The state of the supervision literature pales in comparison to the psychotherapy evidence base (Reiser & Milne, 2012), despite reviews of research on the effectiveness of supervision dating back to the mid-1970s (e.g., Hansen, Pound, & Petro, 1976). Four decades later, research has confirmed the general importance of supervision. Specifically, didactic training, when combined with ongoing supervision or consultation, has been demonstrated as an effective strategy for mental health clinician training (e.g., Sholomskas et al., 2005) and for encouraging sustained fidelity to evidence-based practices (EBPs; Wittey Stirman et al., 2012). Said differently, recent literature demonstrates that didactics alone are not sufficient to bring about clinician behavior change (Jensen-Doss, Cusack, & de Arellano, 2008), but that supervision or consultation is necessary to promote EBP adoption, implementation, and sustainment (e.g., Sholomskas et al., 2005). However, despite general support for supervision as a vehicle for enhancing care delivery, the necessary structure, methods, and content of evidence-based supervision remain quite elusive.

Milne (2008) defines supervision as “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 colleagues” (p. 15). His elaborate definition is precise, specific, carefully operationalized, and differentiates supervision from related activities, thereby allowing for rigorous outcome evaluation. Even so, Reiser and Milne (2012) highlight that the extant literature lacks methodological rigor, as only narrative accounts of outcomes are available, making findings nearly impossible to replicate. Before we can explore ways to maximize supervision effectiveness, standardized evaluation of key outcomes is necessary.

Unfortunately, objective assessment of supervision outcomes is rarely applied systematically. The limited application of supervi-
Supervision outcome assessment highlights a gap in the literature that has thus far prevented the identification of supervision elements that optimize EBP effectiveness and client outcomes. How can systematic assessment of supervision outcomes be accomplished in practice? Two steps are necessary to bridge this gap: (a) identify clinician and client-level domains that are considered key supervision outcomes, and (b) establish reliable and valid measures and procedures to assess these domains. Without completion of these two steps, establishing evidence-based supervision will remain an impossible goal. Furthermore, these two steps alone might serve to enhance supervision practices and improve clinical care. For example, Reese et al. (2009) found that clients who were assigned to trainee therapists with supervisors receiving data on client outcomes (i.e., feedback) improved more than clients of trainees whose supervisors did not receive outcome data. Moreover, trainees in the client feedback condition appeared to more accurately assess their own skills by the end of training. Therefore, supervision outcome assessment has the potential to make improving mental health care a more reachable goal.

**Aims and Objectives**

This article aims to prime the field to evaluate supervision by presenting an example of a doctoral clinical training program that engages in systematic evidence-based assessment of supervision effectiveness. This article begins with a brief review of the literature related to the identified steps (i.e., the identification of relevant supervision outcome domains and associated measures), and highlights measures and procedures to assess clinician- and client-level outcomes. Following the model established by Falender and Shafranske (2004)—which delineates supervisor-level outcomes—supervisee-level outcomes of knowledge gain, skill development, and changes in attitudes and values are explored. Our model builds upon Falender and Shafranske’s (2004) work by including general clinician competencies (i.e., self-efficacy, interpersonal effectiveness) that have an established evidence base, as well as by highlighting the role of the supervisory relationship (see Figure 1). This article extends two recent reviews (Muse & McManus, 2013; Simons et al., 2013) that focused on cognitive-behavioral therapy (CBT) implementation outcomes by including important supervision outcome domains (e.g., clinician attitudes and the supervisory relationship). Finally, given evidence in support of the influence of supervision on client care (Reese et al., 2009), a brief, low-cost client assessment battery for evaluating symptom change, life satisfaction, putative mechanisms of change, and the therapeutic relationship is presented. Details of the established research infrastructure in our training clinic serve to model evidence-based assessment procedures that may be employed to systematically evaluate supervision outcomes.

**Measures and Procedures for Assessing Key Domains of Supervision Outcomes**

**Knowledge Systems**

To achieve competent EBP implementation, one of the primary functions of supervision may be to improve clinician EBP knowledge. Jensen-Doss et al. (2008) suggested that knowledge change alone is not sufficient to change practice, but that it might be a necessary precondition for clinician behavior change. Bennett-Levy, McManus, Westling, and Fennell (2009) delineated knowledge gain as it occurs across three systems: declarative, procedural, and reflective. The declarative knowledge system refers to knowledge of facts about CBT. The procedural knowledge system involves the development and application of CBT skills. The reflective knowledge system represents ongoing refinement of both declarative and procedural knowledge. Reflective knowledge enables clinicians to reflect on, adapt, problem solve, and implement CBT techniques when idiosyncratic issues arise in the treatment process (Bennett-Levy et al., 2009). Each of these systems serves as a precondition for the next, as declarative knowledge must be acquired before techniques can be applied procedurally (McCall, Arnold, & Sutton, 2008), and both declarative and procedural knowledge must exist before they can be further refined through clinician reflective skills (Bennett-Levy et al., 2009).

As an example, a clinician has demonstrated declarative knowledge if she identifies agenda setting as a core CBT treatment component and can cite the typical elements of agenda setting (e.g., mood check, bridge sessions, prioritize agenda, review
homework, discuss problem, introduce skill, create new homework assignment, summary and feedback; Beck & Beck, 2011). Procedural knowledge is present if this clinician can skillfully implement all of these elements in a session. However, reflective knowledge is deemed present only if the clinician can collaboratively set and follow an agenda with a client who appears resistant to structure, for example.

Declarative Knowledge

There are surprisingly few examples of validated measures for assessing CBT declarative knowledge. In their comprehensive review, Simons et al. (2013) found only one CBT questionnaire for assessing declarative knowledge. Specifically, Myles and Milne (2004) developed the Cognitive Behavioral Therapy Knowledge Questionnaire (CBT-KQ), a 26-item multiple-choice test evaluating (a) general CBT issues, (b) theoretical underpinnings of behavioral approaches, (c) theoretical underpinnings in cognitive approaches, (d) practice of behavioral psychotherapy, and (e) practice of cognitive therapy.

In addition to the CBT-KQ, the Knowledge of Evidence-Based Services Questionnaire (KEBS-Q; Stumpf, Higa-McMillan, & Chorpita, 2008) assesses clinician declarative knowledge about evidence-based child psychotherapy treatment across four problem areas: anxious/avoidant, depressed/widrawn, disruptive behavior, and attention/hyperactivity. The KEBS-Q is a 40-item questionnaire that uses a multiple true–false response format requiring clinicians to indicate how appropriate each item is as a practice element for treating the target problem areas.

Despite few validated measures of clinician EBP knowledge, researchers have prioritized the assessment of knowledge as a feasible way to demonstrate the effects of training (e.g., Bennett-Levy et al., 2009) and supervision (e.g., Falender et al., 2004). Because declarative knowledge is viewed as a precursor to skill development, it might be important for trainers and researchers to develop and use declarative knowledge tests to (a) assess the impact of training on clinician knowledge to tailor supervision to the needs of each clinician, and (b) contribute to the scientific basis of effective supervision. Evaluation of knowledge may be especially important, given that lack of knowledge may serve as a barrier to EBP implementation (Stumpf et al., 2008). However, just as development of knowledge is not sufficient for clinician behavior change, clinician declarative knowledge assessment is not sufficient for understanding the impact of supervision.

Skill as a Function of Procedural and Reflective Knowledge

Relevant research provides numerous terms to capture clinician “skill.” Simons et al. (2013) relate procedural knowledge to fidelity, which is demonstrated by EBP practice that is adherent (i.e., clinician practice includes the prescribed unique EBP elements), differentiated (i.e., clinician practice does not include proscribed EBP elements), and competent (i.e., skillful clinician delivery of the EBP; e.g., Perepletchikova, Treat, & Kazdin, 2007; Waltz, Addis, Koerner, & Jacobson, 1993). The gold-standard approach to assessing clinician skill (i.e., procedural and reflective knowledge; fidelity: adherence, differentiation, competence) is the coding of video-recorded therapy sessions by objective raters (Waltz et al., 1993). This procedure is considered the gold standard because it is believed that clinicians may not accurately self-report on their skill in delivering EBPs (Perepletchikova et al., 2007). Indeed, objective ratings of clinician behavior have consistently been found to diverge from clinician (Davis et al., 2006), client (Kuyken & Tsivrikos, 2009), and supervisor (Reiser & Milne, 2012) ratings. As such, the procedure of using evidence-based rating systems to objectively code therapy sessions will remain the gold standard, at least until the discrepancy between raters is better understood.

Simons et al. (2013) identified several measures that assess clinician fidelity broadly. However, it should be noted that a combination of measures and procedures are likely necessary to carefully assess these three components of fidelity. The most widely used CBT adherence and differentiation measure (though not capturing competence), the Collaborative Study Psychotherapy Rating Scale (CSPRS; Hollon et al., 1988), was generated for the early CBT randomized clinical trials (RCTs), notably the Treatment of Depression Collaborative Research Program (Elkin et al., 1989). In the context of the RCT by Elkin and colleagues (1989), the CSPRS enabled objective raters to confidently conclude that CBT was delivered adherently and that it could be differentiated from interpersonal therapy (IPT) and medication management conditions. The CSPRS has 96 items reflecting each treatment modality (i.e., CBT, IPT, and medication management), with items rated from 1 = not at all (behavior not present) to 7 = extensively (behavior present to a great extent). A recent exploratory factor analysis indicated that a subset of items load onto three CBT factors (Strunk, Cooper, Ryan, DeRubeis, & Hollon, 2012): Behavioral Methods/Homework, Cognitive Methods, and Negotiating/Structuring. One of the benefits of the CSPRS is that the structure allows for reliable administration by undergraduate research assistants (e.g., Strunk et al., 2012), making it an ideal measure for reducing some of the burden commonly associated with objective rating procedures.

The Therapy Process Observational Coding System for Child Psychotherapy Strategies-Scale (TPOCS-S; McLeod, 2001; McLeod & Weisz, 2010) is a 31-item adherence and differentiation rating scale used by objective coders to rate child psychotherapy sessions that is based on a previously established self-report, the Therapy Procedures Checklist (Weersing, Weiss, & Donenberg, 2002). The TPOCS-S includes items relevant to cognitive, behavioral, psychodynamic, family, and child-centered therapies. Clinician behaviors are rated for extendensiveness of application using a 7-point Likert scale (ranging from not at all to extensively).

Measures of CBT competency were similarly developed for use in RCTs as a way to identify when clinicians required immediate supervision to prevent fidelity lapses. It follows that assessment of competency may play a valuable role in enhancing supervision outcomes. Indeed, leading CBT trainers recommend measuring competency at multiple times throughout the training and supervision process (Sudak, Beck, & Wright, 2003). The most widely used CBT competency measure is the Cognitive Therapy Rating Scale (CTS; Young & Beck, 1980), which assesses clinician competence regarding general therapy skills (e.g., understanding, interpersonal effectivesness), CBT-specific skills (e.g., focus on key cognitions and behavior, strategy for change), and structure elements (e.g., agenda, pacing, and use of homework assignments). The CTS is an 11-item measure with each item scored on
Attitudes and Values

In addition to the importance of knowledge and skill, clinician attitudes and values regarding clinical work are considered a core competency domain. Drawing upon Falender et al.’s (2004) competency definitions aimed at the supervisor level, it seems that many of the same attitude and value subthemes they identify are relevant at the supervisee level, notably (a) responsibility for sensitivity to diversity in all its forms, (b) committing to lifelong learning and professional growth, (c) valuing ethical principles, (d) committing to knowing and utilizing available psychological science related to therapy, and (e) committing to knowing one’s own limitations as a clinician. The role of supervision in the development of these general attitudinal and value-based competencies should not be overlooked. However, specific attitudes and values pertaining to clinician training in EBPs like CBT are of noteworthy importance.

Clinician attitudes about EBPs have been identified as a barrier to implementation in community settings (e.g., Lewis & Simons, 2011), which suggests this domain may be an important target for supervision. Simons et al. (2013) describe commonly endorsed urban myths about CBT, for instance, that it is too rigid, does not honor the therapeutic relationship, and does not focus on the role of emotions. For many clinicians, CBT does not appear to align with their core attitudes and values. Fortunately, literature suggests that these myths can be dispelled and attitudes improved through training and supervision (Borntrager, Chorpita, Higa-McMillan, & Weisz, 2009).

There are several measures that can be administered to enable attitude comparisons across groups of clinicians. For instance, the Evidence Based Practice Attitude Scale (EBPAS; Aarons, 2004) assesses clinician opinions and attitudes regarding EBP adoption. The EBPAS is a 15-item self-report that assesses: (a) appeal of EBPs, (b) requirements of EBP use, (c) openness toward innovation, and (d) perceived divergence from usual practice. The clinician rates each item using a 5-point Likert scale ranging from not at all to a very great extent. Given the role of clinician attitudes in the success (or failure) of EBP implementation, and because attitudes and values reflect a core domain of supervisor and clinician competence (Falender et al., 2004), it will be important for researchers and trainers to incorporate systematic assessment of this domain into supervision using validated measures such as the EBPAS.

Relationship

Researchers suggest that the supervisory relationship may serve as a vehicle (a moderator or mediator) for bringing about change in clinician knowledge, skills, and attitudes in a process that parallels the therapeutic relationship between clinician and client (e.g., Kazdin, 2007). A strong supervisory relationship might be a necessary, but not sufficient, element for maximizing supervision outcomes. In Roth and Pilling’s (2008) supervision competence framework, the “ability to form and maintain a supervisory alliance” is listed as one of the main “generic competences.” From their literature review, they conclude that the alliance may impact supervision processes such as structuring the supervision session, assisting trainees in their presentation of clinical work, facilitating trainee self-reflection, providing and eliciting feedback, and aiding the trainee in accurately gauging their competence.

Given the importance of the supervisory relationship, coupled with the difficulties clinicians face when providing supervisors with feedback (due to the hierarchical position of the supervisor), routine assessment of the supervisory relationship is critical. The Supervisor Working Alliance Inventory (Efstation, Patton, & Kar-dash, 1990) is a psychometrically validated self-report measure that includes a supervisor and a trainee-clinician version, with items rated on a 7-point Likert scale. Efstation and colleagues’ factor analysis revealed that the supervisor version has three factors (Client Focus, Rapport, and Identification), whereas the trainee version has two factors (Rapport and Client Focus). An additional evidence-based measure of the relationship is the Supervision Relationship Questionnaire (SRQ; Palomo, Benuart, & Cooper, 2010). The SRQ is a 67-item supervisee self-report of the
supervisory relationship, with subscales assessing safe base, structure, commitment, reflective education, role model, and formative feedback, using a 7-point Likert scale, with higher scores reflective of a stronger supervisory relationship.

The supervisory relationship is one of the most highly discussed domains, yet little empirical research exists and it is therefore difficult to delineate its role in optimizing supervision outcomes. However, recent advances include the development of the SRQ, which demonstrates preliminary evidence that the quality of the supervisory relationship predicts not only professional development but also supervision outcomes such as clinician competence and client outcomes (Palomo et al., 2010). It will be important for future research to assess the supervisory relationship simultaneously with clinician knowledge, skills, and attitudes to appreciate its role in optimizing the effectiveness of the supervision process.

General Competencies

Finally, there is a large body of literature assessing constructs that do not fit neatly within the Falender et al. (2004) framework but are purported to be central supervision outcomes. For instance, there is panoply of research investigating the impact of supervision on clinician self-efficacy (e.g., Cashwell & Dooley, 2001; Koob, 2002; Ladany, Ellis, & Friedlander, 1999; Reese et al., 2009). Self-efficacy refers to a clinician’s confidence in his or her clinical abilities and self-perceptions of the clinical work quality (Ladany et al., 1999). Research has demonstrated that clinician self-efficacy is related to client outcomes when clinicians receive feedback about client progress (Reese et al., 2009), and supervision has been identified as a key factor in developing clinician self-efficacy across professional development (Cashwell & Dooley, 2001; Koob, 2002).

There are numerous measures available to assess counselor self-efficacy (see Larson & Daniels, 1998, for a review). The Counseling Self-Estimate Inventory (COSI; Larson et al., 1992) is a 37-item self-report questionnaire that targets the trainee’s perception of self-efficacy across five domains: confidence executing microskills, attending to process, dealing with difficult client behaviors, culturally competent behavior, and awareness of one’s values. Each item is scored on a 1 (strongly disagree) to 6 (strongly agree) Likert scale.

Other generic competencies have been identified, including ethical practice, clinician professionalism, assessment skills, knowledge of disorders, interpersonal effectiveness, cultural competency, and efficient use of time (Falender & Shafranske, 2004; Milne, Baker, Blackburn, James, & Reichelt, 1999; Roth & Pilling, 2008). Many training program directors create and administer a general competency evaluation to assess clinician progress across these areas but do not make their assessment tools widely available. Our team created a General Competency Inventory by pulling from the best available literature (e.g., Hatcher & Lassiter, 2007) and readily available competency forms online (e.g., Clinical Psychology Practicum Evaluation Form, 2004) to include items capturing (a) Assessment Competence, (b) Psychotherapy Competence, (c) Consultation Competence, (d) Professionalism Competence (e.g., use of supervision, interprofessional behavior, ethical behavior, work habits, and professional development). These domains are rated from “unsatisfactory” to “excellent,” and individual items are scored from “needs practice” to “competent.” This evaluation can be used to provide concrete feedback to the supervisee over the course of training.

These general competencies are especially important for trainees in the early stages of their professional development. Careful assessment and documentation of competencies such as professionalism, ethics, and report writing is standard practice within the predoctoral internship year and for the majority of clinical training programs. However, use of an established, universal competency evaluation might optimally prepare trainees for their next stage of training, regardless of the setting or role. This idea is not particularly new to professional psychology. Kaslow et al. (2009) published guiding principles for the assessment of competence in hopes of creating an assessment toolbox for the field. Through systematic and standardized assessment of the specified competencies, measures can be refined to prepare trainees for fruitful careers, and facilitate an understanding of the link between competencies and outcomes.

Client Outcomes

Even if progress is made through the supervision process with respect to improving clinician EBP knowledge, skills, and attitudes, as well as general competencies, the ultimate goal is to improve the lives of clients seeking services. A well-established system for monitoring client outcomes is integral to any evidence-based treatment program. To enhance the clinical utility of process and outcome evaluation, researchers have developed methods for providing clinicians with feedback about client progress, which has been demonstrated to improve client outcomes and decrease clinical deterioration (Lambert et al., 2003). The benefit of this feedback process parallels the support for providing feedback to supervisors to enhance clinician competence (Edmunds, Beidas, & Kendall, 2013) and client outcomes (Reese et al., 2009). Therefore, it is imperative to measure client outcomes across the process (e.g., therapeutic relationship), outcomes (e.g., symptoms), and putative mechanisms of change (e.g., readiness to change) to gain a better understanding of the role that supervision plays in improving client care.

Although a review of psychometrically validated measures that assess process, outcomes, and mechanisms of change at the client level is beyond the scope of this article, highlighted below is a low-cost, low-burden assessment battery currently used in many of the Group Health Cooperative (i.e., a member-governed, nonprofit health care system that coordinates care and coverage) clinics to aid readers in implementing client level supervision outcome measures (Steinfield, 2013). Specifically, the Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001) and the General Anxiety Disorder 2-item screening tool (Kroenke, Spitzer, Williams, Monahan, & Lowe, 2007) are widely used self-administered diagnostic instruments for assessing depression and nervousness/anxiety/worry, respectively. The client completes these two instruments prior to each treatment session. At pretreatment, the client answers questions on a 7-point Likert scale regarding the importance of initiating psychotherapy (from not at all important to extremely important) and confidence that therapy will be helpful (from not at all confident to extremely confident). Clients also provide self-report information on the therapeutic
A Model of Evidence-Based Assessment in a CBT Training Clinic Setting

The clinical science program at Indiana University, in the Department of Psychological and Brain Sciences, prides itself on training doctoral-level students to competence in evidence-based practices. To the extent possible, training and supervision procedures are also evidence based, with outcome assessment occurring at regular intervals across the aforementioned domains. A key goal of the CBT Research and Training Clinic, led by the first author, is to evaluate training and supervision outcomes at the level of both the clinician and the client. What follows is a concise description of the assessment protocol currently being implemented at Indiana University’s CBT Research and Training Clinic that has been derived from the literature reviewed here to make use of evidence-based assessments and procedures. The following description may serve as a useful exemplar for the field to facilitate broad implementation and engagement in evidence-based evaluation across training programs.

Pretraining Assessments for New Trainees

Prior to beginning training in the CBT Research and Training Clinic practicum, new trainees are required to complete a behavioral rehearsal (i.e., role play) session (typically a first session) with a standardized client (a trained undergraduate assistant). The trainee clinician is instructed not to prepare for the session in any way (i.e., no preparatory readings, online trainings, etc.), although trainees are given the opportunity to review a fictional intake report for the standardized client. Trainees are instructed to lead a first session with this standardized client using a typical first CBT session structure (see, e.g., Beck & Beck, 2011). The purpose of this baseline assessment is to evaluate whether the trainee has sufficient knowledge to deliver a skillful CBT session. This session is video recorded, reviewed, and rated by the supervisor using the Cognitive Therapy Scale (CTS) to assess CBT competency. This baseline session and competency rating provides the supervisor with information regarding trainee CBT skills and allows for individualized supervision focusing on competencies that will be crucial for the trainee to achieve in order to provide effective CBT.

In addition to observing and rating the trainee clinician CBT competency, trainees complete a self-report of general clinical competencies to focus supervision efforts. The trainee clinician also completes the CBT-Knowledge Questionnaire and the Evidence Based Practice Attitudes Scale to assess pretraining declarative knowledge and attitudes. Results are reviewed with the trainee at a first supervision session that focuses on developing the supervisory relationship, and maximizing the efficiency and effectiveness of subsequent supervision sessions.

During Training

One of the initial foci of the supervision process is to orient the trainee to the CTS and manual as it serves to guide the training process. The trainee is instructed to review the CTS after each session to promote self-assessment and to complete the self-report form of the CTS at Sessions 2, 5, and 8. At these sessions, the clinician also completes a modified version of the CTS, as does the supervisor (who either watches the session live or codes the video recording). The supervisor then provides the trainee with written feedback and CTS scores, and leads a discussion regarding ongoing skill development.

In addition to regular CTS administration, a standardized battery of client self-reports are completed at intake (assessing depression, anxiety, hopelessness, life satisfaction, dysfunctional attitudes, readiness to change), the feedback session (assessing depression, anxiety, and additional putative mechanisms of change measures), each therapy session (assessing depression and anxiety), and Sessions 5 and 10 (assessing therapeutic working alliance, putative mechanisms of change measures, and life satisfaction). The trainee is responsible for graphing the client scores at Sessions 5 and 10, and reviewing outcome trajectories in session, either confirming progress or discussing lack of progress and potential treatment adaptations. The intake battery is readministered in full at client termination.

Midway through training, the CBT-Knowledge Questionnaire is readministered. The trainee and supervisor also complete the Supervisory Relationship Questionnaire to assess the quality of the supervisory relationship and both parties complete the General Competencies Inventory. All forms are reviewed in supervision to discuss progress and identify growth areas. Finally, a trained team of undergraduate coders rate the first three sessions of each clinical case using the Collaborative Study of Psychotherapy Rating Scale (CTB subscales) to evaluate CBT adherence during the initial stages of treatment.

Posttraining

At the completion of the practicum-training year, the trainee completes the self-reported General Competencies Inventory and the CBT-Knowledge Questionnaire. The supervisor also completes the General Competencies Inventory and the supervisor and trainee discuss whether additional CBT training is needed. Trainees who have developed CBT knowledge, skill, and favorable attitudes are invited to retake the CBT practicum as a peer supervisor with training focused on delivering evidence-based CBT supervision.

This evaluation model attempts to optimize both the trainee experience and client care, while building a database that can contribute to the supervision outcomes literature. This example may inspire others to explore a similar evidence-based supervision evaluation process. However, despite the potential benefits of the evaluation approach outlined here, this approach is not without limitations and feasibility challenges.

Limitations and Future Directions

Although this article addresses a prominent gap in the supervision outcome literature, there are several noteworthy limitations.
First, the article presents a model for evidence-based assessment within a clinical psychology doctoral training program, but our preliminary research currently lacks sufficient data to explore whether an evaluation infrastructure alone improves clinician and client level outcomes. Moreover, we did not focus on the specific supervisory structure, methods, and content necessary to optimize outcomes. The ultimate goal for the field may be to establish an evidence-based supervision model that delineates key mechanisms responsible for change. There are measures such as the Methods of Learning Therapist Skills Questionnaire (Bennett-Levy et al., 2009) that could aid in this effort. However, the information provided in this article regarding supervision outcome domains, a battery for evidence-based assessment, and a model for evaluating supervision outcomes serves as a call to action for other graduate and professional training settings to engage in data collection to address the ‘embarrassing situation’ in the supervision literature (Reiser & Milne, 2012, p. 162).

Second, the evidence-based assessment protocol provided in our model requires substantial infrastructure and time to allow for self-reported and objective assessment of supervision outcomes. Our model assumes that training facilities are able to video record sessions, access copyrighted measures with associated costs, and leverage technological resources to maximize data collection. Given the complexity, necessary time commitment, and heavy resource demand of this supervision assessment model, it may not be an ideal match for all settings. However, settings with limited resources may be able to implement components of the supervision outcome assessments, beginning with application of the brief and low-cost client measures presented here and drawing upon technological innovations to overcome facility limitations (e.g., flip cameras instead of permanent video cameras).

Finally, the Falender et al. (2004) framework delineates clinician knowledge, skills, and attitudes as central competence domains for evaluating supervision outcomes. However, despite the literature supporting these domains as key to effective clinician training, it is quite possible that supervision variables not accounted for by the Falender et al. (2004) model play a vital role in enhancing outcomes. For instance, Wheeler and Richards (2007) reviewed the supervision outcome literature and noted that supervision has also been found to affect clinician self-awareness and theoretical orientation. Furthermore, although an overview of the relevant literature and examples of measures assessing specific supervision outcomes was provided, this article is by no means an exhaustive review.

Implications and Conclusions

This article delineated key domains of supervision outcomes, highlighted established measures for evaluating these domains, and provided a model of a training clinic engaged in supervision outcome assessment. By highlighting key domains of supervision outcomes and presenting examples of psychometrically validated measures, the ultimate goal of establishing evidence-based supervision structures can be more easily achieved. This article has the potential to engage the field in a necessary dialogue and evaluation of the primary functions and goals of supervision, as well as to spur development and use of evidence-based measures and procedures for assessing supervision outcomes.

References


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