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# Psychotherapy

## **Differences Among Trainees in Client Outcomes Associated With the Phase Model of Change**

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# Differences Among Trainees in Client Outcomes Associated With the Phase Model of Change

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This study investigated psychotherapy trainees' ability to facilitate change in outcomes (e.g., well-being, symptom reduction, and life functioning) specifically related to the phase model. Four different psychotherapist experience levels (beginning practicum, advanced practicum, intern/postdoc, and psychologist) were compared to determine whether there are training differences related to significant change for psychotherapy outcomes according to the phase model. A total of 1,318 clients from a university counseling center, treated by 64 psychotherapists, were included in the analysis for this study. Results indicate that interns/postdocs' clients achieve more significant change than psychologists' and advanced practicum students' clients related to life functioning. In addition, interns/postdocs' clients achieve more significant change related to symptom reduction, when compared with the clients of psychologists. Implications for these results, given the hypotheses of both the phase model and competency models, are discussed.

*Keywords:* phase model, psychotherapy outcomes, training, training levels

The assertion in support of psychotherapy training is obvious: training should lead to better, more effective psychotherapists. The existence of training programs in psychotherapy is predicated on this assertion, and state licensing laws further affirm the legitimacy of these programs. However, there is a peculiar gap between the literature on psychotherapist training and psychotherapy outcome, and researchers have repeatedly questioned whether training is actually associated with client outcomes (Ridley & Mollen, 2011). Indeed, reviews of the literature point to a lack of research evidence, indicating that training leads to better results (e.g., Christensen & Jacobson, 1994). In addition, Fauth, Gates, Vinca, Boles, and Hayes' (2007) review indicated that psychotherapy research regarding trainees is rife with gaps such as evaluating only short-term outcome data, ignoring client factors, and including small number of psychotherapy cases. Thus, the purpose of the current study was to test whether psychotherapists' training level was related to a variety of clients' outcomes—based on the Phase Model of Change (Howard, Lueger, Maling, & Martinovich, 1993)—in a large sample of clients and therapists.

## Psychotherapy Training Models

Within the last several decades, numerous authors have conceptualized psychotherapist training with an aim on building psychotherapy competencies. Rodolfa et al. (2005) advocated for the competency cube, which covered three domains: (a) foundational competency domains (e.g., self-awareness, scientific knowledge, ethics), (b) functional competency domains (e.g., case conceptualization, consultation, supervision), and (c) stages of professional development (e.g., graduate training, continuing education). The model did not address the three domains in a mutually exclusive fashion but rather emphasized the holistic development of the therapist. Similarly, in 2006, the Task Force on the Assessment of Competence in Professional Psychology (APA Task Force) was charged with evaluating relevant literature on psychotherapy competence, which emphasized that a developmental approach was necessary and recommended that competence should be assessed throughout the professional life span of the psychotherapist. As such, the emphasis of these reviews on the importance of assessing psychotherapist development is consistent with the overall assumption behind psychotherapist training—that training should lead to the development of psychotherapist competencies.

However, as exemplified with the aforementioned two reviews, most of the literature on psychotherapist training focuses on the content of training rather than on the purported goal, that is, competencies. Studies have shown that first semester trainees increase exploration and insight skills, manage more countertransference, and exhibit less anxiety as they progress in training (Hill, Sullivan, Knox, & Schlosser, 2007; Williams, Judge, Hill, & Hoffman, 1997). Therefore, research implies that training should lead to an acquisition of these skills. Instead, training research

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focuses mainly on assessing beginning trainees' basic counseling skills and/or their self-reflections of their affect, cognition, and skills. What has often been measured as trainee competencies consists of limited aspects of what they are trained to do in their profession (e.g., microskills) or a proxy for actual performance (e.g., self-efficacy).

In contrast to the psychotherapy training literature, psychotherapist competencies have been defined by directly assessing the degree to which their clients improved. Referred to as psychotherapist effects (e.g., [Huppert et al., 2001](#); [Okiishi, Lambert, Nielsen, & Ogles, 2003](#); [Wampold & Brown, 2005](#)), researchers have statistically estimated to what degree treatment outcomes differ based on who the treating psychotherapist was. Defining psychotherapists' competencies based on their clients' actual outcomes has obvious advantages for psychotherapy training, as it provides a clear barometer for how trainees are progressing in assisting their clients. In doing so, it is important to contextualize client outcomes and the specific types of outcomes based on training levels (APA, 2006).

It is difficult to understand specific mechanisms of how training works without first knowing whether psychotherapists at different experience levels vary in their abilities to help clients. Research to this very question provides little clarity. Several studies indicate a positive relationship among process and outcome variables with training level. For example, [Burlingame, Fuhriman, Paul, and Ogles \(1989\)](#) showed that experienced psychotherapists had better outcomes on symptoms and target complaints than trainees when conducting time-limited therapy. Similarly, two studies reported that more doctoral clinical and training hours led to lower client drop-out rates when compared with doctoral students who had fewer hours ([Driscoll et al., 2003](#); [Powell, Hunter, Beasley, & Vernberg, 2010](#)). In contrast, several studies indicated either modest effect sizes or no differences in outcomes between trainees and more experienced psychotherapists (e.g., [Nyman, Nafziger, & Smith, 2010](#); [Stein & Lambert, 1995](#)). Another study reported that the relationship between training level and treatment outcome may not be linear, such that interns displayed the highest outcomes, followed by practicum students, and then by psychologists ([Minami et al., 2009](#)). Therefore, contrary to the assumptions of most training models, there is no consistent evidence that training leads to better client outcomes.

### The Phase Model of Change

To conceptualize client outcomes in psychotherapy, [Howard et al. \(1993\)](#) provide theoretical and empirical bases for how outcomes are achieved. They theorized that psychotherapy change occurs in three phases throughout the psychotherapeutic process: (a) remoralization, (b) remediation, and (c) rehabilitation. They contend that remoralization constitutes setting up the therapeutic relationship and instilling hope with the client, which will lead to increased well-being. Next, remediation focuses on alleviating the client's symptoms and enhancing coping skills, which will lead to symptom reduction. Last, rehabilitation focuses on addressing the client's long-standing patterns and addressing how to achieve longer term life goals, all of which are referred to as life functioning.

Howard et al. tested their phase model and found empirical support for their theory, with larger changes in well-being at the

beginning of therapy leading to symptom reduction, which in turn led to improvement in life functioning. More specifically, clients' well-being improved over the course of therapy ( $d = 1.0$ ), with >70% of improvement occurring early in treatment. Symptom reduction also improved over the course of therapy ( $d = 0.80$ ); however, approximately 50% of the change was demonstrated early in therapy and subsequent improvement was more gradual. Clients reported less overall improvement in life functioning ( $d = .068$ ) over the course of therapy, and with the exception of a decline at Session 4, approximately 50% of change in life functioning was demonstrated early in therapy with gradual increases thereafter.

From the time when this seminal article was released, several studies have replicated findings from [Howard et al. \(1993\)](#). For example, [Kopta, Howard, Lowry, and Beutler \(1994\)](#) found that 50% of clients recovered (i.e., achieved reliable significant improvement) in less than 10 sessions and that the greatest recovery in life functioning occurred by clients' 52nd session. [Hilsenroth, Ackerman, and Bligys \(2001\)](#) also found support for improvement in well-being and symptom reduction for short-term psychodynamic therapy. Occasionally, the phase model has been met with mixed results, with large-sized effects reported for an increased well-being by the 4th session; however, outcomes plateaued as therapy continued through the 17th session ([Callahan, Swift, & Hynan, 2006](#)).

The majority of scholarship has replicated the findings from Howard et al.'s (1993) phase model and therefore should provide an ideal frame to test psychotherapist training effects. More specifically, according to the competency model, trainees learn certain skills throughout the course of their training (e.g., foundational competency; [Rodolfa et al., 2005](#)), which may potentially have large implications for the phase model when conceptualizing how trainees achieve outcomes in increased well-being, symptom reduction, and enhanced life functioning. According to foundational competencies, it is unlikely beginning practicum students will help promote the same levels of well-being in their clients as compared with more experienced therapists by the second session. However, it is likely that beginning practicum students' clients may achieve greater well-being by the end of therapy. The same is likely to be true for symptom reduction and life functioning. Regardless of timing, it is essential to determine whether trainees even achieve any of the three-phase model outcomes. The phase model thus becomes uninterpretable for trainees if, at different stages, they are not able to demonstrate helping their clients reach these three milestones.

### The Current Study

The purpose of the current study was to examine the relationship between psychotherapist experience level (beginning practicum, advanced practicum, interns/postdoctoral psychotherapist, and psychologist) and achievement of specific client outcomes based on the Phase Model of Change. We hypothesized that there would be a positive relationship between psychotherapist experience level and increased well-being, symptom reduction, and enhanced life functioning. As indicated in the previous section, it is difficult to test the phase model if it is unclear whether trainees' clients even attain the three outcomes outlined in the model. Thus, we set

out to test whether trainees, when compared with one another, demonstrate different levels of client outcomes.

## Method

### Setting

For this study, data were collected at a university counseling center located in the Midwestern United States. The counseling center provides direct clinical services (individual and group therapy), as well as consultation and outreach to the university community. The counseling center exclusively serves graduate and undergraduate students who are currently enrolled at the university. Clients do not pay a per-session fee as long as they are enrolled full-time at the university; during the summer, clients who are not enrolled will pay a \$15.00 per session fee. Individual therapy is limited to 13 sessions per year but can be extended at the therapists' discretion and agreement with a consulting team to extend session limits. Intakes at the counseling center are considered to be the first session with the therapist and do not occur separately from the therapy process. Therapists provide therapy that is based on empirically supported treatments but do not provide any manualized treatments. Clients are primarily assigned to psychotherapists based on availability and sometimes, but rarely, by client requests to see a therapist based on specific factors (e.g., gender, sexual orientation, familiarity with specific issues). Although assignment is based on these factors, the empirical question within this study is to ultimately understand the degree to which clients differ among therapists. In addition, the majority of clients who attend the counseling center do not request specific types of therapists and are assigned primarily based on when the next counseling slot is available. There is relatively little screening out during the process of assigning clients to therapists; however, beginning practicum students are typically assigned clients who enter therapy for career and/or academic counseling. Clients who indicated a level of severity at intake that included self-harm or suicidality were not referred to beginning practicum students. Clients are administered the Behavioral Health Measure-43 (BHM-43) prior to their first intake session; clients are administered the Behavioral Health Measure-20 (BHM-20) for each session after their intake until they reach termination.

### Clients

Analyses for this study were conducted using data from 1,318 clients from a university counseling center in the Midwest. During May 2008 through May 2011 in which these data were collected, 2,574 clients were served at the center; however, only 2,112 (82.1%) clients reported their psychological distress using the Behavioral Health Measure (BHM-43; BHM-20, Kopta & Lowry, 2002) at intake. Clients are given the option to take the BHM prior to completing the intake; thus, these numbers are likely indicative of clients who chose to not complete the measure. As this study was interested in the clients' progress in therapy, clients who attended less than two sessions ( $N = 794$ ; 30.8%) were further dropped from the analyses, resulting in data from 1,318 (51.2%) clients. Many clients at the counseling center enroll in academic or career counseling as opposed to personal counseling; many clients who attend academic or career counseling sessions only require

one session—thus indicating the percentage of clients who had more than one session.

Regarding the 1,318 clients included in the analysis, a total of 66.5% reported being female ( $N = 1,711$ ), 33.4% ( $N = 860$ ) reported being male, and 0.1% ( $N = 3$ ) did not specify their gender. For ethnicity, the following demographics were reported: "other" 49.8% ( $N = 1,282$ ), White 31.7% ( $N = 817$ ), Asian/Pacific Islander 11.5% ( $N = 297$ ), African American 3.6% ( $N = 92$ ), Latina/Latino/Hispanic 2.5% ( $N = 65$ ), and Native American/American Indian 1% ( $N = 21$ ). Of the 2,574 clients, 8.3% ( $N = 214$ ) indicated that their nationality originated outside of the United States.

### Psychotherapists

The 1,318 clients were treated by 64 psychotherapists. Although we have information about the psychotherapists' training level, we do not have any other demographic or in-session treatment information. Psychotherapists at the counseling center included psychologists (licensed Ph.D. or Psy.D. psychologists,  $N = 12$ ), postdoctoral therapists and psychology predoctoral interns ( $N = 20$ ), advanced practicum students ( $N = 20$ ), and beginning practicum students ( $N = 12$ ). The average number of clients per therapist is as follows: psychologists ( $M = 59.42$ ), interns/postdocs ( $M = 20.15$ ), advanced practicum ( $M = 8.45$ ), beginning practicum ( $M = 2.75$ ). Psychologists at the counseling center provide supervision to postdoctoral therapists, interns, and advanced practicum students—they also have 1 hr biweekly peer consultation with other psychologists at the counseling center. Interns provide supervision to the beginning practicum students, and in turn receive supervision-of-supervision from a psychologist. Beginning practicum students receive 1 hr a week of individual supervision and are watched live (by an intern, a psychologist, and peers who are not seeing clients at that time) and provided feedback at the end of each day they do therapy. Advanced practicum students receive 2 hrs of individual supervision a week; they are required to video-record their sessions and, depending on the style of the supervisor, will watch their videos both in and out of supervision. Interns' amount of client-related weekly supervision is as follows: 2 hrs of individual supervision, 1½ hrs of group supervision, 1½ hrs of supervision-of-supervision, biweekly 1 hr peer consultation, and 1 hr of supervision for live supervision of beginning practicum students. Postdoctoral psychologists also receive 2 hrs of individual supervision a week; postdoctoral psychologists typically see clients on a part-time basis and were trained at the same counseling center for their internship year.

### Measure

**Behavioral Health Measure-43 and Behavioral Health Measure-20 (BHM-43; BHM-20).** The BHM-43 is a 44-item client-report measure; the BHM-20 is a shorter version of the BHM-43, with 21 items (Kopta & Lowry, 2002). The scales are composed of three main clusters of items, notably Well-Being, Psychological Symptoms, and Life Functioning. The Well-Being cluster includes three items that assesses overall distress, life satisfaction, and motivation (e.g., "How satisfied have you been with your life?"). In the BHM-20, the Psychological Symptoms cluster contains 14 items that assesses clinical symptoms such as

depression, anxiety, and substance use (e.g., “Feeling sad most of the time.”). The Life Functioning cluster contains four items that assesses relationships, life enjoyment, and work/school functioning. All items are on a 4-point Likert-type scale ranging from 0 to 4. For purposes of this study, all items were coded such that higher scores indicating better functioning. Thus, higher scores on well-being and life functioning indicate better mental health. Also, higher scores on psychological symptoms indicate *less* psychological distress. In the current study, Cronbach’s  $\alpha$ s were .82 for Well-Being, .88 for Psychological Symptoms, and .75 for Life Functioning. Correlations for scales are as follows: well-being and symptoms ( $r = .62, p < .01$ ), well-being and life functioning ( $r = .67, p < .01$ ), and life functioning and symptoms ( $r = .52, p < .01$ ).

The psychometric properties of the BHM-20 for use in university counseling settings were assessed using 673 undergraduates, of which 208 were in treatment and 465 were not (Kopta & Lowry, 2002). The 2-week test–retest reliability for the BHM-20 was .71 for well-being, .83 for symptom reduction, and .80 for life functioning. Concurrent validity of the BHM-20 has been supported in prior studies using the Behavior and Symptom Identification Scale-32 (BASIS-32; Eisen, Grob, & Klein, 1986), Outcome Questionnaire-45.2 (OQ-45; Lambert et al., 1996), and the Symptom Checklist-90-R (SCL-90-R; Derogatis, 1994). Correlations between the total BHM-20 and the BASIS-32, OQ-45, and SCL-90-R were .83, .81, and .85, respectively (after matching direction), which indicated that the BHM-20 shares >65% of the variance with other well-established general clinical symptom measures (Kopta & Lowry, 2002). Clinical cut off scores, where clients are considered “at risk,” are as follows: 2.16 for well-being, 2.91 for symptoms, and 2.64 for life functioning.

## Procedure

The BHM is administered via a computer-based system (CelestHealth) that derives electronic input from the client and provides an electronic output that is available to the psychotherapist. Prior to the first session, clients are administered a longer version of the BHM (e.g., the BHM-43). When clients arrive for all subsequent sessions, they are directed to take the BHM-20 prior to each session. Clients were informed that they were being administered the measures to help inform future research and provide feedback to the psychotherapists regarding clients’ improvement.

## Data Analysis Strategy

To provide a clinically meaningful metric of psychotherapy change, we analyzed the clients’ outcomes on the well-being, psychological symptoms, and life functioning subscales using the Reliable Change Index (RCI) proposed by Jacobson and Truax (1991). Prior to conducting the RCI analyses, we adjusted the prescores to correct for regression to the mean using the following formula:  $[r_{xx}(X - M) + M]$ , where  $r_{xx}$  = test–retest reliability,  $X$  = clients’ prescore, and  $M$  = mean score at pre for all clients (Speer, 1992). Reliable change was calculated using the following equation:  $RCI = [(Adjusted\ prescore - post\ score)/Sdiff]$ , where  $Sdiff$  = standard difference which equals the square root of  $[2(Standard\ Error\ of\ Measurement^2)]$ . We utilized the RCI score for the three subscales as a continuous outcome variable in the main analyses. Additionally, the classifications for reliable im-

provement/deterioration/no change are reported (a change in pre to post RCI scores of  $\pm 1.96$  or more). The RCI has multiple advantages over using the raw observed pre–post effect sizes. The RCI estimate is based on meaningful clinical change beyond what one would expect based on measurement error. Further, the RCI has practical value—that is, supervisors can easily determine whether their trainees’ clients are progressing on the three subscale domains.

As is common with psychotherapy studies, data were nested as multiple clients who were treated by the same psychotherapist. Thus, we conducted our main analyses with two-level multilevel models (MLM). In the models, we predicted clients’ RCI scores of well-being, psychological symptoms, and life functioning, respectively. At level 1, we also controlled for the number of sessions attended by clients as well as their adjusted prefunctioning score on well-being, psychological symptoms, and life functioning, respectively (both grand-mean centered). Given the quasi-experimental nature of our study, controlling for differences in clients’ prefunctioning will help alleviate some, but clearly not all, of the variability in caseloads among trainees and psychologists (see client assignment above). At level 2, we included psychotherapists’ training level: psychologists, intern/postdocs, advanced practicum students, and beginning practicum students. Multilevel models were conducted using Hierarchical Linear Modeling Version 6 (Raudenbush, Bryk, Cheong, & Congdon, 2005).

## Results

Descriptive statistics and reliable change estimates for the BHM well-being, psychological symptoms, life functioning, and therapist training variables are included in Tables 1 and 2. The percentage of clients who achieved reliable improvement for well-being and psychological symptoms was similar—it ranged from 37.7% to 48.5% for well-being and ranged from 39.4% to 45.9% for psychological symptoms. In contrast, the percentage of clients who achieved reliable improvement for life functioning was lower—ranged from 18.9% to 27.3% (see Table 2).

Prior to conducting our main analyses, we examined differences in prepsychotherapy functioning for the three outcomes across psychotherapists’ training level. As to be expected, the psychologists’ clients reported significantly lower scores on well-being than interns/postdocs’ clients ( $p = .03$ ) and advanced practicum students’ clients ( $p = .01$ ). Psychologists’ clients also displayed more psychological symptoms ( $p = .01$ ) and worse life functioning ( $p = .01$ ), when compared with interns/postdocs’ clients. There were no significant differences in clients’ prepsychotherapy functioning among the trainees.

Based on our MLM (using interns/postdocs as the reference group), several relationships were significant (see Table 3). In the model comparing clients’ reliable change on well-being, there were no statistically significant differences based on training level. However, there were two results that were marginally statistically significant ( $p < .10$ ). Specifically, advanced practicum students’ and psychologists’ clients achieved less reliable change ( $ds = -0.38$  and  $-0.30$ , respectively) as compared with interns/postdocs’ clients. Clients’ initial well-being was a significant predictor of the degree to which they experienced increases in their well-being at the end of therapy ( $d = 0.52$ ).

Table 1  
Descriptive Information for Outcomes by Training Level

	Sessions	Well-being <i>M (SD)</i>		Psychological symptoms <i>M (SD)</i>		Life functioning <i>M (SD)</i>	
		Pre	Post	Pre	Post	Pre	Post
Psychologists	9.11 (7.96)	1.57 (0.74)	2.22 (0.85)	2.62 (0.78)	3.14 (0.70)	1.94 (0.70)	2.37 (0.82)
Interns/postdocs	8.55 (5.49)	1.67 (0.70)	2.36 (0.84)	2.75 (0.70)	3.28 (0.60)	2.03 (0.66)	2.53 (0.77)
Advanced practicum	8.51 (5.73)	1.74 (0.71)	2.26 (0.89)	2.77 (0.76)	3.23 (0.63)	2.02 (0.67)	2.39 (0.81)
Beginning practicum	5.7 (3.05)	2.08 (0.66)	2.56 (0.94)	2.99 (0.51)	3.42 (0.45)	2.37 (0.59)	2.82 (0.67)

Note. The clinical cut off for Well-being is 1.90, Symptoms is 2.56, and Life Functioning is 2.45. The pre-scores do not reflect the adjusted means utilized in the reliable change analyses. Higher scores on Symptoms indicate less distress. Higher scores on Well-being and Life Functioning indicate better mental health.

In the model comparing clients' reliable change on psychological symptoms, the clients of psychologists reported less reliable change in their symptomology as compared with the clients of interns/postdocs ( $d = -0.35$ ). There were no other statistically significant differences based on training level, number of sessions, or prepsychological symptoms.

Related to clients' reliable change on life functioning, significant differences arose for advanced practicum and psychologists when compared with interns/postdocs. Both advanced practicum students' ( $d = -0.42$ ) and psychologists' ( $d = -0.38$ ) clients achieved less reliable change as compared with intern/postdocs' clients. Number of sessions was not significant in this model, and prelife functioning scores were marginally statistically significant ( $p < .10$ ). We had hypothesized that there would be a positive relationship between psychotherapist experience level and increased well-being, symptom reduction, and enhanced life functioning. Our hypotheses were partially supported; interns/postdocs' clients had small-to-moderate greater improvement on life functioning and well-being when compared with advanced practicum students (but not beginning practicum).

### Discussion

The purpose of this study was to examine the *degree to which* trainees are able to assist their clients to achieve reliable change on the three main outcomes outlined in the phase model by the end of psychotherapy. We were less concerned about *when* these out-

comes occur, as the phase model proposes that changes in well-being, symptoms, and life functioning are central to clients' overall functioning and all three domains have demonstrated change throughout the process of psychotherapy.

Regarding well-being, there were no statistically different findings among any of the groups of psychotherapists. According to the phase model theory (Howard et al., 1993), increases in well-being represent clients' feelings of remoralization and hope about their life. The null statistical findings in this study indicate that, at any level of training, individuals may do equally well at helping their clients with feelings of remoralization and hope. It is of note that findings were approaching significance ( $p < .10$ ), with interns/postdocs having 9% more reliable change in their clients' well-being than psychologists and advanced practicum students. Previous studies have shown mixed results when reporting differing outcomes for trainees and more experienced psychotherapists. The nuance of the results for well-being showing a disparity between a lack of statistical significant at the .05 level, but clinically meaningful differences of 9% improvement for interns/postdocs' clients, sheds light on the complicated nature of researching differences based on experience level of psychotherapists.

An additional finding from this study was that interns/postdocs achieved better, statistically significant outcomes in their clients' psychological symptoms when compared with psychologists. According to the phase model theory (Howard et al., 2003), reme-

Table 2  
Reliable Change by Training Level

	Psychologist <i>N (%)</i>	Intern/postdoc <i>N (%)</i>	Advanced practicum <i>N (%)</i>	Beginning practicum <i>N (%)</i>
Well-being				
Reliable change	269 (37.7)	188 (46.7)	64 (37.9)	16 (48.5)
No change	415 (58.2)	202 (50.1)	98 (58.0)	16 (48.5)
Deteriorated	29 (4.1)	13 (3.2)	7 (4.1)	1 (3.0)
Psychological symptoms				
Reliable change	286 (40.1)	185 (45.9)	70 (41.4)	13 (39.4)
No change	404 (56.7)	209 (51.9)	97 (57.4)	20 (60.6)
Deteriorated	23 (3.2)	9 (2.2)	2 (1.2)	0 (0.0)
Life functioning				
Reliable change	159 (22.3)	106 (26.3)	32 (18.9)	9 (27.3)
No change	531 (74.5)	288 (71.5)	133 (78.7)	24 (72.7)
Deteriorated	23 (3.2)	9 (2.2)	4 (2.4)	0 (0.0)

Table 3  
 Summary of Fixed Effects: Main Effects on Training Status and Session

Training level	Well-being		Psychological symptoms		Life functioning	
	Coefficient (SE)	<i>d</i>	Coefficient (SE)	<i>d</i>	Coefficient (SE)	<i>d</i>
Advanced practicum vs. I-P	-0.28* (.15)	-0.38	-0.13 (.14)	-0.17	-0.29*** (.10)	-0.42
Beginning practicum vs. I-P	0.14 (.36)	0.19	0.23 (.15)	0.31	0.25 (.22)	0.36
Psychologists vs. I-P	-0.22* (.13)	-0.30	-0.26** (.11)	-0.35	-0.26*** (.10)	-0.38
Session	0.01 (.01)	0.01	0.01 (.01)	0.01	-0.01 (.01)	-0.01
Prefunction	0.38** (.19)	0.52	-0.38 (.23)	0.51	0.34* (.18)	0.49

Note. I-P = intern/post-doc. Cohen's *d* can be interpreted as: 0.30 is a small-sized effect, 0.50 is a medium-sized effect, and 0.80 is a large-sized effect. Comparing the Advanced practicum and Beginning practicum students to Psychologists only yielded one significant finding. Clients of Beginning practicum students reported a greater degree of change in life functioning as compared with clients of Psychologists ( $B = 0.50$ ,  $SE = .22$ ,  $p = .03$ ).

\*  $p < .10$ . \*\*  $p < .05$ . \*\*\*  $p < .01$ .

diation focuses on alleviating the client's symptoms and enhancing coping skills, which will lead to symptom reduction. The findings here run counter to most in the literature that show either: (a) experienced psychotherapists display better client outcomes than trainees (e.g., [Burlingame et al., 1989](#); [Powell et al., 2010](#)), or (b) that there are no differences based on experience level (e.g., [Nyman et al., 2010](#)). Instead, results of the current study indicate there were differences; however, the most advanced psychotherapists did not achieve the best outcomes.

Clients of interns/postdocs also displayed more significant change in life functioning when compared with clients of psychologists and advanced practicum students. [Howard et al. \(1993\)](#) suggested that changes in life functioning correspond with the rehabilitation phase of psychotherapy, wherein clients' long-standing patterns are addressed to achieve longer term life goals. Presumably, interns/postdocs may have more knowledge and skills to understand and effect changes in clients' overall life functioning as compared with advanced practicum students. Developmentally, this is to be expected, as beginning and advanced practicum students are still developing their conceptualization abilities and typically focus more attention on immediate stressors ([Fouad et al., 2009](#)). However, psychologists should theoretically achieve higher results than interns/postdocs, if the developmental rationale is true for all therapists. Instead, it is likely that there is a unique experience that occurs during the internship/postdoc years that is above and beyond reactions to clients.

The findings from this study are partially in alignment with recent counseling center research that shows that interns had better overall outcomes than any other experience level ([Minami et al., 2009](#)), which supports a hypothesis that the internship year may provide unique opportunities to achieve certain types of client outcomes. It is possible that the amount and level of supervision that occurs at internship/postdoctoral training contributes to their ability to help clients regarding well-being, symptom reduction, and life functioning. [Hoffman, Hill, Holmes, and Freitas \(2005\)](#) hypothesized that supervision during the internship year is the most critical year, as it may be the last year when psychologists will receive feedback, which results in supervisors attempting to give more direct and difficult feedback. Although practicum students also receive supervision, they may be more likely to not talk about clients who they are having strong reactions to, based on feeling shame for not being helpful or incompetent ([Ladany, Hill, Corbett, & Nutt, 1996](#)). Beginning practicum and advanced practi-

cum students at this particular counseling center have devoted 1 hr every week to individual supervision; however, this is a far cry from the 7–10 hrs of individual and group supervision that interns receive per week. In addition, although psychologists engage in biweekly peer consultation, the nature of supervision during internship year provides more clinical support than peer consultation.

We anticipated that psychologists' clients would achieve more significant client change in well-being, symptom reduction, and life functioning when compared with trainees. The findings that interns/postdocs' clients improve on symptoms and life functioning when compared with psychologists are interesting, as these findings are opposite to the theory posed in support of competency models ([Rodolfa et al., 2005](#)). Although we do not want to extend our speculation too far without follow-up in-depth examination of the treatments, we should note that all of the trainees received formal supervision. In prior studies, supervision has been associated with better psychotherapy outcomes ([Bambling, King, Raue, Schweitzer, & Lambert, 2006](#)).

Last, there was a large percentage of individuals who did not achieve reliable change, and a small percentage of clients who reported deterioration (see Table 2). The results found in this study are comparable with other large counseling center studies (e.g., [Baldwin, Berkeljon, Atkins, Olsen, & Nielsen, 2009](#); [Draper, Jennings, Baron, Erdur, & Shankar, 2000](#); [Hannon et al., 2005](#)). When using the RCI, it is common to report findings that indicate approximately 50% of clients do not report improvement. However, the findings also indicate higher instances of a lack of reliable change for life functioning within the current study, which is consistent with the phase model. This may be due to the construct of life functioning for this particular study, where items center around social relationships and how clients are feeling at work/school. These may be less demonstrable for RCI than a symptom or well-being measure.

### Limitations and Future Research

One of the major strengths of this study is it is one of the largest data sets of its kind to take into account training level and psychotherapy outcomes. In addition, it addresses the large gap in the research of assessing outcomes based on phase model theory and how these variables relate to training. However, there are several limitations to this study. First, inclusion of the beginning practi-

cum students may not contribute much to the literature, given how clients are selected for these psychotherapists. Additionally, there was a low number of beginning practicum students practicing psychotherapy at the counseling center. At the same time, this practice of selecting less-distressed clients for beginning psychotherapists may be a good training practice. The psychologists, interns/postdocs, and advanced practicum students are assigned clients mainly based on availability, whereas beginning practicum students' clients are more closely screened and assigned based on developmental appropriateness. To address this issue, future research could compare beginning practicum students who are assigned clients based on a developmental approach and beginning practicum students who are randomly assigned clients; it is possible that this research may not find a difference in outcomes.

Further, it may be difficult to truly assess the phase model with populations that engage in shorter term therapy, especially for changes in life functioning. The median number of sessions in previous studies of phase model ranged from 3 to 18 (e.g., Howard et al., 1993; Kopta et al., 1994). For instance, only 36% of the clients in the Howard et al. study reached Session 17. In the current study, some clients were granted extensions past the 13 session limit, and there is some indication that shorter term therapy may be suitable for some clients to achieve changes in well-being, symptoms reduction, and life functioning. Ultimately, what is not known is whether the dose-response model or the good-enough level model (i.e., where clients who attend therapy at different lengths change at different rates) is a better fit when describing changes across well-being, symptoms, and life-functioning (see Baldwin et al., 2009).

Additionally, it is theorized that supervision may play a role in the findings for this study. A limitation of this particular study is that there are no data available to confirm how supervision may impact intern/postdoc training and outcomes. Future research would benefit from collecting this specific psychotherapist variable to determine how they are related to clients' RCI in well-being, psychological symptoms, and life functioning.

Last, the data may not be generalizable to outpatient populations who are not college students. Although it can be argued that college student populations are unique and pose different challenges than independent practice, inpatient, or general outpatient populations, it is likely that the gap of differences is slowly closing. Research shows that college counseling center clients' presenting concerns are more reflective of the general population than previously considered (Gallagher, 2010). In addition, the demographics of the clients indicate a wide range of clients that differs from previous research that mostly included White higher socioeconomic status students.

### Implications for Training & Practice

There are several implications for training and practice from the current study. First, the findings from this study only partially support the competency models or theories that have been outlined by the 2006 report by the APA Task Force on the Assessment of Competence in Professional Psychology. The result that advanced practicum students had fewer clients reach RCI for some of the outcomes fits a developmental model; however, this trend was not replicated with other training levels or outcomes. Examining more

nuanced clinical outcomes for trainees may enhance competency models; failure to do so may erroneously mask similarities.

Beginning and advanced practicum students may need more training and supervision to assist clients on outcomes (e.g., well-being and life functioning). Potentially, beginning and advanced practicum students face a combination of challenges and stressors in becoming a psychotherapist—learning a new role with complex theories and techniques combined with daily stressors of classes, research, and personal lives. Prevention programs for trainee stress, such as Mindfulness-Based Stress Reduction (MBSR), have been found to be beneficial for trainee's self-care (Shapiro, Brown, & Biegel, 2007).

The findings in this study indicate that there are unique factors during the internship and postdoctoral years that contribute to helping clients with their symptom reduction and life functioning. It is likely that these factors are related to the type of supervision and support that is received during these formative last years of training. When supervisors see that practicum students report clients who are struggling with well-being and life-functioning issues, this should be an indicator to explore these issues. In addition, it may be helpful to have discussions about countertransference when clients report specific life-functioning concerns (e.g., a graduate student client who is struggling with the demands of their program) and to raise self-awareness for the trainee about increases in anxiety related to countertransference and effectiveness.

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