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Training in the Use of Psychotherapy Outcome Assessment Measures at Psychology Internship Sites

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American Psychological Association accredited psychology internship training programs ($N = 407$) were surveyed concerning their attitudes, beliefs, and practices with regard to outcome assessment measures. Results indicated that 47% of surveyed sites use outcome measures for assessment, and 66% used these measures for diagnostic purposes. In addition, 79% of respondents supported using outcome assessment measures to evaluate client progress, 61% supported training interns in the use of outcome assessment measures, and 87% felt outcome assessment measures would increase in importance in the future. The discrepancy between support for outcome assessment measures and actual use is discussed and recommendations provided.

Keywords: psychology, training, internship, outcome measures, interns

Psychologists traditionally have answered questions about treatment outcome in clinical practice by routinely assessing their clients in an informal manner without the use of outcome measures. These clinicians have often used the clients themselves as the measure of satisfaction, believing that the clients' self-reported progress or termination of therapy was a sufficient measure of therapeutic outcome. However, self-report satisfaction measures have only a low-to-moderate correlation with other measures of outcome (Greenfield & Atkisson, 1989; Lambert, Salzer, & Bickman, 1998; Lunnen & Ogles, 1998; Pekarik & Wolff, 1996). Several studies have found that there is no correlation between satisfaction and outcome (Lambert, Okiishi, Finch, & Johnson, 1998; Lunnen & Ogles, 1998; Pekarik & Wolff, 1996); hence relying on the self-reported satisfaction from clients can have little or no accuracy in demonstrating efficacy of therapeutic procedures.

For psychotherapeutic interventions within a clinical setting to be effective, they must create noticeable change within clients, and this change must be quantifiably measurable across time. In addressing noticeable change and the measurability of therapeutic interventions, three questions need to be addressed: (a) Does the

intervention work under special, experimental conditions?, (b) Does it work in practice?, and (c) Is it working for this client? These questions refer to efficacy, effectiveness, and client response. The first two questions are treatment focused and look at the impact the intervention has across a group of clients. However, the third question is more client focused and seeks information about the characteristics of a particular case. Outcome measures in independent practice, training environments, and in nonresearch clinical settings seek to answer the latter question in regards to a particular case (Howard, Moras, Brill, Marinovich, & Lutz, 1996).

Standardization of Measurement

Outcome measures identify and frequently quantify specific thoughts, feeling, and behaviors of the client at the time of administration. When compared with other data, observations, or previous results from the outcome measure, changes in the client can be noted.

Standardized outcome assessment has been an integral part of psychotherapy research for several years (Ogles, Lambert, & Fields, 2002), and with the recent pressures for profitability and

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accountability by managed care organizations, there is a strong need for standardized outcome assessment measures to be used in clinical practice. Using outcome measures in a clinical setting can provide additional validation of a clinician's judgment and aid clinicians in providing better services for their clients (Hatfield & Ogles, 2004). According to Barlow, Hayes, and Nelson (1984) and Ogles, Lambert, and Masters (as cited in Ogles et al., 2002) there are several reasons for conducting outcome assessments: such as to improve treatment, to enhance clinical science, to provide accountability, and to maintain the ethical responsibility of practitioners to examine quality. In addition, maintaining a clear focus on outcomes may lower the risk of clinicians becoming targets of lawsuits or ethics charges, or of being called before their licensing boards (Clement, 1999).

Prior Data on the Use of Outcome Measures

Prior research in the use of outcome measures clearly indicates that providing feedback to therapists and clients about client change can be beneficial as a performance indicator for therapists (Lambert, Okiishi, et al., 1998; Okiishi et al., 2006) and as a marker for needed redirection in the course of treatment with specific clients (Duncan et al., 2003; Hawkins, Lambert, Vermeersch, Slade, & Tuttle, 2004; Lambert et al., 2001; Miller, Duncan, Brown, Sparks, & Claud, 2003).

Despite the benefits of using outcome measures in practice, it appears that few clinicians are consistently measuring therapeutic outcome on a routine basis and collecting aggregate data to improve their therapeutic practice. One of the first comprehensive studies on outcome assessment measure use was done by the American Psychological Association (APA) Committee for the Advancement of Professional Practice (CAPP). They surveyed psychologists about the effect of managed health care on their practices, and one specific area was outcome measure use (Phelps, Eisman, & Kohout, 1998). They found that 29% of their 15,918 respondents reported using some form of outcome measure in practice (e.g., Beck Depression Inventory [BDI], (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961); Symptom Checklist (Beck, Ward, Mendelson, Mock, & Erbaugh, 1990); Derogatis, 1983; Minnesota Multiphasic Personality Inventory [MMPI], Butcher, et al., 2001). Of these respondents 60% reported using a standardized published instrument, and 40% reported using unstandardized outcome measures. Phelps et al. further found that of their classification categories, psychologists working in a medical setting utilized the highest level of outcome measures (40%), followed by government-based practitioners (35%), academic psychologists (34%), and last independent practitioners (24%). Their data also showed that practitioners who recently had received their license were more likely to use outcome measures than practitioners licensed for a longer period of time.

Bickman et al. (2000) surveyed attitudes of child and adolescent clinicians about outcome assessment. Of the 539 respondents, 23% reported using outcome measures with their adolescent clients. Bickman and colleagues also looked at the type of information that child and adolescent clinicians' value. Information most desired in order of importance was history of maltreatment, past and present youth stressors, family functioning, quality of parent-youth relationship, and therapeutic alliance. They also found that 50% of practitioners were interested in participating in outcome research

and would like to receive outcome information about their clients at intake, during treatment, and after termination.

Hatfield and Ogles (2004) investigated the use of outcome measures by independent private practice clinicians, and looked at what measures were being used, why they were being used, and why some clinicians chose not to use outcome measures. They found that 37% of respondent clinicians used some form of outcome measure. The most common measures were the Beck Depression Inventory, Global Assessment Scale (Endicott, Spitzer, Fleiss, & Cohen, 1976), and Child Behavior Checklist (Achenbach, 1991). These measures are consistent with the meta-analysis conducted by Froyd, Lambert, and Froyd (1996) who found that 1,430 outcome measures were being used across 334 studies. Hatfield and Ogles found that approximately 150 different outcome measures were being used by the clinicians they surveyed. They also found that clinicians choose to use outcome measures for the following reasons: (a) to track client progress, (b) to determine if there is a need to alter treatment, (c) as a matter of ethical practice, (d) to determine the strengths and weaknesses of their clients, and (e) because they were required by their HMO/insurance company. Reasons given for not using outcome measures were (a) it adds too much paperwork, (b) takes too much time, (c) is an extra burden on clients, (d) felt it was not helpful, or (e) did not have the resources. The research of Hatfield and Ogles combined with Phelps et al. (1998), suggests that private insurance and managed care companies are increasingly requiring practitioners to administer outcome assessment measures and make decisions about optimally effective and efficient services.

The rising cost of health care has placed an increasing burden on clinicians. Clinicians frequently find themselves needing to justify their treatments and formally evaluate and report client progress to insurance providers (Lambert & Hawkins, 2004). This trend has been seen throughout the field. When Phelps et al. (1998) surveyed practicing members of the APA regarding the influence of managed care on their work setting, professional activities, income and attitudes; they found that 79% of their 15,918 respondents were negatively affected by changing managed care practices. Respondents in their independent practitioner category reported the greatest proportion of negative impact on their work setting, their income, and the availability of new clients, as well as an increase in ethical dilemmas created from changing managed care practices. Clement (1999) claimed that the effective use of outcome measures in independent practice can lead to increased income, fewer ethical dilemmas, better organization of one's practice, and possible diminished chances of litigation.

Developing Quality Outcome Researchers

It is likely that outcome assessment of clients will continue to be required by an increasing number of insurance companies, federal agencies, and managed care organizations. There is also a need to track client progress, provide accountability, and maintain high ethical standards within the field. Thus, there is an immediate need for training in outcome assessment measurement that is fully integrated at the graduate and internship level as a prelude to implementation in practice. The present training model of developing competent clinicians, who may or may not utilize outcome measures, may be lacking on several levels. Currently, clinical psychology graduate programs provide training in intellectual and

personality assessment but rarely cover methods and measures suitable for outcome assessment (Lambert & Hawkins, 2004). In addition, no governing body has established specific guidelines for the use and implementation of outcome measures in therapeutic practice, yet the *APA Report to the 2005 Presidential Task Force on Evidence-Based Practice* stated: "Developing and maintaining clinical expertise, and applying this expertise to specific patients, entail continually incorporating new knowledge and skills derived from . . . d) monitoring of patient outcomes" (Goodheart et al., 2006, p. 277). In addition, the APA Commission on Accreditation, which established the *Guidelines and Principles for Accreditation of Programs in Professional Psychology*, stipulated that internship site supervisors "are responsible for reviewing with the interns the relevant scientific and empirical bases for the professional services delivered by interns" (APA, 2008, p. 22), yet there are no set standards by which client progress should be measured for the work of interns. It is clear that the development of outcome assessment skills must be introduced at the graduate level, facilitated and practiced at the internship level, and then matured during professional practice. Questions about outcome measure implementation started in the last decade must now be turned to the precursor of clinical practice, that is, training at the doctoral internship level.

Purpose of Research

The purpose of this research was to identify and evaluate the training and use of psychotherapy outcome measures during the psychology internship year by evaluating the type, frequency, and reasons for and against the use of outcome measures. The results further our understanding of the attitudes, practices, and implementation of outcome measures at internship sites. Global questions addressed by this research were: (a) Are internship sites advocating, using, and teaching outcome measurement assessment? (b) What is the frequency of outcome measure use at internship sites? (c) What types of outcome measures are used at internship sites? (d) What types of internship sites use outcome measures? (e) What is the nature of the training that interns receive in outcome assessment measures? (f) What are the attitudes toward training in outcome assessment measures held by internship training directors? The research addressed these questions by surveying training directors at APA accredited, Association of Psychology Postdoctoral and Internship Centers (APPIC) member sites where most psychologists receive their internship training.

Method

Participants

The population was training directors of the 443 APA-accredited, APPIC-member internship programs listed in the 2006 APPIC Directory. Of the 443 sites, 36 requested not to be solicited, thus 407 surveys were mailed to internship directors at APA-accredited, APPIC-member sites in the United States and Canada, with 4 surveys returned as undeliverable. Two hundred forty-four completed surveys were returned, for a 60% response rate. The respondents were comprised of 128 women (53%) and 108 men (44%), with 8 undesignated surveys (3%). Respondents' primary ethnicity was White (87%), followed by African American (4%),

Asian (3%), Hispanic (3%), while Pacific Island, Native American, and other comprised 3%. Their professional degrees were mainly PhD (82%), followed by PsyD (16%), and EdD (2%). The predominant age group of respondents was 46 to 55 (40%), followed by 36 to 45 (27%), 56 to 65 (23%), 25 to 35 (8%), and over 66 years (2%).

Measure

A 40-question survey was developed by the authors, based on prior research in the area of outcome measures in clinical practice (Hatfield & Ogles, 2004; Phelps et al., 1998). The measure was designed to capture the attitudes of training directors toward the use of outcome assessment measures, the characteristics of their institutions, and the practices of interns with regard to outcome assessment measure use. The survey was comprised of three sections. The first section (demographics) requested demographic information to compare site categories and users versus nonusers of outcome measures. Within the demographic section it was clearly stated "For the purposes of this survey, *outcome measure assessment* is defined as: Routinely collecting data through individualized outcome measures or in relationship to a specified treatment plan, in order to monitor client progress." The second section (Section A) of the survey was filled out by internship training directors whose sites routinely used outcome assessment measures. This section requested information such as why the internship site used outcome measures, which measures they used, what the director's attitude was toward outcome measures, and how the site facilitated training in the use of outcome measures. The third section (Section B) of the survey was completed by internship training directors whose sites did not routinely use outcome measures in clinical practice. This section consisted of questions such as, why the site did not routinely use outcome measures, what would facilitate the site using outcome measures in the future, and what was the director's attitude toward outcome measures? Questions in Sections A and B were either asked in a format requesting the respondent to "check all that apply" (supplied answers) or given in one of two anchored 1- to 5-Likert scales (*strongly disagree to strongly agree or not important to very important*).

Question and answer responses previously investigated by Hatfield and Ogles (2004) and Phelps et al. (1998) with regard to theoretical orientation (of the internship site), type of outcome measures used by clinicians, who completed the outcome measure, the reason the clinician used the outcome measure or did not use outcome measures, and the type of institutional/work setting in which the clinician worked, were added to the survey to compare the training interns receive versus their use of outcome measures after licensure and in a professional setting. Through this comparison, the influence and impact of training in outcome measures at internship training centers would be gauged and conclusions drawn.

Procedure

In March 2006, directors of APA accredited, APPIC member internship programs were mailed a survey packet including the questionnaire, cover letter, and a \$4 Starbucks gift card. The survey process followed the general survey and mailing format of

Dillman (2000), to assure a high participant response. A second mailing of the questionnaire and cover letter to nonresponsive programs occurred approximately 3 weeks after the first mailing.

Results

The results reflect the training directors' perceptions of their interns and the training practices at their internship sites. Internship training sites were classified according to the APPIC classification system, and the return is reflective of the APA accredited membership. Respondents classified their internship site as a university counseling center (18%), community mental health clinic (15%), Department of Veterans Affairs (13%), state mental hospital (10%), and medical school (8%). With regards to therapeutic theoretical orientation, training directors listed their site's primary orientation as cognitive (31%), eclectic (30%), and psychodynamic/psychoanalytic (12%), and the site's secondary orientation as cognitive (28%), behavioral (21%), and psychodynamic/psychoanalytic (15%).

Outcome assessment measures can be differentiated from diagnostic measures by their frequency of use with a particular client. Diagnostic measures are often used only once, whereas outcome assessment measures are used more frequently with an individual client. Although this is a simplistic view of outcome measures, in practice this distinction may be less clear. Ultimately, individual clinicians are differentiating between what they consider an outcome assessment measure and a diagnostic measure.

Within the demographic section of the survey, respondents were asked "Is it a standard of practice at your site to routinely use measures such as the Beck Depression Inventory, Global Assessment Scale, Child Behavior Checklist, or the Outcome Questionnaire-45 [OQ-45] (Lambert et al., 1996) with therapy clients as an outcome assessment measure" and in a similarly worded question "as a diagnostic measure?" Forty-seven percent of respondents indicated their site routinely used measures for outcome assessment purposes, and 66% indicated their site routinely used measures for diagnostic purposes. Respondents who answered "yes" that their site routinely used outcome measures for assessment purposes were requested to continue with only Section A of the survey (47%), those who answered no that their site did not routinely use outcome measures for assessment purposes were requested to continue with only Section B of the survey (53%). In exploring whether internship site classification or theoretical orientation differentiated the sites who used outcome measures (Section A responders) from those who did not (Section B responders) there were no significant differences based on site classification, $\chi^2(14, n = 235) = 17.59, p = .23$; or theoretical orientation, $\chi^2(14, n = 233) = 12.41, p = .57$; and the use of outcome assessment measures.

Results From Section A Responders

Section A responders were asked what standardized outcome measures the site used. Among the most prevalent were the Beck Depression Inventory, Child Behavior Check List, Beck Anxiety Inventory (Beck & Steer, 1990), Global Assessment Scale, and Structured Clinical Interview (First, Spitzer, Gibbon, & Williams, 1996). Within the same question respondents were asked what individualized/unstandardized measures the site used, they most

frequently indicated progress against treatment goals as outlined in the client's treatment plan, individualized target behaviors, and target complaints (see Table 1). There were 72 "other measures" listed (other than the fixed choices listed under standardized or individualized/unstandardized), with the greatest frequency being the Behavior Assessment Scale for Children [BASC]/Behavior Assessment Scale for Children, Second Edition [BASC-II] (Reynolds & Kamphaus, 1992, 2004) (13%), followed by the Ohio Scales (Ogles, Melendez, Davis & Lunnen, 2000) (6%), with most other measures being reported only once.

When respondents were asked to rank who completes the outcome measures, their primary choices were clients (46%), therapists (29%), and parents (14%). Fifty-eight percent of respondents indicated that outcome assessment measures were used with each client seen, followed by, as needed (33%), other (8%), and when requested by client or insurance company (less than 2%). The frequency with which internship sites used outcome assessment measures was: periodically throughout treatment (61%), the first and last session (9%), each session (5%), the first session only (2%), and other (9%). More than one answer was indicated by 14% of the respondents. The meaning of the fixed choice "periodically throughout treatment" was left to the interpretation of the respondents. The most frequently indicated reasons for using outcome assessment measures were to track client progress, determine if there is a need to alter treatment, and as a program evaluation (see Table 2).

Several questions addressed the type and quantity of training interns received in outcome assessment measures. The training directors indicated that interns received the most training in "The

Table 1
Standardized and Unstandardized Outcome Assessment Measures Used by Sites

	% of respondents chose	N
Standardized measures		
Beck Depression Inventory	71.8	79
Child Behavior Check List	49.0	54
Beck Anxiety Inventory	45.4	50
Global Assessment Scale	30.0	33
Structured Clinical Interview	26.3	29
Brief Symptom Inventory	22.7	25
Symptom Check List-90	20.9	23
Outcome Questionnaire-45	18.1	20
Children's Global Assessment Scale	15.4	17
SF-36 Health Survey	6.3	7
Basis-32	5.4	6
No standard measure	3.6	4
Individualized/unstandardized measures		
Progress against treatment goals as outlined in the patient's treatment plan	65.4	72
Individualized target behaviors	60.9	67
Target complaints	45.4	50
Other measures used ^a	39.0	43
Symptom check list	32.7	36
Goal attainment scaling	22.7	25

Note. The measures were used for assessment use only, no diagnostic use.
^a Seventy-two "other measures" were listed, with the Behavior Assessment Scale for Children/Behavior Assessment Scale for Children, Second Edition (13%), followed by the Ohio Scales (6%), and most other measures being reported only once.

Table 2
Reasons for the Use of Outcome Assessment Measures

Reason indicated	%	N
Track client progress	96.6	114
Determine if there is a need to alter treatment	65.2	77
Program evaluation	60.1	71
Determine strengths and weaknesses of client	35.6	42
Ethical practice	35.6	42
Research publication	27.9	33
Required by site	27.1	32
Evaluation of the intern's performance	23.7	28
Evaluation of the therapist's performance	21.1	25
Required by MCO/insurance	7.6	9
Business marketing	2.5	3
Other	1.7	2

Note. MCO = Managed Care Organization.

use of outcome measures to evaluate client improvement," followed by "the types of outcome measures available to psychologist," and the "validity and reliability of outcome measures." Training directors also indicated that interns spent approximately 2½ hr per week ($M = 2.53$, $SD = 2.96$, $Mdn = 2.0$, $Min = 0$, $Max = 15$) evaluating clients through the use of outcome measure assessments. Ninety percent of respondents stated that these evaluations were reviewed by a supervisor, and 63% reported that the information was stored in a database.

Results From Section B Responders

Respondents who answered "no" to the question regarding the use of outcome assessment measures continued with Section B of the survey. These respondents replied that the reason their site chose not to use measures for outcome assessment was that they did not have the resources (e.g., money or personnel; 44%), it adds too much paperwork (36%), or it takes too much time (31%), extra burden to clients (23%), feel it is not helpful (19%), and a simple measure distorts the effect of treatment (17%). An other reason was given 42% of the time; with the main other reasons being handwritten by the respondents as "use other measures than ones listed" (18%), "In the process of implementing some form of outcome assessment" (10%), and "Don't have the resources" (10%). When queried about what would facilitate the use of outcome measures at their site, respondents indicated more time, increased funds, and increased resources (see Table 3).

Results From All Responders

Several questions on the survey were designed to capture the attitudes of all training directors, regardless of their routine use of outcome assessment measures. All training directors were asked questions such as, "to what degree do you agree or disagree with the following statement?" Fifty-three percent of training directors whose site used outcome measures, agreed or strongly agreed that it is important to use outcome assessment measures in evaluating a therapist's performance. Coincidentally, 53% of respondents whose program did not use outcome measures for assessment purposes agreed or strongly agreed that it is important to use them in evaluating a therapist's performance. With regard to evaluating a client's progress, 79% of internship training directors (91% of

those whose site used outcome assessment measures and 68% of those whose site did not report using outcome assessment measures) agreed or strongly agreed that it is important for internship sites to use outcome assessment measures in evaluating a client's progress. Also, 84% of internship training directors (87% of those whose site used outcome measures for assessment purposes and 81% of those whose site did not) agreed or strongly agreed that the use of outcome measures for assessment purposes will be increasingly important in the future.

Overall, 61% of all internship training directors agreed or strongly agreed that interns should be trained in outcome assessment measures. As one might expect, 91% of training directors whose sites used outcome measures for assessment purposes agreed or strongly agreed with the statement that it is important that interns be trained in the use of outcome measures as an assessment tool; however, 33% of directors whose site did not use outcome measures for assessment purposes, agreed or strongly agreed with this statement, while 30% were neutral and 37% disagreed or strongly disagreed. Eighty-eight percent of internship training directors, whose site did not use outcome measures for assessment purposes, believed that outcome measures as a diagnostic tool were important or very important.

Discussion

This research suggests that science is informing and influencing training in the majority of internship sites, either through assessment measure used for diagnostic purposes (66%) or as a measure of treatment progress (47%). Although approximately half of APA accredited APPIC internship sites use outcome measures to inform their decisions, treatments, and clinical practices, is this sufficient? Should there be a greater emphasis on teaching outcome measure assessment at predoctoral internship sites? There is a strong show of support for outcome assessment measures through attitudes and beliefs among internship directors and a moderate amount of support shown through implementation of training in this area; however, the relationship between attitudes, training practices, and outcome measure use in clinical practice needs review.

The current research on internships was specifically designed for comparison with prior research on outcome measures in the field (Hatfield & Ogles, 2004; Phelps et al., 1998). When the current data is compared to these findings, patterns of results emerge. Among the studies, there are strong similarities with regard to the theoretical

Table 3
Facilitators Toward Outcome Assessment Use in the Future

Facilitators	%	N
More time	48.7	51
Increased funds	42.7	45
Increased resources	42.7	45
Proof that the measure was empirically valid	36.7	35
Additional training in outcome measures	29.9	34
Computerized scoring	26.4	26
Other answers ^a	20.5	24
More available client centered measures	17.0	18

^a Twenty-four responses were listed in the other category: commitment/decision to implement (17%), motivation (13%), all other responses were listed less than twice.

orientation of respondents, the outcome measures used by respondents, who completes those outcome measures, and the reasons clinicians use or do not use outcome assessment measures. The most obvious discrepancy is between the percentage of interns who are trained in outcome assessment measures during internship and those that utilize outcome assessment measures in practice. Forty-seven percent of APA accredited, APPIC member internship sites reported the use of outcome assessment measures, yet Hatfield and Ogles reported 37% of clinicians using outcome assessment measures, and Phelps et al. reported only 29% of respondents using outcome measures. There may be several reasons for this discrepancy, including an increase in barriers to use after licensure (limited resources, increased paperwork and administrative time, and burdensome for the client), the perception of limited monetary benefit for the extra time and effort needed for outcome assessment measures, a reluctance to acknowledge the potential lack of therapeutic improvement, or a lack of training and familiarity with outcome assessment measures.

With less than half of APA accredited, APPIC member internship sites using outcome assessment measures, barriers to use at internships may be similar to the barriers encountered by clinicians in practice; however, it might also reflect the lack of a consensual norm or expectation from within the internship community. With managed care and the APA continuing to emphasize empirically validated treatments models, training directors may be at the point of understanding the need for outcome measure assessment, but have not reached consensus on implementation. In addition, most training directors may not know the level of support for outcome assessment measures across APA accredited internship programs, and thus, directors may not realize that outcome assessment measures are becoming the standard of practice within the psychology training community.

Another factor that may have an influence on the use of outcome measures is the way in which the data is potentially utilized. Monitoring of outcomes is the use of outcome assessment data during treatment to track the progress of clients; however, managing outcomes involves using outcome data to modify treatment. Managing outcomes extends the use of the data and potentially includes a third party who is not involved in direct treatment (Ogles et al., 2002). As such, the data can be used to track therapists' performance and "success" rates. This creates a dilemma when considering the use of outcome assessment measures. Are they to be used for internal purposes (self-evaluation and client improvement) only or should they also be used for external evaluative purposes by administrators looking at job performance, and third-party payors looking at cost-benefit ratios? Having outcome measure assessment utilized for external evaluative purposes would make many psychologists uncomfortable, yet in response to the general statement, "I think it is important for internship sites to use outcome measure assessment in evaluating therapist performance" over half of the respondents (53%) agreed or strongly agreed. This statement does not address internal versus external use, but does suggest that many training directors see evaluating therapist performance as important.

Implications for Training Interns

Emphasis within the profession toward evidence-based practices and a requirement by insurance companies for demonstrated out-

comes necessitates competence and continued training in these areas by psychologists. There is also clear support within APA accredited, APPIC member internship programs for demonstrated outcomes; however, if training and the use of outcome assessment measures are to increase, several steps are required. Specifically, these steps include the creation of training expectations for the use of outcome assessment measures by the Commission on Accreditation, either specialty specific or profession wide guidelines for the training of interns in outcome assessment measures, and an effort at reducing the perceived barriers to outcome assessment use at internship training facilities (e.g., money, personnel, additional paperwork, time).

As the primary source of guidelines for internship training, the Commission on Accreditation could develop guidelines for internship programs to incorporate training in the administration and use of standard outcome assessment practices for diagnostic and treatment progress purposes. Exposure to the use of outcome assessment during the internship year may generalize to clinical practice as the interns see the utility of monitoring outcome.

It would be helpful for psychology trainees to incorporate these measures in daily practice to become proficient in their use. Sixty-one percent of training directors whose programs use outcome assessment measures stated they do so periodically throughout treatment. For the regular use of outcome measures to be practical at internship sites there must be investment, structure, and support. Internship programs need to commit to their students becoming proficient and productive in the field of psychology, contributing to the welfare of their clients, and ultimately benefiting society as a whole. An investment in financial resources toward training interns (e.g., purchase of outcome assessment measures, computer systems to score measures, track progress, store data as well as administrative support) is part of the commitment a program should make toward their intern's future as a psychologist.

The structure and nature of a training program should also take into account outcome assessment measures. Training in outcome assessment measures can be facilitated through didactic presentations, seminars, literature review, and direct modeling. The most important component of training interns is quality supervision, and the support of outcome assessment measure use should start with the intern's immediate supervisor. Supervisor knowledge, attitude, and modeling will have a direct influence on the intern's use of outcome measures. Therefore it is important that supervisors know what type of assessment measures are being prominently used in the field and under what circumstances, how to administer and score the assessment measures, and have the ability to advise interns on appropriate assessment measure selection. Most important, supervisors should be able to convey how outcome assessment data can be integrated into feedback with clients and how it ultimately influences therapeutic practice, through making direct and indirect changes by the therapist or client.

The finding that 63% of the users of outcome assessment measures store their results within a database is promising. These individual and aggregate results may be used for assessing client change, determining therapeutic efficacy, profiling individual therapists, establishing decision algorithms to empirically determine appropriate session limits (e.g., expectancy tables), or used in future research (Lambert, Gregersen, & Burlingame, 2004). Ultimately, the collection and storage of outcome data helps facilitate

the dissemination of relevant information about client progress to clinicians, the clients themselves, and administrators.

Successful monitoring and management of outcome data, which internship sites may find helpful, is now available within the research literature (Asay, Lambert, Gregerson, & Goates, 2002; Hawkins et al., 2004; Lambert, Okiishi, et al., 1998; Okiishi, Ogles, & Lambert, as cited in Ogles et al., 2002). These studies combined with many others provide examples for the development of systematic assessment of client progress, feedback tools for clinicians, and examples of ways aggregate data can improve treatment and reduce costs.

This study has several limitations. A potential weakness is questions on the survey that asked respondents about their sites (“does your site . . .”). It is unclear if respondent’s answers were referencing all staff members, licensed psychologists, or just interns. Because the survey questioned only training directors, the reliability and validity of answers with regard to the “site” is unknown, and questions concerning specific intern activities may have been better answered by the interns themselves (training received and hours spent evaluating clients). Great care was taken to clarify and simplify survey questions; however, some respondents answered, “no” to the question concerning outcome assessment measure use at their site, and yet wrote “use other measures than ones listed” as a reason for not using measures. This indicates that they under reported their use of outcome measures. Had these respondents correctly indicated their use of those measures on the survey, outcome measure use would have been acknowledged by 51% of respondents. Finally, an overarching limitation on all broad studies of outcome measure use is a concrete definition of what encompasses an outcome measure. Although Newman, Ciarlo, and Carpenter (1999) outlined 11 criteria for judging outcome measures based on the National Institute of Mental Health (NIMH) guidelines, the field has allowed individual clinicians to decide the type and appropriateness of measures they use. Because this research was based on prior research that included diagnostic measures (e.g., MMPI-II), diagnostic/treatment progress measures (e.g., BDI-II), and purely outcome measures (e.g., Outcome Questionnaire-45 and SF-36 Health Survey, Ware, Snow, Kosinski, & Grandek, 2000) in their outcome measure classification systems, a clear indication of which measures clinicians are using to solely assess treatment progress is difficult to determine. Many of the measures reported in this research were either idiosyncratic to the particular institution or the population being treated, and their adherence to NIHM guidelines are unknown.

Some of the most compelling data from our survey is in the area of attitudes and beliefs of APA internship site directors. Continued research into the attitudes and beliefs of internship directors with regards to outcome assessment measures as well as the attitudes and beliefs of licensed clinical psychologists would be beneficial to the field. Because this research focused more on the perception of training and use of outcome assessment measures by interns, than their actual use of these measures, future research is recommended to explore intern attitudes, training, and use of outcome assessment measures. It would also be beneficial to the field if similar research was conducted on the training, attitudes, and beliefs, as well as actual usage of outcome assessment measures by graduate students in psychology, resident psychologists, and interns at APPIC member programs that are not APA accredited sites.

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