sought questions from the participant as both a means to learn more about how they interpreted the concept and to reach a

common understanding of the concept which could inform their responses to later questions in the interview. A basic definition of the concept was read in response to initial questions about the concept to generate a consistent understanding among participants. As displayed in Table 5.2, questions from supervisors were coded as belonging to one of three themes: questions about the concept, questions about the method, and questions about resources for FIT.

Table 5.2

Knowledge Levels & Questions about FIT

Theme	Group A	Group B	Group C
Interviewees	4	7	5
FIT Knowledge level			
Minimal	4	2	0
Partial	0	5	1
Thorough	0	0	4
Questions			
Concept	4	4	0
Method	3	2	0
Resources	2	2	0

Supervisors who had indicated awareness of FIT (Groups B and C) were asked broadly what they would like to say about FIT. Four supervisors in Group B (aware but not using FIT data in supervision) indicated not knowing much about the concept and seeking clarification of the definition. Supervisor answers to the prompt about what they had to say about FIT were revealing of the degree of their knowledge about the concept. Knowledge levels were coded in a range of minimal (n = 6), partial (n = 6), and thorough (n = 4). The minimal knowledge code was used when participants

indicated questions or confusion about the basic concepts of FIT and noted no experience or training with FIT models. The partial knowledge code was used when supervisors indicated some understanding of basic concepts or noted some experience or training with FIT models but described being unfamiliar or confused about methods or resources. The code for thorough knowledge was used when the interviewee indicated extensive knowledge of basic concepts, methods, and resources for FIT or noted extensive experience or training with FIT models.

Within responses to the prompt about FIT knowledge, supervisors discussed various other themes that should be acknowledged. Awareness of FIT as a process being used within community mental health centers was indicated by six supervisors from Groups B and C. Supervisors from each group suggested FIT as helpful in nature as well as having a potential for problems. Two supervisors from Group C also described reasons for using FIT, noting the value of FIT in determining effectiveness of treatment and in providing direct feedback to counselors about how they are performing in therapy.

Model Recognition

Although not directly asked in the interview protocol, supervisor responses to various prompts revealed recognition of different models of FIT. Specific models mentioned in the interviews included the Outcomes Questionnaire (OQ) and the Partners for Change Outcome Management System (PCOMS). Table 5.3 illustrates the distribution of recognition of models among the three interview groups. The most recognized of the models, PCOMS (n = 9), was referred to in acronym form as PCOMS, CDOI (Consumer-Directed, Outcome-Informed), or by the specific scales: ORS and

SRS. Only three supervisors mentioned awareness of the Outcomes Questionnaire (OQ). Surprisingly, two supervisors also reported use of the Counseling Center Assessment of Psychological Symptoms (CCAPS) that was left out of the survey list of options but not added as other in any responses.

Table 5.3

FIT Model Recognition

Theme	Group A	Group B	Group C
Interviewees	4	7	5
Model Recognition			
CCAPS	0	0	2
OQ	0	0	3
CDOI/PCOMS	0	5	4

Motivation

The category of motivation was organized around responses to interviewee responses to either what would motivate them to adopt FIT data in their supervision practice or what has motivated them to adopt FIT data in their supervision practice. Themes coded in this category as motivating for FIT data adoption in supervision were client benefit, being mandated, more knowledge about FIT, prior experience, recommendations of peers, reputation, better supervision, and uses for the data. The breakdown of responses for motivation are displayed in Table 5.4.

Table 5.4

Motivation

Theme	Group A	Group B	Group C
Interviewees	4	7	5
Motivation			
Client Benefit	1	2	3
Mandate	1	1	1
More FIT info	2	0	0
Prior Experience	0	0	1
Recommendation	1	1	1
Reputation	0	0	1
Better Supervision	0	3	5
Use for data	1	4	4

Impact of FIT

Interviewee responses to query about how FIT might affect or has affected their practice as a counselor or in supervision. Answers were coded as helpful, unhelpful, or not sure. Only one supervisor response reflected a sense that FIT would be unhelpful to their counseling or supervision practice. This was stated plainly: “Well, as a counselor, I think that daily or by session feedback might not be so helpful. But maybe quarterly or every six months or at the end of treatment (B4).”

Another 14 supervisors responded with descriptions that indicated FIT would be helpful to their counseling practice or supervision. Many noted that FIT provides important information about client and supervisee progress that can be used to reflect on what is working in supervision. In a different example, one supervisor said:

> I think it would actually help me. Because there is sometimes… especially if I've had a therapist for, you know, at least say a year that sometimes it gets stagnant

> in the sessions. And so, I think that would be a good tool to help elicit conversation. And again, hone in on what they specifically need and their clients specifically need (A2).

Three of the supervisors who described FIT as having a helpful impact joined one other supervisor in acknowledging some uncertainty about the impact of FIT in counseling practice or supervision. Responses of uncertainty shared basic questions such as how collecting feedback might negatively affect routines with clients or how to handle discrepancies in what clients report on feedback instruments and what counselors observe through other methods of assessment. Supervisors who reported uncertainty about it were all from Groups A and B as shown in Table 5.5.

Table 5.5

Impact on Counseling Practice or Supervision

Theme	Group A	Group B	Group C
Interviewees	4	7	5
Impact			
Helpful	3	7	4
Unhelpful	0	1	0
Not sure	2	2	0

Concerns

Supervisors were overtly prompted in the interview protocol to consider their concerns about using FIT data in supervision. Six supervisors initially resisted the idea of having concerns about it, resulting in a shift in language in how the prompt was presented to replace concerns with challenges. Of the concerns or challenges supervisors shared, seven were rooted in not understanding how FIT worked or how it would be implemented in their work. Two supervisors described potential barriers in

gaining agency support. Seven supervisors identified practical burdens associated with adopting FIT in their supervision practice such as the time spent on it, added paperwork, or remembering to do it. One supervisor framed it as:

> The only concern is that the therapists, already have so much paperwork that they're responsible for. And even though it's just like a survey. They are really not responsible for it. Just taking the time and remembering to do it every session. (A2)

Some supervisors indicated that utilizing FIT data in supervision might pose risks or threats to clients and supervisees. One supervisor described observations from experience using FIT in their practice as a counselor that suggested perceived threats to clients:

> There are some clients who just adamantly refuse. And I'm not sure if its related to where some of the insecurities lie in participating in this response system and they, they just flat out won't do it. And I don't know if it is related to, you know I don't know what it is, you know, they can't read or write. They didn't go so far in school. They were criticized by their teachers. I don't know what it is. But some are adamantly opposed to participating in it. So, I don't push it. That's fine. Some of them, it increases their anxiety. They look at it like a pass/fail. A rating or a measure of their value or their success, the necessity of their being in therapy. I try to explain to them this is not me assessing whether or not you should be here. That's not it at all. This is your feedback on where you are. We can use it as a tool to help or we can talk about this in other ways. So sometimes, it is grounding for some clients and other clients it is anxiety-causing (A9).

Supervisors indicating potential threats to supervisees as being connected to their sensitivities to obtaining any feedback that what they are doing is not effective. One example of this concern was described in this way:

> Because what I see from brand new therapists, is that they put a lot of pressure upon themselves to, to make changes. So, if there is some regression there. Then, it could potentially have a negative impact on the, on the therapists. (A3)

In a different way of being concerned about supervisees, one supervisor noted concern that the data might be used for performance evaluation: "I could see where

people have a concern if it's through an agency, and they feel like they're going to be judged and their jobs can be in danger for that" (C4).

Validity of the data generated in the FIT model process was also a concern for many supervisors. In varying degrees of concern, seven supervisors questioned the accuracy or validity of FIT data. For one supervisor, the concern about validity of FIT data was the driving factor in their resistance to using it. This supervisor responded:

> When I think about asking a client for, to complete an assessment at the end of the session. Maybe it's different in other healthcare fields. But there's that desire to please your counselors. There's that desire not to be, perhaps, honest, because you don't want it to be perceived that you are unhappy with the services. Maybe you're afraid that you're going to be terminated too soon. Or so, I know when I receive a survey after I get a certain treatment. It's mailed to me, and I feel like I could be more honest than it being handed to me as I am at the end of the session, or that I have to leave it with the front desk because there is not that anonymity (B4).

In another example, a supervisor described their concern about validity of the FIT data as being specific to their primary clientele. The concern about validity also seemed to be tied to anxiety about the potential for data to be used to evaluate counselors in this quote:

> I would say, our... my biggest concern is the work that I do with children, that we often see, even with some support and explanation that some of the kiddos that we work with are kind of just scoring based on how they feel in the moment. We have some providers that see kids at school, for example, and it's the kiddo, had a referral or a bad day with the teacher, then rather than rating the therapist, they're really rating their experience with the teacher that day. So that's kind of, that's just one of the struggles that we had. And I think why I struggled to get some buy in from some of the people that I supervise administratively. Like, this is not me they're not rating me, they're rating me because... they're rating me to say because the teacher got onto them before they came to session or whatever. (B10)

Supervisors using FIT also acknowledged this concern and described questions about validity of FIT data as an expected part of the supervision process. Supervisors

using FIT data in supervision described the data as being only a part of what informs their supervision focus. One supervisor using FIT data in supervision talked about validity of data and the role of supervisees in collecting feedback from clients:

> Some of the challenge is when the supervisee potentially is not collecting the data in an effective way. And so, they're, they're feeling like they're getting either positive or negative feedback from the client and that doesn't seem to be kind of the reality of what's going on in the treatment process. (C8)

There were differences in the frequencies of themes supervisor groups identified as concerns about using FIT data in supervision, but practical burdens were acknowledged by supervisors from each group. Fittingly, FIT aware supervisors not using FIT data in supervision (Group B) were represented more frequently in expressing concerns overall. The distribution of concerns reported by the supervisor groups is displayed in Table 5.6.

Table 5.6

Concerns about Using FIT Data

Theme	Group A	Group B	Group C
Interviewees	4	7	5
Concerns about FIT			
Uninformed Worry	4	3	0
Practical Burdens	2	3	2
Risk to Supervisees	2	0	2
Validity	0	5	2
Resisting Concern	1	2	3
Threatening to Clients	0	1	0
Agency Support	0	1	1

Benefits of FIT

Despite not being asked directly in the interview protocol, supervisors indicated perceived benefits spontaneously in response to various prompts in the interview protocol. Besides a few exceptions, benefits to using FIT suggested generally fit into themes of either client care improvements (*n* = 11) or better supervision (*n* = 15). Two supervisor responses that were coded as exceptions related to FIT model recognition as evidence-based practice. Another supervisor remarked about a surprising benefit that using FIT in practice has had in their daily routine which would also apply to using FIT data in supervision. This supervisor described it this way:

> Honestly, I like math. Just doing the simple, ridiculous, uncomplicated, adding the numbers. Math. I know that's not counseling oriented. I know it's not therapy oriented. But I will look throughout my day to find things that that keep me engaged in what I'm doing. That simple, tiny little break unrelated to counseling motivated me. (A9)

The theme of better supervision as a benefit of using FIT data was organized into subthemes for information about supervisee performance (*n* = 13), more specific direction to supervisees (*n* = 9), quality (*n* = 8), and efficiency (*n* = 4). Supervisors representing each group in the interview protocol described benefits of using FIT data that relate to having better supervision. Table 5.7 displays the distribution of themes about benefits according to the case selection groups.

Table 5.7

Benefits of FIT – Better Supervision & Other

Theme	Group A	Group B	Group C
Interviewees	4	7	5
Better Supervision			
Efficiency	1	3	0
Information about Supervisee Performance	3	6	4
More specific direction to supervision	1	3	5
Quality	1	3	4
Other	0	1	2

Within the theme of client care improvements as a benefit of using FIT data in supervision, supervisor responses were also coded into subthemes for client voice (n = 8), adjustments to therapy (*n* = 3), effects of routine (*n* =3), effects of visualizing data (*n* =2), individualized attention (*n* = 2), modeling healthy relationships (*n* = 2), measuring client satisfaction (*n* = 1), and solution-focused (*n* = 1). Interview groups responses suggesting client care improvements are compared in Table 5.8.

Table 5.8

Benefits of FIT – Client Care Improvements

Theme	Group A	Group B	Group C
Interviewees	4	7	5
Better Supervision			
Adjustments to Practice	1	0	2
Client Voice	2	4	2
Effects of Routine	0	2	1
Effects of Visualizing Progress	0	2	0
Individualized Attention	1	1	0
Measures Satifaction	1	0	0
Models Healthy Relationships	0	0	2
Solution-Focused	0	1	0

Data Input for Evaluation

Supervisors were asked broadly to talk about their thoughts on evaluation of supervisee development and performance. Their answers varied from aspects of format, frequency, theory, and uncertainty. Some supervisors independently noted the ways in which they gain information about supervisee performance while others were prompted to describe this if their response left this unclear. Themes identified should not be interpreted as inclusive of all methods that supervisors have used to evaluate supervisees. Instead, the themes identified represent how they typically collect information to inform their evaluations. Most supervisors (n = 10) noted utilization of supervisee self-report, but only two suggested that this was exclusive evidence used for evaluation. Other types of data input for evaluation included documentation review (n = 7), live observation (n = 6), session recordings (n = 3), and role-play (n = 2). References

to feedback in answers were also mentioned including informal client/colleague report (*n* =3), systematic supervisee feedback (*n* = 2), and systematic client feedback (*n* = 4). It was common (*n* = 11) for supervisors to describe combining inputs in their evaluation process.

Differences were noted in how the groups were distributed in their reported input for evaluating supervisees. Group A supervisors reported less variety and combinations of data input for evaluation. Group B supervisors reported more frequent use of live observation documentation review, and informal supervisee self-report. Group C supervisors reported more variety and combinations of methods in their evaluation process. Group frequencies of these themes are displayed in Table 5.9.

Table 5.9

Data Input for Supervisee Evaluation

Theme	Group A	Group B	Group C
Interviewees	4	7	5
Data Input			
Documentation review	0	6	1
Informal client/colleague report	0	1	2
Live Observation	1	4	1
Recordings	1	0	2
Role-play	1	1	0
Informal self-report	2	5	3
Systematic client feedback	0	1	3
Systematic supervisee feedback	0	0	2

Giving Feedback

Supervisors responded to the prompt in the interview about their thoughts on giving challenging feedback in two ways: their methods for giving constructive criticism and comments about the experience of doing it. The most frequent theme involving methods of giving constructive criticism was balancing positive and negative feedback (*n* = 5), which was followed by setting expectations for feedback (*n* = 3), centering feedback on the client (*n* = 3), using tools like data (*n* = 3), and prompting supervisees for self-reflection (*n* =1). In an example of the balancing positive and negative feedback theme, one supervisor said, “if I give a constructive criticism, to a supervisee I try to balance that out with something positive. Because I don't, I don't want to crush anybody spirits.” The distribution of themes for giving feedback among supervisor groups is displayed in Table 5.10.

Table 5.10

Methods of Giving Constructive Criticism in Supervision

Theme	Group A	Group B	Group C
Interviewees	4	7	5
Methods			
Balance positive & negative	1	3	1
Client centered	1	1	1
Self-reflection by supervisee	1	0	0
Set expectation for it	0	1	2
Use of tools	2	1	0

In describing their experiences with giving challenging feedback, half of the supervisors emphasized supervisee openness to feedback and half stated firmly that giving challenging feedback to supervisees was necessary. One supervisor put it this

way: “I think it has to happen. I don’t think there is any point in supervision otherwise.” Other themes that were revealed from supervisor responses included challenges in giving this type of feedback (*n* = 6), confidence in their ability to do it (*n* = 6), and evidence that giving this type of feedback helps supervisees (*n* = 4).

FIT Data in Evaluation and Giving Challenging Feedback

In the interview protocol, supervisors were asked about their thoughts on using FIT data in their evaluation process and in giving challenging feedback to supervisors after being asked about their thoughts on both of those supervision responsibilities in general. Almost all supervisors described perceived benefits to using FIT data in the context of these responsibilities. Among the supervisor groups, more benefits of using FIT data for evaluation and giving challenging feedback than challenges or concerns were noted by each supervisor groups but the strongest sense of benefits was reported by groups A and B as indicated in Table 5.11. Some examples of responses that mentioned the perceived benefits include:

> I can see the thing… I could see those… this could be a good tool for supervision because there are so many instances where certain techniques like audio and video are just really hard to come by. (A10)
> I think it would be a tool that I have that is concrete, that the client is identifying. So it's client-driven, and we all want to do what's best for our client. So, I think that, that it coming from that perspective, would be more helpful. (A2)

Table 5.11

FIT Data Use in Evaluation and Giving Constructive Criticism

Theme	Group A	Group B	Group C
Interviewees	4	7	5
Benefits & Concerns			
Benefits of Using	4	6	5
Challenges & Concerns	1	5	1

Some supervisors described concerns or challenges in using FIT data in their responsibilities to evaluate supervisees and give challenging feedback. The sole supervisor who did not mention a perceived benefit to using FIT data for this purpose said plainly that feedback informed treatment data evaluations are “not that informative”. More specific types of challenges mentioned by supervisors included concerns about working with quantitative data such as getting a large enough number of clients to be useful or being uncomfortable working with numbers. Two supervisors talked about readiness for or acceptance of FIT model utilization among their supervisees as barriers to using the data effectively. The point was explained by one supervisor in this way:

> If the person who's using it doesn't believe or agree with the tool or that it fits with their model of their approach to therapy, then you're just going to get some resistance and stuff. I mean, so I don't know if it would… If it is something that you should continue if, if they’re really being resistant to it. (C4)

Changes to Supervision after using FIT Data

Only supervisors who reported using FIT data in supervision were asked to talk about how supervision has been changed by having FIT data available. Of the six supervisors in Group C, four responded with descriptions about improvements in their supervision such as “it makes me more comfortable presenting a challenge to the therapist”. Two supervisors noted that not much had changed in their supervision because they have nothing else to compare it to as all their supervision experience has featured the use of FIT data.

Model Choice

Although only supervisors in Group C or otherwise indicated use of a FIT model were asked to identify how the FIT model they use was chosen, many other supervisors

also mentioned their beliefs about how model choice would be made in their practice. Distribution of themes among supervisor groups are displayed in Table 5.12. Themes about model choice were structured as choices are either agency-determined (*n* = 8), supervisee-determined (*n* = 2), or supervisor-determined (*n* = 3). As an example of the agency-determined theme, one supervisor said "the people in power or the people with making… or decision making power decided it." Another supervisor provided talked about how their supervisees determine the model choice: "I think the clinicians that I have using it, have examples from their past work. So, they have ones that they're more comfortable with that they're using." Finally, one supervisor provided additional context in their thoughts about choosing a model:

> I can get it (PCOMS) for free. I think the thing that might keep me from using it the most, is that I have to sit there and graph it manually because I'm not gonna pay for the programs and databases they have. I guess if I spend extra time on Excel maybe I could come up with a sheet to do that on my own, but I think that's really the only reason why. I think some of the other ones I've heard that are really long surveys, and possibly something I may have to pay for. So I don't do enough business at the private practice to do that. (C4)

Table 5.12

Model Choice

Theme	Group A	Group B	Group C
Interviewees	4	7	5
Model Choice			
Agency Determined	1	2	5
Supervisee Determined	0	0	2
Supervisor Determined	0	1	2

Best Explains Use of FIT Data

Supervisors in groups B and C were directly asked what best explained their using or not using FIT data in supervision. Responses explaining the use of FIT data offered combinations of the following themes: effectiveness of client therapy (n = 2), prior experience (n = 1), problem-solving (n = 2), reputation/credibility (n = 2), supervisee improvements (n = 3), and utility in supervision (n = 3). Examples of each theme are included in Table 5.13:

Table 5.13

Best Explanation for Using FIT Data in Supervision

Coded Theme	*n*	Illustrative responses
Effectiveness of Client Therapy	2	Client care and increasing kind of effectiveness of, of clinical intervention, you know, for the client (C8)
Prior Experience	1	I was aware of it (C4)
Problem-solving	2	we were needing to get feedback to figure out what was going on, like not returning clients(C4)
Reputation and Credibility	2	Because I want our center to be reputable on campus. I want it to be, I want students going over this place saying hey that's a good place you should go there. I got help there (C9)
Supervisee Improvements	3	Increasing that self-awareness for the supervisee of what's working and what's not in their interventions, in their approaches (C8)
Utility	3	The ones who use the ORS, for example, to be able to use that kind of breaks it down. And honestly, it simplifies the process, as opposed to talking in an open-ended fashion about it. Like it just makes it more concrete. And then it can be assessed. We can go back to that, that same one and look for progress (C7)

Best Explained Why Not Using FIT Data

Seven supervisors were asked about what best explained not using FIT data in their supervision practice. In addition to the original five supervisors selected from the analysis of the survey data, the two supervisors from group A and C who indicated awareness of FIT but were not using FIT data in supervision were also asked to respond to this item. The coded themes and example responses are included in Table 5.14.

Table 5.14

Best Explained Why Not Using FIT

Coded Theme	N	Illustrative responses
Believes Data is Invalid	1	It goes back to, you know, do we really, accurately fill out those surveys (B4)
Implementation Stage	1	Because we're so new in implementing it… don't have complete buy-in from the clinicians that are utilizing the tools (B10)
Inexperience as Supervisor	2	Experience as a supervisor and gaining knowledge and information and experience in my role as supervisor (A9)
Lack of Access	1	Because I don't have a system for it, like the place that I work has not provided me a specific system for it (C6)
Uninformed about FIT	3	Lack of awareness (B5)

The most frequent themes in the responses were that supervisors were uninformed about FIT (n = 3) or inexperienced as supervisors (n = 2). One supervisor explained a combination of these themes in their answer "not keeping up on the trends" and "still kind of figuring out my approach on this". More than half of the supervisors

designated as aware of FIT but not using FIT data in supervision reported not using it for what could be described as a lack of training and experience.

Three of the seven supervisors not using FIT data in supervision had responses that fit into the final three themes. One of these supervisors suggested that not using FIT data in supervision would soon change as implementation of a FIT model in their practice developed further. Another supervisor citing a lack of access as the reason noted simply "because I don't have a system for it, like the place that I work has not provided me a specific system for it". Implementation factors, developing expertise and problems with accessing a model, helped explain why these two supervisors are not using FIT data in supervision at this time. The remaining supervisor explained not using FIT data as being a result of believing the data is invalid. Although this supervisor also lacked training in FIT and access to a model, concerns about the validity of client reported data were repeated and seemed to explain for this supervisor why FIT data was not being used in supervision.

Integration with Quantitative Results

When considering integration of the qualitative and quantitative results in the explanatory sequential mixed methods study design, the research questions were to determine results emerging from the comparison of the quantitative data about supervisor attitudes and the explanatory qualitative data. Discrepant findings must also be resolved such as the discovery of inconsistencies of supervisor reports of awareness of FIT and use of FIT data in supervision between the survey collection and the interview data collection. An additional research question seeking integration is how

different models and administration methods related to adoption of FIT data by supervisors.

Discrepant finding resolution.

Discrepant findings will be reviewed and integrated first. Two supervisors designations must be resolved, one being identified as unaware of FIT yet revealing in the interview that they use PCOMS in practice and another being identified as using FIT data in supervision however in the interview they clarified that they do not have access to FIT data. The relationships of factors to the use of FIT data in supervision in the quantitative analysis were determined based upon only the survey data. The relationships were analyzed again to consider if resolving the discrepancies affected any of the measures of relationship identified in the quantitative results analysis.

Supervisors using FIT data in supervision shifted from 9 (18%) to 8 (16%) and supervisors reporting use of FIT in practice increased from 12 (24%) to 13 (26%). Supervisors who were aware of FIT but not using FIT data in supervision increased from 20 to 22 (44%), while supervisors who were unaware of FIT decreased from 21 to 20 (40%). Current use of FIT in counseling practice remained a related factor to the use of FIT data in supervision. Supervisors reporting current use of FIT in counseling practice were more likely to also report use of FIT data in supervision than their peers who were unaware of FIT or aware but not using. Current use in practice and use of FIT data in supervision were related at a statistically significant level ($\chi^2 = 19.601$, $df = 4$, $p < .01$). The relationship between use in counseling practice and use of FIT data in supervision remained moderately strong (*rho* = .582) after accounting for discrepancies in survey and interview data.

Integrating discrepant data in the analysis of attitudinal factors resulted in reducing the significance of differences between groups A, B, and C for perceived benefit. For perceived benefit, supervisors using FIT data in supervision still indicated stronger agreement (m = 4.65, sd =.337) with items in the scale than their peers (Group B m = 4.20, sd = .58391; Group A m = 4.41, sd = .48979), but this difference was no longer at the statistically significant level of .05. The overall pattern of agreement strength (Group C with the strongest favorability to FIT use) remained the same for items associated with perceived harm, clinical utility, and practicality, but the differences remained statistically insignificant.

The treatment planning variable focusing on how information from standardized assessment "helps planning for sessions" was associated with stronger agreement from supervisors who reported using FIT data in supervision with statistically significance at the .01 level in the initial quantitative analysis. Following the resolution of discrepant data, supervisors reporting use of FIT data in supervision still reported stronger agreement with their peers who were unaware and aware but not using FIT data in supervision. The difference remained statistically significant at the .01 level (F [2, 47] = 5.274).

Attitudes about the use of FIT data for supervision responsibilities of evaluation and giving feedback were also reviewed to resolve discrepant data. An ANOVA of means across groups A, B, and C determined statistical significance of difference at .01 level (F [2, 47] = 6.844). Supervisors using FIT data in supervision still reported stronger agreement with items favorable of using FIT data in evaluation than their peers in groups A and B. An ANOVA comparing the three group means for the overall giving

feedback variable did not indicate statistical significance of differences between the means, although the pattern of favorability remained the same between the groups.

Explanations.

In the quantitative analysis, state designated community mental health center choice as practice setting was suggested as being related to use of FIT data in supervision as 44% of supervisors using FIT data recorded that as their primary practice setting. The survey item asked narrowly about the current primary practice setting and not about experience at other practice settings. Following the qualitative analysis, this factor appears even stronger in influence as multiple interviews revealed either past exposure, training, or use of FIT by supervisors who previously were working at community mental health centers or recognition of the use of FIT by supervisees working at community mental health centers. Two-thirds of interviews with supervisors who reported awareness of FIT provided evidence of community mental health center implementation of PCOMS as their means of becoming aware of FIT as a concept. When combining exposure to FIT in previous employment at community mental health centers and reported practice settings at community mental health centers in the survey, all but one supervisor using FIT data in supervision (87.5%) has been exposed to FIT through this practice setting.

Reasons given in the interviews by supervisors for not using FIT data in supervision among those who were deemed as aware based on survey responses suggested that level of awareness and understanding of FIT as a concept was a much bigger factor than the survey detected. Three of five of those originally designated in group B as supervisors who were aware of but not using FIT data in supervision cited

lack of awareness of FIT as the best explanation for not using it. The two supervisors joining this group as a result of resolving discrepant data indicated explanations for not using it as lack of experience as a supervisor or lack of access to a FIT model at their practice.

Revisiting FIT experience and attitudes.

The qualitative analysis raised questions about how the range of awareness levels categorized supervisors as aware but not using FIT data in supervision. Interviews with supervisors in Group B indicated confusion over basic aspects of the concept and process of FIT models. The inclusion of supervisors who had read an article or heard something about it from peers as being aware of FIT grouped together supervisors who were not in a position to consider using FIT data in supervision with those who reasonably could have included FIT data in supervision. Why supervisors who could use FIT data in supervision but do not has remained unclear.

In testing whether experience using FIT or being trained in a FIT model was related to attitudes, alternate subgroups of supervisors were arranged for additional analysis. The first group, inexperienced supervisors (n = 33), was formed of supervisors who indicated being unaware of FIT (n = 20) and those who had not participated in training or used FIT in practice (n = 13). There was only one item from the attitude scales in which FIT-unaware and those who had not participated in training or used FIT in practice reported statistically significant difference. Unaware supervisors indicated stronger disagreement with the reverse-scored item about whether FIT measures were worth the time spent on them in practice was related to practicality of using FIT (t = -2.466, df = 31, p < .05).

The second group was established for those supervisors who had used FIT in practice or attended training in a FIT model but were not using FIT data in supervision (n = 9). This second group reported less agreement than those supervisors who were also aware of FIT but reported no experience or training for one attitude item about perceived benefit that referenced the regular use of feedback as creating an expectation for positive change (t = 2.707, df = 20, p < .05).

The final group for this comparison was the group of supervisors using FIT data in supervision (n = 8). Generally, supervisors using FIT data in supervision reported the most favorable attitudes towards FIT, while FIT experienced supervisors who do not use FIT data in supervision had the least favorable attitudes. The inexperienced with FIT supervisors had attitudes between the other two groups, suggesting that experience with FIT can influence attitudes in either direction.

Group C, supervisors using FIT data in supervision, had reported stronger perceived benefit than their peers who had experience using FIT but do not use FIT data in supervision. The difference between the means is statistically significant at the .01 level (t = -3.721, df = 15). Specific items in the perceived benefit scale "with statistically significant differences between supervisors using FIT and those experienced with FIT but not using it in supervision were: "Clients want their therapists to provide them with information about treatment progress." (t = -3.321, df = 15 p < .01), "Providing clients with regular feedback about treatment progress creates an expectation for positive change" (t = -2.442, df = 15 p < .05), and "Providing feedback to clients about treatment progress (or lack thereof) can lead to better treatment outcomes" (t = -3, df = 15 p < .05).

Supervisors using FIT data in supervision had reported stronger attitudes for the value of FIT in clinical utility (t = -2.668, df = 15, p < .05) and treatment planning (t = -2.911, df = 15, p < .05) than their peers who had experience using FIT but do not use FIT data in supervision. Regarding clinical utility, FIT using supervisors also reported stronger agreement than their FIT experienced peers not using FIT data in supervision with the following specific item: "Standardized progress measures gather information about the client that may not otherwise come up in session" (t = -3.053, df = 15 p < .01). For treatment planning, "Information from standardized progress measures can help me plan for sessions" was found to demonstrate stronger agreement among supervisors using FIT data in supervision than their experienced peers not using FIT data in supervision (t = -2.642, df = 15 p < .05).

The FIT data using supervisors also held more favorable attitudes about using FIT data in the evaluation of supervisees (t = -4.615, df = 15 p < .001). Three items related to evaluation in supervision had statistically significant different means between supervisors using FIT data in supervision and their experienced peers not using FIT in supervision: "Using client feedback data in supervision enhances the evaluation of treatment effectiveness" (t = -3.449, df = 15 p < .01), "Discussing client feedback data in supervision encourages supervisee self-reflection" (t = -5.918, df = 15 p < .001)., "Client feedback data provides me a more accurate understanding of skill development among my supervisees" (t = -2.941, df = 15 p < .01).

FIT inexperienced supervisors also reported more favorable attitudes towards FIT than those FIT experienced supervisors not using FIT data in supervision. Specific items related to perceived benefit with statistically significant differences included:

"Providing clients with regular feedback about treatment progress creates an expectation for positive change" ($t = 3.153$, $df = 18.747$ $p < .01$) and "Providing feedback to clients about treatment progress (or lack thereof) can lead to better treatment outcomes" ($t = 3.714$, $df = 32$ $p < .001$).

There were also statistically significant differences for items related to treatment planning, practicality, and evaluation in supervision between FIT experienced supervisors not using FIT in supervision and their inexperienced peers. For treatment planning, FIT inexperienced supervisors indicated more favorable attitude towards the item "information from standardized progress measures can help me plan for sessions" ($t = 2.238$, $df = 40$ $p < .05$). They also reported stronger disagreement than the experienced but not using in supervision group with the statement "the information that I receive from standardized progress measures isn't worth the time I spend administering, scoring, and interpreting the results" which was a reverse-scored item associated with attitude about the practicality of using FIT ($t = -3.048$, $df = 40$ $p < .005$). The pattern continued with the following statement associated with evaluation in supervision "discussing client feedback data in supervision encourages supervisee self-reflection" ($t = 2.466$, $df = 25.014$, $p < .05$)

Specific cases.

Another format for integrating data between the quantitative and qualitative phases of the study is through considering the results from the perspectives of specific supervisors. Three supervisors offer distinctive insights about how the use of FIT data in supervision is understood. First, the discovery of discrepant data in the interview with supervisor A9 showed that awareness of the terminology variations for FIT can create

confusion even for a supervisor who uses FIT in routine counseling practice. They had recorded in the survey recognizing the name but little else, however early in the interview they realized that this was about something that they commonly used and had a lot to say about. Supervisor A9 revealed significant knowledge and reflection on using FIT in practice, but also noted that their experience as a supervisor was just beginning and that even a basic plan for supervision was still in formation.

Second, only one supervisor revealed a strong opinion opposing the use of FIT data in supervision. For supervisor B4, the practice was something brought to their attention through supervisees who had been mandated to use it through their placements at community mental health centers. “PCOMS is the devil,” supervisor B4 repeated in the interview and explained concerns about the method of obtaining feedback and validity of any data in client feedback. This concern was consistent with responses to the attitudinal items in the survey and text entry to item seeking awareness of other FIT models stating “None; client’s may not be truthful”. Interestingly, supervisor B4 noted challenges in evaluation of supervisees associated with clients not returning for therapy sessions and not knowing if they did not return because they were better or frustrated about a lack of something in the therapy. This challenge is raised in the literature as something that FIT can help to clarify or prevent and other supervisors cited as a benefit in the interviews.

Supervisor C4 was one of the supervisors who described using FIT data in supervision for a specific purpose tied to addressing what supervisor B4 described as a barrier to evaluation. Interestingly, supervisor C4 had indicated in the survey that they did not currently use FIT in their counseling practice. In the interview, C4 explained

that their current practice was not sufficient to afford the expense of a computer-assisted tracking system for a FIT model and that certain therapy modalities in their practice, such as play therapy and EMDR, are less practical for FIT when administered on paper during a session. Despite not currently using FIT in their own practice, C4 described using PCOMS as means to solve a problem that one supervisee had with clients not returning after appointments early in treatment. By using the SRS from PCOMS, C4 tailored supervision sessions to incorporate what clients were saying about the therapeutic alliance with the supervisee.

Summary

Interviews were conducted with supervisors selected following preliminary survey data analysis. Sixteen supervisors were interviewed using an interview protocol designed to explore perspectives about the use of FIT data in supervision. Overall, FIT is viewed favorably but is only minimally understood by supervisors who do not have direct experience with training or use of it in practice. Despite supervisors seemingly being aware of FIT, many had basic questions about the concept as well as methods of collecting client feedback and resources for learning more. Supervisors reported FIT as a helpful for supervisees, clients and their responsibilities as supervisors. Specific supervision functions for FIT emerged in responses including the use of FIT data to engage supervisees in problem solving or to supplement observation of supervisee practice with evidence for evaluation. Concerns were also noted such as perceived threats to clients or supervisees, validity of data from client self-report, and practical burdens associated with the added tasks involved with FIT.

Qualitative and quantitative data were then integrated to resolve discrepancies in the initial survey responses and more specific questioning in the interviews. In the integrated results, eight supervisors reported using FIT data in supervision overall, five of these supervisors participated in interviews and offered direct explanations for using FIT data in supervision, resulting in six themes: effectiveness of therapy, prior experience, problem solving, reputation or credibility, supervisee improvements, and general utility. Experience as a supervisor and with using FIT in practice facilitated the use of FIT data in supervision. Organizational support was also cited as a factor as most supervisors indicated that agency leadership influenced decisions about using a FIT model. Finally, interview data revealed an even stronger connection between the use of FIT data in supervision and a community mental health center practice setting.

CHAPTER 6

DISCUSSION

Although the FIT literature is extensive and stretches over two decades, the availability for supervision informed by client feedback data remains limited. The findings of the study indicate that review of FIT data in supervision was rare in the supervision of counselors as only 16% of supervisors in the sample reported using FIT data in supervision. The main factors associated with using FIT data in supervision emerging from the results included prior training or use of FIT in practice, being employed at a community mental health center, and highly favorable attitudes about the perceived benefit, clinical utility, and treatment planning function of FIT. The most recognized and used model of FIT among the supervisors in the sample was the Partners for Change Outcome Management System (PCOMS) but it should be noted that some supervisors referred to it by other names.

Overall supervisors reported favorable attitudes towards FIT regardless of prior training or use of FIT in practice. Supervisors described perceived benefits of FIT as being utility for supervisee development, improved client care, and fulfilling supervision responsibilities. It should be noted that most supervisors in the sample had many questions about what FIT was, how it worked, and where to get information about it despite reporting in the survey that they had read about it or heard about it from

colleagues. Supervisors also noted potential challenges about the use of FIT data in supervision such as perceived threats to clients and supervisees, practical burdens associated with the added tasks, and validity of data collected from client self-report. Potential uses for FIT data in supervision were identified. Some supervisors reported using FIT data to compensate for limitations in observation opportunities to evaluate supervisee development. Others noted the potential for using FIT data to assess problems supervisees are experiencing with clients. Supervisors also indicated that having client feedback to link to constructive criticism makes it easier to give or more effective.

The evidence of low utilization of FIT data in supervision confirmed the hypothesis and echoed prior research of FIT use in practice from samples drawn from professional associations (Ionita & Fitzpatrick, 2014; Jensen-Doss et al., 2018). Over a fourth of supervisors (26%) indicated experience using FIT in practice in the sample, which is below the reported percentage of ever using a FIT model by Jensen-Doss et al. (2018) but above the reported use by Ionita and Fitzpatrick (2014). It should be noted that both studies used the terminology of standardized progress measures that is more inclusive of broad types of assessments than FIT.

Key Themes and Interpretations

Through a combination of the survey and interview results, the relationship between employment with community mental health centers, whether currently or in the recent past, and the use of FIT data in supervision was highlighted. Of the 8 supervisors in the sample reporting use of FIT data in supervision, 7 of them either reported their current practice setting as a community mental health center or noted being exposed to

FIT training or use when they worked at a community mental health center in the past. It might be suggested that the implementation of PCOMS mentioned in Duncan (2014) in one of the local community mental health center has sprouted volunteers in the local practice community. Despite this documented implementation effort of PCOMS in a local CMHC and numerous former employees citing experience from there as their introduction to FIT, no supervisors from this CMHC participated in the study.

The survey and interview results distinguished some of what was thought to influence the adoption of FIT data in supervision. As predicted, age, gender, and theoretical orientation were not found to have significant relationships to the use of FIT data in supervision. Unlike results reported by Jensen-Doss et al. (2018), a theoretical orientation preferring cognitive behavioral therapy was not associated with using FIT data in supervision. Educational factors considered such as degree type, state in which the degree was attained, and accreditation status of supervisors' academic programs were also not shown to have significant relationships with the use of FIT data in supervision. However, it would be difficult to detect relationships to using FIT data because the sample was not diverse in the educational factors included in the survey.

Practice specialties, size, payor sources, and primary clientele similarly were not identified as having relationships to using FIT data in supervision. Other researchers had suggested or found that there were stronger relationships with FIT use in practice and these factors in practice settings (Ionita & Fitzpatrick, 2014; Jensen-Doss et al., 2018). Although it might be speculated that supervision circumstances influence the use of advanced practices such as FIT, the results of the study did not support this. Years of experience as a supervisor, number of supervisees, and the placement of supervisees

within the same agency of the supervisors were also not linked significantly with the use of FIT data in supervision.

Reconfiguring supervisor groups.

In the preliminary analysis, it was assumed that reading about FIT or hearing about it from colleagues was enough to designate a supervisor as having the potential to choose to use FIT data in supervision. The interview data suggested otherwise; supervisors indicating their awareness level in these categories asked basic questions to clarify their understanding of the concept and noted a lack of awareness as a barrier to adoption of FIT in their supervision. In hindsight, level of awareness was not measured effectively within the survey item choices, making distinctions between some levels difficult.

An alternative arrangement of subgroups in the sample emerged in the analysis that should offer more implementation-oriented information. In this arrangement, the groups of supervisors unaware of FIT and using FIT data in supervision remained as described above. But the group of supervisors not using FIT data in supervision but deemed aware were divided into groups for FIT experienced (18%) and FIT inexperienced (26%) supervisors. Separating supervisors who were trained in or used FIT but not using FIT data in supervision from others in the aware but not using group narrows the focus of factors influence supervisors to not use FIT data in supervision by setting aside those who only know it from reading or hearing about it from a colleague.

Organizing the sample into four groups by experience with FIT also links well with implementation planning contexts, because for each of these groups different steps are needed to increase the use of FIT data in supervision. For the unaware group,

implementation efforts should begin with introductory information in widely accessible media and publication formats, professional association conferences, and online webinars. Presentations about specific models and benefits in advance of training and ongoing coaching should be considered for supervisors who are aware of FIT but lack personal experience and training.

Three FIT experienced supervisors not using FIT data in supervision participated in interviews. For two of them, the best explanation that they offered for not using FIT data in supervision was that they were not experienced as supervisors in general and were still figuring out their supervision process. The other supervisor in this group reported that their agency was working through an implementation phase for using PCOMS and that they are not using FIT data in supervision yet because clinicians are still getting used to and in the process of buying into it.

Reviewing assumptions about using FIT.

It was hypothesized that mandated use of assessment procedures or evidence-based practices would be associated with the use of FIT data in supervision. The analysis indicated that this relationship was not statistically significant in this sample. The high levels of mandated assessment and EBPs reported in the sample contributed to little clarity about the relationship. Most supervisors reported pressure to use assessments or EBPs, but there are many other ways of responding to this pressure besides using FIT.

Despite the low prevalence of using FIT in practice and supervision, supervisors reported positive attitudes about FIT and using FIT data in supervision. This is consistent with the results of Jensen-Doss et al. (2018). Logically, supervisors using FIT

data in supervision reported the strongest attitudes favoring the use of FIT. Training or experience with a FIT model was related to both attitudes and use of FIT data in supervision in a complex way. This complexity was revealed by supervisors who had experience with FIT but reported not using it in supervision having the least favorable attitudes towards the practice.

An important question considered was: in what way were attitudes about FIT and use of FIT data in supervision related? FIT unaware supervisors may provide some clues, because their input would not reflect influences from colleagues about the practice and they do not have personal experience with using it. Their attitude towards the practice is shaped by interpretations of the described procedures and how it aligns with their values as counselors. This group has also not encountered potential irritants in using FIT described by others such as added tasks or sorting out what the data means. Their position in the middle of reported favorable attitudes suggest that counselors begin with mostly favorable attitudes about the practice before experience with it. Some have positive experiences using it and are more likely to use it in supervision, while others do not have as positive experiences and are less likely to use it in their supervision.

Limitations of the Present Study

The study sample was not created by convenience or probabilistic sampling. Instead there was a genuine, yet unsuccessful attempt to reach out to the full population of eligible supervisors. Supervisors with publicly available email contact information were sent an invitation and those willing to participate responded. It is not reasonable to think that this sample was representative of counseling supervisors of the state. The

only data matched to the target population of supervisors was region. Analysis of the sample by region suggested that the sample was disproportionally drawn from a few regions of the state.

Items in the survey measuring attitudes about using FIT data in supervision were developed to explore the concept in this study and have not been reviewed or tested by other researchers. More investigation is needed to determine the content validity of items to distinguish attitudes about specific applications of FIT data in supervision. Items were developed to target two supervision responsibilities: evaluation and giving feedback. Further development into establishing standardized items about attitudes about the use of FIT data in supervision should include a broader array of supervision responsibilities and explore factor analysis for items.

In the qualitative analysis, multiple coders were not feasible in the design of the study, so confirmation of identified themes was not completed. Inter-rater reliability of coded themes should be used to identify conflicting interpretations of supervisor responses to prompts in the interview protocol or bolster findings. Without this mechanism, themes identified in the qualitative analysis should be interpreted with caution and understood as exploratory in nature.

As only a small number of supervisors indicated awareness of more than one model of FIT, the study did not clarify how different models and administration methods related to the use of FIT data in supervision. The few supervisors who did note experience with multiple models provided some perspective for comparing the use of PCOMS, the OQ, and the CCAPS. However, the evaluations of how these models

related to their specific practice circumstances are difficult to generalize to the sample or the broader population of supervisors.

Future Research Directions

There is more to discover about using FIT data in supervision. Any investigations that increase the sample size will help to further clarify factors that are associated with using FIT data in supervision. The study could be repeated with a bigger sample to better understand factors for which the sample in the study offered little diversity. Alternatively, the results of this study could be utilized to develop and test a scale of attitudes about using FIT data in supervision. A validated scale for measuring attitudes about the use of FIT data in supervision would be useful to the counseling field as well as a broad range of psychotherapy disciplines.

The findings from this study have been related mostly to the use of the Partners for Change Outcome Management System (PCOMS). Supervisors described being exposed to this model through employment in agencies, mostly community mental health centers. Another factor cited was that it is available for free online. As awareness of alternative models increases, future studies could focus more on comparisons among models in the supervision context. Case study analysis of supervisors using multiple models such as two supervisors in this study would present practical considerations about how FIT models interact with each other and how use varies by model.

In this study, model adherence was not examined. Protocols for using FIT models in practice have been established to make application consistent. Duncan and Reese (2016) outlined a protocol for using PCOMS in supervision that if followed will help to maximize benefits and mitigate concerns. Studies that examine the degree of

fidelity in evidence-based practices use are important to understanding implementation status and achieving outcomes that align with those in research studies. Future studies should explore beyond awareness of the practice and self-reported use to include measurement of fidelity to FIT model protocols. Without determining the degree of adherence to model protocols, it is unclear if benefits or concerns identified are rooted in the use of FIT itself or in deviations from protocols.

Supervisees should not be ignored in research about using FIT data in supervision. Past research about using FIT data in supervision has shown improved supervisee satisfaction with supervision when using FIT data but sample size was small (Grossl et al., 2014). Despite potential benefits to supervisees, supervisors in this study described concerns about potential threats to supervisees, noting that supervisees are sensitive to feedback that says what they are doing is not working. Investigating perceptions of supervisees about incorporating FIT data in supervision will provide other important insights into how this data relates to supervision practice and clarify to what degree concerns that they are threatened by reviewing this data are warranted.

Recommendations for Students and LPCAs

Supervisees naturally seek out guidance and feedback on their performance from supervisors, harboring questions about being effective as counselors. The incorporation of FIT data in supervision represents an opportunity for supervisees to get more data about their effectiveness and become better therapists (Duncan, 2014). Supervisees who seek to maximize the benefits associated with FIT models in their professional development should partner with their supervisor in looking at the data collected using FIT with clients. In this study, supervisors described several benefits for supervisees

such as more specific direction in supervision as well as improved efficiency and quality of supervision overall.

Although most supervisors seem open to using FIT model data in supervision, supervisees may need to seek out supervisors with experience using FIT models in practice to find a someone who will effectively incorporate FIT data as part of their supervision experience. In this study, supervisors who used FIT data in supervision described roles of interpreting how the data represents treatment effectiveness and therapeutic alliance as well as how the data was collected by the therapist. Supervisees will need guidance in how they collect FIT data to keep data relevant to their skills as counselors and client outcomes in therapy.

Recommendations for Supervisors

As a group within the profession of counseling, supervisors should take the lead in adopting evidence-based practices and reinforce the use of effective practices in supervision. But, supervisors face implementation barriers to practices like any other professionals. This study reinforced the intuition that training and experience with FIT models in practice leads to increased likelihood that this will be incorporated into supervision. Expanding supervisor awareness and experience with FIT models would have a positive effect on the profession and must go beyond conference presentations and journal articles. Supervisors should seek out specific training in how specific FIT models are used in practice and supervision.

A supervisor without training or experience using a FIT model may struggle to determine the meaning of the data or resolve the pitfalls associated with validity of data described by supervisors in the interviews of this study. Supervisor questions about

validity of FIT data are no different than data derived from any self-report measure and are addressed in training about use of FIT models. Duncan and Reese (2015) described procedures for effectively using PCOMS in supervision, while Lambert (2010) has described supervision using the OQ and its associated clinical support tools. Guidance in how supervisors use supervision dialogue to clarify discrepancies in the data collected and supervisee reflections on their experiences with clients is available and being described by some of the supervisors from this study who reported using FIT data in supervision.

To overcome implementation barriers, supervisors should seek out opportunities to learn more about the options within FIT models to determine what models will fit their practice best. In the interviews, supervisors revealed a variety of potential barriers to using FIT data in supervision to consider. Some supervisors noted that agency support through either funding for access or aligning data collection with other documentation expectations was needed. Others described flexible applications for the use of FIT data such as allowing supervisees to pick FIT models from their previous experience or using the paper version of PCOMS to avoid spending money on a systemic process for data collection. Although the flexibility of these solutions is appealing, the consequences incur other burdens such as more time spent collecting, scoring, interpreting, and storing the data or having to learn the nuances of multiple FIT models being used by supervisees. The limited variety of FIT model awareness found in this study suggested that supervisors lack the exposure to the options available to make informed choices about what model would fit their practices best.

The incorporation of FIT data is also an effective quality control for supervision. As alternative information about practice, FIT data can complement or supplement traditional information supervisors use for the basis of evaluations of supervisee skill and understanding. It is unique from data gathered from self-report or observations of practice in that it can provide data about the overall practice of the supervisee and include the direct voice of clients working with the supervisee. Supervisors using FIT data in supervision in the sample noted using FIT data as an adjunct to other inputs about the supervisee's practice to create a more balanced understanding.

Using FIT data to inform supervision should also be established in supervision contracts to clarify how the data would be used for evaluating supervisee performance and address concerns raised by supervisors in the sample about potential threats to supervisees from client feedback that suggests problems in therapy delivery or skills. Previous authors have argued against using FIT data solely for decisions about employment status or other incentives (Duncan & Reese, 2015; Sparks et al., 2011). If supervisees were to experience excessive pressure to obtain favorable results from FIT model data, the integrity of the data as a learning and quality control mechanism is undermined. Although incentives may be linked with the act of faithfully collecting data, supervisors must advocate that incentives for supervisees not be tied to client outcomes as reported in the data or else the benefits of the practice vanish.

Recommendations for Counselor Educators

Counselor educators have a significant role in the implementation of evidence-based practices such as the use of FIT in practice. The utility of FIT data to inform supervision practice is only beginning to be understood by supervisors of counselors.

Very few supervisors in the study mentioned learning about FIT or supervision in their academic training. Some supervisors who are not using FIT data in supervision reported not being informed enough about FIT or experienced enough with supervision to have a plan for using it. Moreover, supervisors who reported reading about or hearing about FIT from colleagues acknowledged in interviews that they had basic questions about the concept, suggesting that hands on experiences with FIT were key to understanding it.

Counselor educators can promote the practice in the classroom setting and encourage the field to incorporate it in supervision through experiential learning courses. Examples in case vignettes provided by Shaw and Murray (2014) and Tilsen and McNamee (2015) offered opportunities for counselors to consider how FIT is applied in counseling dialogue Yates et al. (2016) and Schmidt (2014) suggested several applications of FIT within the typical course planning in counselor education. Future counselors and their clients and supervisors stand to benefit from following those recommendations.

Recommendations for Implementation Leaders

For implementation leaders, it is not good news that the use of FIT data in supervision is rare. It means that a challenge remains to increasing the use of EBPs in routine care. For the use of FIT in practice, it also means that there are few supervisors to support technical adherence to specific FIT models when planning implementation of FIT. The lack of local supervisors to serve as champions of the practice will be a barrier to helping new professionals stick to procedures and interpret client feedback data in meaningful ways.

Despite the finding that use of FIT data in supervision is rare, there are some promising signals for implementation leaders. Attitudes towards using FIT data in supervision were favorable among those who were previously unaware of FIT, other non-users, and users of FIT data in supervision. This bodes well for future expansion of FIT as attitudes towards EBPs influence adoption in practice settings (Aarons, Hurlburt, & Horwitz, 2011). Moreover, supervisors identified benefits and utility of FIT data in supervision that balance client welfare, supervisee development, and supervisor responsibility.

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APPENDICES

[Appendix A: Survey Script]

[Appendix A: Survey Script]

Outcome-Informed Supervision: A Mixed Method Investigation of Counseling Supervisors' Utilization of

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Start of Block: Survey Information and Consent

Q82 **Consent to Participate in a Research Study** Outcome-Informed Supervision: A Mixed Method Investigation of Counseling Supervisors' Utilization of Feedback Informed Treatment Data **Key Information** You are being invited to participate in a research study. This document includes important information you should know about the study. Before providing your consent to participate, please read this entire document and ask any questions you have. **Do I have to participate?** If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering. If you decide to participate, you will be one of up to 600 people in the study. **What is the purpose of the study?** This voluntary study is intended to increase understanding of factors associated with supervisor utilization of Feedback Informed Treatment (FIT) data in supervision. Yates, Homes, Smith, and Nielson (2016) described Feedback Informed Treatment as "continual assessment procedures that include weekly feedback about a client's current symptomology and perceptions of the therapeutic process in relation to previous counseling session scores".

Other terms used to describe this type of process include routine outcome monitoring, measurement feedback, client feedback, or progress monitoring. You have been contacted because you are listed as an eligible supervisor by Kentucky's Board of Licensed Professional Counselors. **Where is the study going to take place and how long will it last?** The research procedures will be conducted in two phases: first through electronic survey then for some participants through telephonic interview or other preferred methods of correspondence of participants. The survey will take about 10 minutes to complete. The follow-up interviews for selected and volunteering participants are expected to take no more than 20 minutes. The total amount of time you will be asked to volunteer for this study is less than one hour. **What will I be asked to do?** As a participant in this study you will be asked to complete a survey including some items about yourself, your practice, and your attitudes about psychotherapy and supervision. You will then be given the opportunity to indicate your preference for being available for follow-up contact in the qualitative phase. In the qualitative phase, some participants will be contacted to elaborate on the relationship of factors identified in quantitative phase as being relevant to use of FIT data in supervision. **Are there reasons why I should not take part in this study?** There are no anticipated reasons why any eligible supervisor should not take part in this study. **What are the possible risks and discomforts?** To the best of our knowledge, the things you will be doing have no more risk of harm or discomfort than you would experience in everyday life. **What are the benefits of taking part in this study?** You are not likely to get any personal benefit from taking part in this study. Your participation is expected to provide benefits to others by clarifying the

factors associated with and prevalence of this strategy in clinical supervision and increasing understanding of how it influences supervision practice and counselor development. **If I don't take part in this study, are there other choices?** If you do not want to be in the study, there are no other choices except to not take part in the study. Now that you have some key information about the study, please continue reading if you are interested in participating. Other important details about the study are provided below. **Other Important Details Who is doing the study?** The person in charge of this study is Michael Lewis at Eastern Kentucky University. He is being guided in this dissertation research by Dr. Ken Engebretson, Dr. Charles Myers, and Dr. Angela Spiers. There may be other people on the research team assisting at different times during the study. **What will it cost me to participate?** There are no costs associated with taking part in this study. **Will I receive any payment or rewards for taking part in the study?** All supervisors who are contacted about the study will be offered a continuing education opportunity in the next year for up to 3 hours of NBCC credit as approved by the Department of Educational Leadership, Counselor Education, and Communication Disorders at Eastern Kentucky University. Dr. Ken Engebretson will present an advanced supervision training. Choosing to participate is not necessary for the opportunity for continuing education units **Who will see the information I give?** Your information will be combined with information from other people taking part in the study. When we write up the study to share it with other researchers, we will write about this combined information. You will not be identified in these written materials. We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what

that information is. However, there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information to a court. Also, we may be required to show information that identifies you for audit purposes. We will make every effort to safeguard your data, but as with anything online, we cannot guarantee the security of data obtained via the Internet. Third-party applications used in this study may have terms of service and privacy policies outside of the control of the Eastern Kentucky University. **Can my taking part in the study end early?** If you decide to take part in the study, you still have the right to decide at any time that you no longer want to participate. You will not be treated differently if you decide to stop taking part in the study. The individuals conducting the study may need to end your participation in the study. They may do this if you are not able to follow the directions they give you, if they find that your being in the study is more risk than benefit to you, or if the University or agency funding the study decides to stop the study early for a variety of reasons. **What happens if I get hurt or sick during the study?** If you believe you are hurt or get sick because of something that is done during the study, you should call Michael Lewis at 859-622-3417 immediately. It is important for you to understand that Eastern Kentucky University will not pay for the cost of any care or treatment that might be necessary because you get hurt or sick while taking part in this study. Also, Eastern Kentucky University will not pay for any wages you may lose if you are harmed by this study. These costs will be your responsibility. Usually, medical costs that result from research-related harm cannot be included as regular medical costs. Therefore, the costs related to your care and treatment because of something that is done during the study

will be your responsibility. You should ask your insurer if you have any questions about your insurer's willingness to pay under these circumstances. **What else do I need to know?** You will be told if any new information is learned which may affect your condition or influence your willingness to continue taking part in this study. We will send a copy of this consent form to your email address. **Consent** Before you decide whether to accept this invitation to take part in the study, please ask any questions that come to mind now. Later, if you have questions about the study, you can contact the investigator, Michael Lewis at michael.lewis@eku.edu. Faculty advisors may be reached at ken.engebretson@eku.edu, charles.myers@eku.edu, and angela.spiers@eku.edu If you have any questions about your rights as a research volunteer, you can contact the staff in the Division of Sponsored Programs at Eastern Kentucky University at 859-622-3636. If you would like to participate, please read the statement below and indicate your choice.

○ I am at least 18 years of age, have thoroughly read this document, understand its contents, have been given an opportunity to have my questions answered, and voluntarily agree to participate in this research study. (1)

○ I do not consent to participate in the study (4)

Skip To: End of Survey If Consent to Participate in a Research Study Outcome-Informed Supervision: A Mixed Method Investi... != I am at least 18 years of age, have thoroughly read this document, understand its contents, have been given an opportunity to have my questions answered, and voluntarily agree to participate in this research study.

End of Block: Survey Information and Consent

Start of Block: Demographic Information

QD1 Choose your age among the following ranges.

- ○ 21-30 years (1)
- ○ 31-40 years (2)
- ○ 41-50 years (3)
- ○ 51-60 years (4)
- ○ 61-70 years (5)
- ○ 71 years or older (6)
- ○ Choose not to respond (7)

QD2 To which gender identity do you most identify?

- ○ Male (1)
- ○ Female (2)
- ○ Prefer not to say (3)
- ○ Prefer to self-describe (4)

_____

QD3 What is the highest degree you have obtained?

- ○ Masters (1)
- ○ Doctorate (2)

QD4 Where did you obtain your degree?

- ○ In Kentucky (1)
- ○ Not in Kentucky (2)

QD5 What was the CACREP status of your University at the time you completed your degree?

- ○ Accredited (1)
- ○ Not accredited (2)
- ○ Not sure (3)

QD6 In what year did you complete your highest degree?

_____

QD7 How many years have you been a supervisor for counselors or student counselors?

- ○ 0-3 years (1)
- ○ 4-6 years (2)
- ○ 7-9 years (3)
- ○ 10-13 years (4)
- ○ 14-17 years (5)
- ○ 18 years or more (6)

QD8 What best describes your theoretical orientation as a counselor?

- ○ Cognitive Behavioral Therapy (1)
- ○ Humanistic (2)
- ○ Family Systems (3)
- ○ Psychodynamic (4)
- ○ Eclectic (5)
- ○ Integrated (Multi-Modal) (6)
- ○ Other (7)

End of Block: Demographic Information

Start of Block: Practice Conditions

QP1 What counseling practice specialties are representative of your current practice as a counselor?

- [ ] Substance Use (1)
- [ ] Severe Mental Illness (2)
- [ ] Couples/Families (3)
- [ ] Trauma (4)
- [ ] Career and Lifestyle Counseling (5)
- [ ] Group Counseling (6)
- [ ] School Settings (7)
- [ ] General (8)

QP2 What best represents your primary clientele?

- ○ Adults (1)
- ○ Children and Adolescents (2)
- ○ Geriatric (3)
- ○ General (4)

QP3 Which of the following best represents your practice setting?

- ○ Private Independent Practice (1)
- ○ Private Group Practice (2)
- ○ State Designated Community Mental Health Center (3)
- ○ Other Outpatient Mental Health Agency (4)
- ○ K-12 School (5)
- ○ Higher Education (6)
- ○ Hospital Setting (7)
- ○ Day Treatment Facility (8)
- ○ Residential or Group Home Facility (9)
- ○ General Medical Practice (10)

QP4 Which of the following payor sources fund your practice the most?

- ○ Medicaid Managed Care (1)
- ○ Private Insurance (2)
- ○ Government Agencies (3)
- ○ Grant Funding (4)
- ○ Direct Client Payment- Fee for Service (5)

QP5 At your practice for therapy, records are primarily managed through which type of system?

- ○ Predominantly Paper-Based Record System (1)
- ○ Predominantly Electronic Record System (2)

QP6 What is the estimated number of clients engaged in treatment at your entire agency annually?

- ○ Less than 100 (1)
- ○ 101-200 (2)
- ○ 201-300 (3)
- ○ 301-400 (4)
- ○ 401-500 (5)
- ○ 501 or more (6)

QP7 To what degree are assessment procedures mandated in your practice setting?

- ○ Not a lot (1)
- ○ Some (2)
- ○ A lot (3)

QP8 To what degree are evidence-based practices mandated in your practice setting?

- ○ Not a lot (1)
- ○ Some (2)
- ○ A lot (3)

QP9 What is your current average of direct hours per week with clients?

- ○ 0-5 (1)
- ○ 6-10 (2)
- ○ 11-15 (3)
- ○ 16-20 (4)
- ○ 21-25 (5)
- ○ 26-30 (6)
- ○ 31 or more (7)

End of Block: Practice Conditions

Start of Block: Supervision Conditions

QS1 For how many LPCA supervisees are you currently responsible?

_____

QS2 How many students did you supervise in the past year?

_____

QS3 How many of your supervisees are employed at your agency?

- ○ All (1)
- ○ Most (2)
- ○ About half (3)
- ○ Less than half (4)
- ○ None (5)

QS4 In which of the following ways do you seek continuing education or scholarship? (Check all that apply)

- ☐ Professional Associations (1)
- ☐ Reading Academic Journals (2)
- ☐ Research Participation (3)
- ☐ Conference Presentations (4)
- ☐ Agency-hosted Training (5)
- ☐ Online Continuing Education Systems (6)
- ☐ Other (7)

End of Block: Supervision Conditions

Start of Block: MFA Items

Q80 The following items refer to routine progress monitoring and providing feedback to clients about treatment progress. Jensen-Doss et al. (2018) defined routine progress monitoring as the administration of measures to clients every 1-2 sessions to monitor treatment progress. Providing feedback is referred to as discussing data collected from routine progress monitoring.

QAMF1 Monitoring treatment progress is an important part of treatment

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

QAMF2 Monitoring treatment progress is valuable for supervision

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

QAMF3 Providing feedback to clients about treatment progress helps to increase client motivation and engagement

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

QAMF4 Providing feedback to clients about treatment progress (or lack thereof) would potentially harm the therapeutic alliance

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

QAMF5 Providing clients with negative feedback about their progress would lead to client deterioration or premature treatment termination

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

QAMF6 Providing clients with negative feedback about their progress would decrease their motivation for and/or engagement in treatment

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

QAMF7 Providing clients with negative feedback about their progress would make them think that their therapist is incompetent

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

QAMF8 Providing clients with feedback about treatment progress empowers them to make informed decisions about their care

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

QAMF9 Providing clients with feedback about treatment progress facilitates collaboration between clients and clinicians

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

QAMF10 Clients want their therapists to provide them with information about treatment progress

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

QAMF11 Providing clients with feedback about treatment progress can increase their insight

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

QAMF12 Providing clients with feedback about treatment progress helps keep treatment focused on treatment goals

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

QAMF13 Providing clients with regular feedback about treatment progress creates an expectation for positive change

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

QAMF14 Providing feedback to clients about treatment progress (or lack thereof) can lead to better treatment outcomes

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

End of Block: MFA Items

Start of Block: ASA-MF

Q81 The following items refer to the use of standardized progress measures. Jensen-Doss et al. (2018) defined this as "client self-report measures with standard items and scoring procedures, such as a rating scale like the Beck Depression Inventory or the Strengths and Difficulties Questionnaire".

QASA1 Standardized progress measures don’t tell me anything I can’t learn from just talking to clients

- Strongly disagree (1)
- Somewhat disagree (2)
- Neither agree nor disagree (3)
- Somewhat agree (4)
- Strongly agree (5)

QASA2 Standardized progress measures help identify when treatment is not going well

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

QASA3 Information from standardized progress measures can help me plan for sessions

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

QASA4 Standardized progress measures gather information about the client that may not otherwise come up in session

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

QASA5 Standardized progress measures can efficiently gather information

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

QASA6 The information I receive from standardized progress measures isn't worth the time I spend administering, scoring, and interpreting the results

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

End of Block: ASA-MF

Start of Block: Supervision Attitudes

QSA1 Using client feedback data in supervision enhances the evaluation of treatment effectiveness.

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

QSA2 It is easier to give challenging feedback to supervisees when informed by client feedback data.

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

QSA3 Discussing client feedback data in supervision encourages supervisee self-reflection.

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

QSA4 Client feedback data provides me a more accurate understanding of skill development among my supervisees.

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

QSA5 Supervision sessions focused on client feedback data lead to negative experiences for supervisees.

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

End of Block: Supervision Attitudes

Start of Block: FIT Exposure & Utilization

QFITD Feedback informed treatment (FIT) has been described by Yates, Homes, Smith, and Nielson (2016) as "continual assessment procedures that include weekly feedback about a client's current symptomology and perceptions of the therapeutic process in relation to previous counseling session scores." Common models of FIT include the Outcomes Questionnaire (OQ), the Partners for Change Outcome Management System (PCOMS), and the Treatment Outcome Package System (TOPS).

QFIT1 What best describes your awareness of Feedback Informed Treatment?

- ○ Never heard of it until now (1)
- ○ Recognized the name but not much else (2)
- ○ Read about it in books or articles (3)
- ○ Heard about it from colleagues (4)
- ○ Attended a conference presentation about it (5)
- ○ Attended training about using it (6)
- ○ Used it in practice (7)

Skip To: End of Block If What best describes your awareness of Feedback Informed Treatment? = Never heard of it until now

Skip To: End of Block If What best describes your awareness of Feedback Informed Treatment? = Recognized the name but not much else

Display This Question:

If What best describes your awareness of Feedback Informed Treatment? = Read about it in books or articles

Or What best describes your awareness of Feedback Informed Treatment? = Heard about it from colleagues

Or What best describes your awareness of Feedback Informed Treatment? = Attended a conference presentation about it

Or What best describes your awareness of Feedback Informed Treatment? = Attended training about using it

QFIT2 Of which of the following Feedback Informed Treatment models are you aware? (Check all that apply)

- ☐ Outcomes Analyst/Outcomes Questionnaire (OQ-Analyst) (1)
- ☐ Partners for Change Outcome Management System (PCOMS) (2)
- ☐ Treatment Outcome Package System (TOPS) (3)
- ☐ Other (4) _____

Display This Question:

If What best describes your awareness of Feedback Informed Treatment? = Used it in practice

QFIT3 Which of the following Feedback Informed Treatment models have you used?

- ☐ Outcomes Analyst/Outcomes Questionnaire (OQ-Analyst) (1)
- ☐ Partners for Change Outcome Management System (PCOMS) (2)
- ☐ Treatment Outcome Package System (TOPS) (3)
- ☐ Other (4) _____

Display This Question:

If What best describes your awareness of Feedback Informed Treatment? = Used it in practice

QFIT4 Do you currently use a Feedback Informed Treatment tool/process in your work as a counselor?

- ○ Yes (1)
- ○ No (2)

Display This Question:

If Do you currently use a Feedback Informed Treatment tool/process in your work as a counselor? = Yes

QFIT5 How often do you administer FIT with clients?

- ○ Every session (1)
- ○ Every other session (2)
- ○ Once Monthly (3)
- ○ Periodically but less often than monthly (4)
- ○ Before and After Treatment only (5)

Display This Question:

If Do you currently use a Feedback Informed Treatment tool/process in your work as a counselor? = Yes

QFIT6 How often would you prefer to administer FIT with clients?

- ○ Every session (1)
- ○ Every other session (2)
- ○ Every few sessions (3)
- ○ Once Monthly (4)
- ○ Periodically but less often than monthly (5)
- ○ Before and After Treatment only (6)

QFIT7 Do you use Feedback Informed Treatment Data in your work as a supervisor?

- ○ Yes (1)
- ○ No (2)

Display This Question:

If Do you use Feedback Informed Treatment Data in your work as a supervisor? = Yes

QFIT8 How often do you review FIT data with supervisees?

- Every session (1)
- Every other session (2)
- Every few sessions (3)
- Once Monthly (4)
- Periodically but less often than monthly (5)
- Before and After Treatment only (6)

Display This Question:

If Do you use Feedback Informed Treatment Data in your work as a supervisor? = Yes

QFIT9 How often would you prefer to review FIT data with supervisees?

- ○ Every session (1)
- ○ Every other session (2)
- ○ Every few sessions (3)
- ○ Once Monthly (4)
- ○ Periodically but less often than monthly (5)
- ○ Before and After Treatment only (6)

End of Block: FIT Exposure & Utilization

Start of Block: Next phase

QNEXT I am willing to be contacted for a brief follow-up interview.

- ○ Agree (1)
- ○ Disagree (2)

End of Block: Next phase

[Appendix B: Interview Protocol]

[Appendix B: Interview Protocol]

Interview Protocol Development

"Thank you for making yourself available to talk with me further about the use of FIT model data in supervision. You were identified as a representative of an important group of respondents from the first phase of analysis: Supervisors who [insert group description here].

As a reminder, this is a voluntary study. This interview is expected to last approximately 10-20 minutes. There are no anticipated risks in continuing to participate. Your identity will only be known to this researcher.

In an effort to ensure accuracy of your input, I want you to consider agreeing to an audio recording of our conversation. This recording will only be used to transcribe responses accurately and will not be associated with your identity."

"OK. Let's begin."

Statement at close of interview:

“Again, I appreciate the time that you have offered to contribute to this research. Before we wrap things up, is there anything else you wish you to say about supervision, the use of feedback informed treatment, or something else we talked about today?”

Group A (Unaware of FIT) Questions and Concepts

1. Tell me about your experience as a supervisor of counselors.

    (Purpose – Orient interviewee to focus, provide opportunity to highlight interviewee perspective of what is important in their experience. Common to all interviewees)

2a. What are your questions about the feedback informed treatment concept?

(Purpose – Group A indicated little to no prior knowledge of FIT. Their questions about what it is, can reveal common impressions held by this group of supervisors)

3a. What might motivate you to investigate FIT as an addition to your practice or supervision process?

(Purpose – Group A indicated little to no prior knowledge of FIT. Their answers can reveal common motivations to adopt FIT)

4a. How do you imagine FIT affecting your practice as a counselor?

(Purpose – Group A indicated little to no prior knowledge of FIT. Their perceptions of how their practice might change could reveal thoughts about benefit, harm, utility, treatment planning, or practicality)

5. What are your concerns about using FIT models? Sub – In supervision?

(Purpose – Concerns about it can reveal philosophical and practical barriers anticipated by this group of supervisors. Common to all interviewees.)

6a. What is your approach to evaluating supervisee skill?

(Purpose – Group A indicated little to no prior knowledge of FIT. Their approach to evaluating supervisee skill should reveal traditional or alternative approaches to evaluation. Common to all interviewees)

7. What are your thoughts about giving supervisees challenging feedback about their performance with clients?

(Purpose – Group A indicated little to no prior knowledge of FIT. Their thoughts about giving feedback might represent common impressions held by this group of supervisors. Common to all interviewees.)

8a. What are your thoughts about using FIT data for evaluation or giving feedback in supervision?

(Purpose – Group A indicated little to no prior knowledge of FIT. Their thoughts about the use of FIT data in supervision in relation to these supervision responsibilities might represents beliefs held by this group of supervisors. Common to all interviewees.)

Group B (Aware but not using FIT in supervision) Questions and Concepts

1. Tell me about your experience as a supervisor of counselors.

(Purpose – Orient interviewee to focus, provide opportunity to highlight interviewee perspective of what is important in their experience. Common to all interviewees)

2b. What would you like to tell me about the use of FIT models?

(Purpose – Group B indicated a range of knowledge levels with FIT models. This item provides opportunity to describe their level of exposure and experience, potentially leading to sub-questions for following items. Common for Groups B & C)

3b. What motivated your interest in FIT?

(Purpose – Group B indicated a range of knowledge levels with FIT models. Responses to this question point at factors influencing adoption of FIT. Common for Groups B & C)

4a. How do you imagine FIT affecting your practice as a counselor? OR
4b. How has experience using FIT affected your practice as a counselor? Sub - How was the FIT model you use chosen?

(Purpose – Groups B & C need to have this question split to fit the different experiences. Answers should help explain, compare experienced users, different learning paths.)

5. What are your concerns about using FIT models? Sub – In supervision?

(Purpose – Concerns about it can reveal philosophical and practical barriers anticipated by this group of supervisors. Common to all interviewees.)

6. What is your approach to evaluating supervisee skill?

(Purpose – Group B represents a range of FIT exposure. Their approach to evaluating supervisee skill should reveal traditional or alternative approaches to evaluation. Common to all interviewees)

7. What are your thoughts about giving supervisees challenging feedback about their performance with clients?

(Purpose – Group B indicated a range of FIT exposure. Their thoughts about giving feedback might represent common impressions held by this group of supervisors. Common to all interviewees.)

8. What are your thoughts about using FIT data for evaluation or giving feedback in supervision?

(Purpose – Group B's thoughts about the use of FIT data in supervision in relation to these supervision responsibilities might represent beliefs held by this group of supervisors. Common to all interviewees.)

9b. What do you believe best explains why you do not utilize FIT data in supervision?

(Purpose – Group B can offer an answer to the main research question directly.)

Group C (Using FIT in supervision) Questions and Concepts

1. Tell me about your experience as a supervisor of counselors.

(Purpose – Orient interviewee to focus, provide opportunity to highlight interviewee perspective of what is important in their experience. Common to all interviewees)

2b. What would you like to tell me about the use of FIT models?

(Purpose – Group C indicated using FIT in supervision but not necessarily in practice. This item provides opportunity to describe levels of exposure and experience, potentially leading to sub-questions for following items. Common for Groups B & C)

3b. What motivated your interest in FIT?

(Purpose – Group C indicated using FIT models in supervision. Responses to this question point at factors influencing adoption of FIT. Common for Groups B & C)

4a. How do you imagine FIT affecting your practice as a counselor? OR
4b. How has experience using FIT affected your practice as a counselor? Sub - How was the FIT model you use chosen?

(Purpose – Groups B & C need to have this question split to fit the different experiences. Answers should help explain, compare experienced users, different learning paths.)

5. What are your concerns about using FIT models? Sub – In supervision?

(Purpose – Concerns about it can reveal philosophical and practical barriers anticipated by this group of supervisors. Common to all interviewees.)

6. What is your approach to evaluating supervisee skill?

(Purpose – Group C indicated using FIT in supervision. Their approach to evaluating supervisee skill might reveal how evaluation is influenced by access to FIT data. Common to all interviewees)

7. What are your thoughts about giving supervisees challenging feedback about their performance with clients?

(Purpose – Group C indicated FIT data use in supervision. Their thoughts about

giving feedback might represent common impressions held by this group of

supervisors. Common to all interviewees.)

8. What are your thoughts about using FIT data for evaluation or giving feedback in supervision?

(Purpose – Group C's thoughts about the use of FIT data in supervision in relation to these supervision responsibilities reflect experience-formed beliefs held by this group of supervisors. Common to all interviewees.)

9c. What do you believe best explains why you utilize FIT data in supervision?

(Purpose – Group B can offer an answer to the main research question directly.)

10. What has changed in your supervision since using FIT data?

(Purpose – Group C indicated using FIT in supervision. Only this group can describe how FIT data influences supervision overall.)

"Again, I appreciate the time that you have offered to contribute to this research. Before we wrap things up, is there anything else you wish you to say about supervision, the use of feedback informed treatment, or something else we talked about today?"

[Appendix C: Qualitative Analysis Code Book]

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OIS Codebook

Nodes

Name	Description	Files	References
Benefits of FIT	Spontaneous identifications of benefits to FIT practice or use of data in supervision in response to any interview query.	15	59
Better Supervision	Spontaneous identifications of benefits to FIT practice or use of data in supervision in response to any interview query. Answers include some description of perceived improvements to supervision.	15	36
Efficiency	Spontaneous identifications of benefits to FIT practice or use of data in supervision in response to any interview query. Answers include some description of perceived improvements to supervision by making supervision more efficient.	4	6

Name	Description	Files	References
Information about Supervisee Performance	Spontaneous identifications of benefits to FIT practice or use of data in supervision in response to any interview query. Answers include some description of perceived improvements to supervision by providing more information about supervisee performance.	13	23
More Specific Direction to Supervisee	Spontaneous identifications of benefits to FIT practice or use of data in supervision in response to any interview query. Answers include some description of perceived improvements to supervision by creating more specific direction to supervisees.	9	16
Quality	Spontaneous identifications of benefits to FIT practice or use of data in supervision in response to any interview query. Answers include some description of perceived improvements to the general quality of supervision.	8	12

Name	Description	Files	References
Client Care Improved	Spontaneous identifications of benefits to FIT practice or use of data in supervision in response to any interview query. Answers that refer to perceived improvements in client care experience.	11	22
Adjustments to Counseling Practice	Spontaneous identifications of benefits to FIT practice or use of data in supervision in response to any interview query. Answers that refer to perceived improvements in client care experience. Statements feature description of FIT data encouraging changes to counseling practice to be more effective.	3	3
Client Voice	Spontaneous identifications of benefits to FIT practice or use of data in supervision in response to any interview query. Answers that refer to perceived improvements in client care experience. Statements highlight benefits in empowering clients to express their perspective about treatment quality or relationship with counselors.	8	13

Name	Description	Files	References
Effects of Routine	Spontaneous identifications of benefits to FIT practice or use of data in supervision in response to any interview query. Answers that refer to perceived improvements in client care experience. Statements relate indirect benefits from the routine of collecting client feedback about treatment progress or therapeutic alliance.	3	3
Effects of Visualizing Progress	Spontaneous identifications of benefits to FIT practice or use of data in supervision in response to any interview query. Answers that refer to perceived improvements in client care experience. Statements relate positive effects from the presentation of progress data in discussion between clients and counselors.	2	4
Individualized Attention	Spontaneous identifications of benefits to FIT practice or use of data in supervision in response to any interview query. Answers that refer to perceived	2	3

Name	Description	Files	References
	improvements in client care experience. Statements indicate that FIT data leads to individualized attention in supervision to help specific clients by improving their care by supervisees.		
Measures Client Satisfaction	Spontaneous identifications of benefits to FIT practice or use of data in supervision in response to any interview query. Answers that refer to perceived improvements in client care experience. Statements note value in that FIT measures client satisfaction.	1	1
Models Healthy Relationships	Spontaneous identifications of benefits to FIT practice or use of data in supervision in response to any interview query. Answers that refer to perceived improvements in client care experience. Statements assert that FIT process with clients models communication in healthy relationships.	2	2
Solution-focused	Spontaneous identifications of benefits to FIT practice or use of data in	1	2

Name	Description	Files	References
	supervision in response to any interview query. Answers that refer to perceived improvements in client care experience. Statements relate connection to solution-focused process in counseling.		
Other	Spontaneous identifications of benefits to FIT practice or use of data in supervision in response to any interview query. Answers that referred to hard to categorize benefits including EBP status, added credibility for reimbursement, and opportunity to shift focus in therapy routine to utilize math skills.	3	6
Best Explained By	Interviewee responses to query about what best explains their status as using or not using FIT data in supervision. Posed to interviewees in Group B and C.	12	18
Why Not Using	Interviewee responses to query about what best explains their status as using or not using FIT data in supervision.	7	17

Name	Description	Files	References
	Posed to interviewees in Group B and C. Answer explains why not using FIT.		
Disagree with approach	Interviewee responses to query about what best explains their status as using or not using FIT data in supervision. Posed to interviewees in Group B and C. Answer explains why not using FIT. FIT is not being used because interviewee disagrees with the approach.	1	3
Implementation phase	Interviewee responses to query about what best explains their status as using or not using FIT data in supervision. Posed to interviewees in Group B and C. Answer explains why not using FIT. FIT is not being used because the implementation phase of FIT model at agency is new.	1	3
Inexperience as a supervisor	Interviewee responses to query about what best explains their status as using or not using FIT data in supervision. Posed to interviewees in Group B and	2	3

Name	Description	Files	References
	C. Answer explains why not using FIT. FIT is not being used because interviewee reports not having enough experience as a supervisor to implement FIT data.		
Lack of access	Interviewee responses to query about what best explains their status as using or not using FIT data in supervision. Posed to interviewees in Group B and C. Answer explains why not using FIT. FIT is not being used because there is a lack of access to FIT models.	1	2
Uninformed about FIT	Interviewee responses to query about what best explains their status as using or not using FIT data in supervision. Posed to interviewees in Group B and C. Answer explains why not using FIT. FIT is not being used because interviewee is not informed enough about how to use it.	3	6
Why Using	Interviewee responses to query about what best explains their status as using	5	19

Name	Description	Files	References
	or not using FIT data in supervision. Posed to interviewees in Group B and C. Answer explains why using FIT.		
Billing Expectations	Interviewee responses to query about what best explains their status as using or not using FIT data in supervision. Posed to interviewees in Group B and C. Answer explains why using FIT. FIT is being used because it supports efforts for reimbursement.	1	1
Effectiveness of Client Therapy	Interviewee responses to query about what best explains their status as using or not using FIT data in supervision. Posed to interviewees in Group B and C. Answer explains why using FIT. FIT is being used because it relates to effectiveness of client treatment.	2	2
Prior Experience	Interviewee responses to query about what best explains their status as using or not using FIT data in supervision. Posed to interviewees in Group B and C. Answer explains why using FIT. FIT	1	2

Name	Description	Files	References
	is being used because supervisor had prior experience with it.		
Problem-Solving	Interviewee responses to query about what best explains their status as using or not using FIT data in supervision. Posed to interviewees in Group B and C. Answer explains why using FIT. FIT is being used to solve problems.	2	4
Reliability of Use	Interviewee responses to query about what best explains their status as using or not using FIT data in supervision. Posed to interviewees in Group B and C. Answer explains why using FIT. FIT being used because of its reliability.	1	1
Reputation	Interviewee responses to query about what best explains their status as using or not using FIT data in supervision. Posed to interviewees in Group B and C. Answer explains why using FIT. FIT is being used to build a positive reputation in community.	2	2

Name	Description	Files	References
Specifics of Outcomes	Interviewee responses to query about what best explains their status as using or not using FIT data in supervision. Posed to interviewees in Group B and C. Answer explains why using FIT. FIT is being used because of specific of outcomes.	1	1
Supervisee Improvement	Interviewee responses to query about what best explains their status as using or not using FIT data in supervision. Posed to interviewees in Group B and C. Answer explains why using FIT. FIT being used because it enhances supervisee improvement.	3	6
Utility	Interviewee responses to query about what best explains their status as using or not using FIT data in supervision. Posed to interviewees in Group B and C. Answer explains why using FIT. FIT is being used because of what its usefulness.	3	9

Name	Description	Files	References
Changes to Supervision	Interviewee responses to query about what has changed in supervision since using FIT data. Posed to interviewees indicating experience using FIT data in supervision.	5	7
Improvements	Interviewee responses to query about what has changed in supervision since using FIT data. Posed to interviewees indicating experience using FIT data in supervision. Answer suggests improvements to supervision.	4	7
Not much changed	Interviewee responses to query about what has changed in supervision since using FIT data. Posed to interviewees indicating experience using FIT data in supervision. Answer indicates little to no change.	2	2
Concerns	Interviewee responses to query about concerns with the use of FIT models	16	43
Agency Support	Interviewee responses to query about concerns with the use of FIT models. Concerns mentioned questions about	2	3

Name	Description	Files	References
	whether or not agencies are supporting FIT implementation.		
Harm to Clients	Interviewee responses to query about concerns with the use of FIT models. Concerns mentioned perceived harm to clients.	1	1
Harm to Supervisees	Interviewee responses to query about concerns with the use of FIT models. Concerns mentioned perceived harm to supervisees.	4	6
Practical Effects	Interviewee responses to query about concerns with the use of FIT models. Concerns expressed related to practical effects on counselor routines and therapeutic alliance.	7	9
Resisting Concern	Interviewee responses to query about concerns with the use of FIT models. Interviewee resisted describing concerns.	6	7
Uninformed Worries	Interviewee responses to query about concerns with the use of FIT models. Concerns featured worries that were	7	15

Name	Description	Files	References
	rooted in not knowing how FIT worked or how it would be implemented.		
Validity	Interviewee responses to query about concerns with the use of FIT models. Concerns mentioned questions about the accuracy or validity of FIT data.	7	17
Constructive Criticism in Supervision	Interviewee responses to query about giving challenging feedback in supervision	16	18
Challenges	Interviewee responses to query about giving challenging feedback in supervision. Answer indicated challenges in giving constructive criticism to supervisees.	6	9
Confidence about	Interviewee responses to query about giving challenging feedback in supervision. Answer indicated confidence in giving constructive criticism to supervisees.	6	7
Method	Interviewee responses to query about giving challenging feedback in	12	17

Name	Description	Files	References
	supervision. Answer described methods of giving challenging feedback.		
Balance positive and negative	Interviewee responses to query about giving challenging feedback in supervision. Answer described methods of giving challenging feedback. Method includes balancing positive and constructive feedback.	5	5
Client-centered	Interviewee responses to query about giving challenging feedback in supervision. Answer described methods of giving challenging feedback. Method includes linking feedback to how clients are impacted.	3	3
Self-reflection by supervisees	Interviewee responses to query about giving challenging feedback in supervision. Answer described methods of giving challenging feedback. Method includes self-reflection tasks for supervisees.	1	2
Set expectation for it	Interviewee responses to query about giving challenging feedback in	3	3

Name	Description	Files	References
	supervision. Answer described methods of giving challenging feedback. Method includes setting expectations for feedback early in supervisory relationship.		
use of tools	Interviewee responses to query about giving challenging feedback in supervision. Answer described methods of giving challenging feedback. Method includes use of tools.	3	3
Purpose of	Interviewee responses to query about giving challenging feedback in supervision. Answer described the purpose of giving challenging feedback.	9	15
Helps supervisees	Interviewee responses to query about giving challenging feedback in supervision. Answer described the purpose of giving challenging feedback. Purpose was described as knowing it helps supervisees from either personal reflection or surveying supervisees.	4	4

Name	Description	Files	References
Necessary	Interviewee responses to query about giving challenging feedback in supervision. Answer described the purpose of giving challenging feedback. Purpose was described as it is necessary or an obligation.	8	13
Supervisee Openness	Interviewee responses to query about giving challenging feedback in supervision. Answer indicated that supervisee openness to feedbak was important in giving challenging feedback.	8	13
Evaluation	Interviewee response to query about current approaches to evaluating supervisee skills	16	25
Data Input	Interviewee response to query about current approaches to evaluating supervisee skills. Answer to query indicated consideration of what data would be used to base evaluation.	16	33
Documentation Review	Interviewee response to query about current approaches to evaluating	7	7

Name	Description	Files	References
	supervisee skills. Answer to query indicated consideration of what data would be used to base evaluation. Data input would include reviewing therapy notes, assessments, and/or treatment plans.		
informal client or co-worker report	Interviewee response to query about current approaches to evaluating supervisee skills. Answer to query indicated consideration of what data would be used to base evaluation. Data input would include asking clients or co-workers of supervisees informally about how therapy is going or how the supervisee is performing in their role as counselor.	3	3
Live observation	Interviewee response to query about current approaches to evaluating supervisee skills. Answer to query indicated consideration of what data would be used to base evaluation. Data	6	7

Name	Description	Files	References
	input would include observing supervisees in sessions with clients.		
Recordings	Interviewee response to query about current approaches to evaluating supervisee skills. Answer to query indicated consideration of what data would be used to base evaluation. Data input would include asking supervisees to record sessions with audio and video and supervisor would review recordings.	3	4
Role-play	Interviewee response to query about current approaches to evaluating supervisee skills. Answer to query indicated consideration of what data would be used to base evaluation. Data input would include engaging supervisees in role-play.	1	1
Self report informal	Interviewee response to query about current approaches to evaluating supervisee skills. Answer to query indicated consideration of what data	10	15

Name	Description	Files	References
	would be used to base evaluation. Data input would be based on supervisee self-report.		
Systematic Client Feedback	Interviewee response to query about current approaches to evaluating supervisee skills. Answer to query indicated consideration of what data would be used to base evaluation. Data input would include FIT data from clients.	4	6
Systematic Supervisee Feedback	Interviewee response to query about current approaches to evaluating supervisee skills. Answer to query indicated consideration of what data would be used to base evaluation. Data input would include asking supervisees to complete a survey or form about how supervision is going.	3	3
Format	Interviewee response to query about current approaches to evaluating supervisee skills. Answer to query	8	10

Name	Description	Files	References
	indicated a format of how supervisees are evaluated.		
Frequency	Interviewee response to query about current approaches to evaluating supervisee skills. Answer to query indicated the frequency of evaluation or schedule of evaluation points.	3	3
Theory	Interviewee response to query about current approaches to evaluating supervisee skills. Answer to query indicated theory as playing some role in evaluation.	4	4
Uncertainty	Interviewee response to query about current approaches to evaluating supervisee skills. Answer to query indicated not being sure how to evaluate or in what ways the interviewee would evaluate supervisees.	5	7
Experience	Interviewee responses to general question about supervision experience	16	26
Academic Training in Supervision	Interviewee responses to general question about supervision experience.	3	4

Name	Description	Files	References
	Answer to query indicated academic training as part of supervision experience and knowledge.		
Brand-new	Interviewee responses to general question about supervision experience. Answer to query indicated a year or less of supervision experience.	6	7
Long-extensive years	Interviewee responses to general question about supervision experience. Answer to query indicated 10 years or more of supervision experience.	3	3
Negative Experiences	Interviewee responses to general question about supervision experience. Answer to query indicated negative experiences with supervision.	4	7
Other States	Interviewee responses to general question about supervision experience. Answer to query indicated experience in other states.	3	3
Positive Experiences	Interviewee responses to general question about supervision experience.	4	4

Name	Description	Files	References
	Answer to query indicated positive feelings about supervision experience.		
Some years	Interviewee responses to general question about supervision experience. Answer to query indicated years of experience from around 2 years to 10 years.	7	8
Varied Types	Interviewee responses to general question about supervision experience. Answer to query indicated varied types of supervision experience.	12	16
FIT Data use in Evaluation & Constructive Criticism	Interviewee responses to query about using FIT data to evaluate supervisee skills or give constructive criticism.	16	21
Benefits of Using	Interviewee responses to query about using FIT data to evaluate supervisee skills or give constructive criticism. Answer indicates perceived benefits of using for FIT for evaluation and/or constructive criticism.	15	19
Challenges & Concerns	Interviewee responses to query about using FIT data to evaluate supervisee	7	7

Name	Description	Files	References
	skills or give constructive criticism. Answer indicates perceived concerns or challenges.		
Impact	Interviewee responses to query about how FIT might affect or has affected their practice as a counselor	15	25
Helpful	Interviewee responses to query about how FIT might affect or has affected their practice as a counselor. Answer suggests that effect would be helpful.	14	23
Not sure	Interviewee responses to query about how FIT might affect or has affected their practice as a counselor. Answer indicates being unsure of the effect.	4	5
Unhelpful	Interviewee responses to query about how FIT might affect or has affected their practice as a counselor. Answer suggests effect as unhelpful.	1	1
Interviewer	Content in transcripts featuring interviewer questions as well as small talk with interviewees at the beginning or end of interviews.	0	0

Name	Description	Files	References
Interviewer Content	Interview Protocol content and extra chit-chat	16	22
Chit-Chat	Idle interviewer talk	16	46
Q Best Explains	What do you believe best explains why you do not utilize FIT data in supervision?	12	15
Q Con Crit	What are your thoughts about giving supervisees challenging feedback about their performance with clients? (Purpose – Group B indicated a range of FIT exposure. Their thoughts about giving feedback might represent common impressions held by this group of supervisors. Common to all interviewees.)	16	17
Q Concerns	What are your concerns about using FIT models? Sub – In supervision? (Purpose – Concerns about it can reveal philosophical and practical barriers anticipated by this group of supervisors. Common to all interviewees.)	16	19

Name	Description	Files	References
Q Evaluation	What is your approach to evaluating supervisee skill? (Purpose – Group B represents a range of FIT exposure. Their approach to evaluating supervisee skill should reveal traditional or alternative approaches to evaluation. Common to all interviewees)	15	25
Q FIT changes to supervision	What has changed in your supervision since using FIT data?	5	6
Q FIT Eval & Con Crit	What are your thoughts about using FIT data for evaluation or giving feedback in supervision? (Purpose – Group B's thoughts about the use of FIT data in supervision in relation to these supervision responsibilities might represent beliefs held by this group of supervisors. Common to all interviewees.)	16	17
Q Gen Exp	Tell me about your experience as a supervisor of counselors. (Purpose – Orient interviewee to focus, provide opportunity to highlight interviewee	16	18

Name	Description	Files	References
	perspective of what is important in their experience. Common to all interviewees)		
Q Impact	How do you imagine FIT affecting your practice as a counselor? OR How has experience using FIT affected your practice as a counselor? Sub - How was the FIT model you use chosen? (Purpose – Groups B & C need to have this question split to fit the different experiences. Answers should help explain, compare experienced users, different learning paths.)	15	18
Q Knowledge	What are your questions about the feedback informed treatment concept? (Purpose – Group A indicated little to no prior knowledge of FIT. Their questions about what it is, can reveal common impressions held by this group of supervisors) OR What would you like to tell me about the use of FIT models? (Purpose – Group B indicated	16	40

Name	Description	Files	References
	a range of knowledge levels with FIT models. This item provides opportunity to describe their level of exposure and experience, potentially leading to sub-questions for follo		
Q Motivation	What might motivate you to investigate FIT as an addition to your practice or supervision process? (Purpose – Group A indicated little to no prior knowledge of FIT. Their answers can reveal common motivations to adopt FIT) OR What motivated your interest in FIT? (Purpose – Group B indicated a range of knowledge levels with FIT models. Responses to this question point at factors influencing adoption of FIT. Common for Groups B & C)	16	18
Knowledge	Interviewee responses to query about their questions about FIT as a concept or what they can say about FIT	16	67
Community mental health	Interviewee responses to query about their questions about FIT as a concept	7	8

Name	Description	Files	References
	or what they can say about FIT. Responses mention the community mental setting.		
General Feedback	Interviewee responses to query about their questions about FIT as a concept or what they can say about FIT. Responses feature description of feedback as a general process in counseling.	7	13
Helpful	Interviewee responses to query about their questions about FIT as a concept or what they can say about FIT. Responses feature description of some type of benefit experienced or anticipated about FIT models.	10	11
Levels of knowledge	Interviewee responses to query about their questions about FIT as a concept or what they can say about FIT. Responses organized by level of knowledge about FIT indicated by the interviewee.	9	19

Name	Description	Files	References
Minimal	Interviewee responses to query about their questions about FIT as a concept or what they can say about FIT. Responses organized by level of knowledge suggested by interviewee response. The minimal level is used when interviewee indicates questions or confusion about the basic concepts of FIT and notes no experience or training with FIT models.	6	14
Partial	Interviewee responses to query about their questions about FIT as a concept or what they can say about FIT. Responses organized by level of knowledge suggested by interviewee response. The partial level is used when interviewee indicates some understanding about the basic concepts of FIT and/or notes some experience or training with FIT models but demonstrates struggle with details or	6	20

Name	Description	Files	References
	notes being unfamiliar with methods or resources.		
Thorough	Interviewee responses to query about their questions about FIT as a concept or what they can say about FIT. Responses organized by level of knowledge suggested by interviewee response. The thorough level is used when interviewee indicates extensive knowledge of basic concepts, methods, and resources of FIT and/or notes extensive experience or training with FIT models.	4	5
Not sure about it	Interviewee responses to query about their questions about FIT as a concept or what they can say about FIT. Responses reflect uncertainty about FIT in some way.	9	25
Concept of FIT	Interviewee responses to query about their questions about FIT as a concept or what they can say about FIT. Responses reflect interviewee being	8	15

Name	Description	Files	References
	unsure of the basic concepts of FIT models.		
Method of FIT	Interviewee responses to query about their questions about FIT as a concept or what they can say about FIT. Responses reflect interviewee being unsure of the method involved with specific FIT models.	5	9
Resources for FIT	Interviewee responses to query about their questions about FIT as a concept or what they can say about FIT. Responses reflect interviewee being unsure of resources for training or access to FIT models.	4	4
Problems	Interviewee responses to query about their questions about FIT as a concept or what they can say about FIT. Responses feature description of some type of problem experienced or anticipated about FIT models.	6	8
Reviewing feedback data	Interviewee responses to query about their questions about FIT as a concept	2	3

Name	Description	Files	References
	or what they can say about FIT. Responses feature description of client feedback being reviewed as part of treatment.		
Specific Models	Interviewee responses to query about their questions about FIT as a concept or what they can say about FIT. Responses mention a specific FIT model.	9	20
CCAPS	Interviewee responses to query about their questions about FIT as a concept or what they can say about FIT. Responses mention a specific model: (CCAPS).	2	5
CDOI	Interviewee responses to query about their questions about FIT as a concept or what they can say about FIT. Responses mention a specific model: Consumer-Directed Outcome-Informed (CDOI).	3	11
OQ	Interviewee responses to query about their questions about FIT as a concept	3	3

Name	Description	Files	References
	or what they can say about FIT. Responses mention a specific model: Outcomes Questionnaire (OQ).		
PCOMS	Interviewee responses to query about their questions about FIT as a concept or what they can say about FIT. Responses mention a specific model: Partners for Change Outcomes Management System (PCOMS).	8	12
Why FIT	Interviewee responses to query about their questions about FIT as a concept or what they can say about FIT. Responses feature description of why FIT is being used.	2	4
Model Choice	Interviewee responses to query about how FIT model that they use was chosen. Query posed to interviewees in Group C as well as interviewees from other groups who indicated current or past use in practice.	8	17
Agency Determined	Interviewee indicated agencies or programs determine FIT model choice	8	14

Name	Description	Files	References
	in response to query about how FIT model that they use was chosen. Query posed to interviewees in Group C as well as interviewees from other groups who indicated current or past use in practice.		
Supervisee Determined	Interviewee indicated supervisees determine FIT model choice in response to query about how FIT model that they use was chosen. Query posed to interviewees in Group C as well as interviewees from other groups who indicated current or past use in practice.	2	3
Supervisor Determined	Interviewee indicated supervisors determine FIT model choice in response to query about how FIT model that they use was chosen. Query posed to interviewees in Group C as well as interviewees from other groups who indicated current or past use in practice.	3	5
Motivation	Interviewee responses to query about motivation to learn more about or adopt	16	23

Name	Description	Files	References
	FIT. Split into two versions of item for Group A and Groups B and C.		
Client Benefit	Interviewee responses that indicated seeking client benefits to query about motivation to learn more about or adopt FIT. Split into two versions of item for Group A and Groups B and C.	6	6
Mandate	Interviewee responses that indicated that mandates were or would be motivation to learn more about or adopt FIT. Split into two versions of item for Group A and Groups B and C.	3	3
More knowledge about FIT	Interviewee responses that indicated that more information about FIT would be motivation to learn more about or adopt FIT. Split into two versions of item for Group A and Groups B and C.	2	2
Prior Experience	Interviewee responses that indicated that prior experience was or would be motivation to learn more about or adopt FIT. Split into two versions of item for Group A and Groups B and C.	1	1

Name	Description	Files	References
Recommendation	Interviewee responses that indicated that recommendations from colleagues or status as EBP were or would be motivation to learn more about or adopt FIT. Split into two versions of item for Group A and Groups B and C.	3	3
Reputation	Interviewee responses that indicated that strengthening reputation was or would be part of motivation to learn more about or adopt FIT. Split into two versions of item for Group A and Groups B and C.	1	1
Supervision Better	Interviewee responses that indicated seeking improvements to supervision to query about motivation to learn more about or adopt FIT. Split into two versions of item for Group A and Groups B and C.	8	11
Use for Data	Interviewee responses that indicated plans for using FIT data in some way to query about motivation to learn more about or adopt FIT. Split into two	9	13

Name	Description	Files	References
	versions of item for Group A and Groups B and C.		