

2016

Getting to Outcomes® in Clinical Practice An Empirical Exploration of a Framework that Supports Quality for Graduate Student Therapy Training

Jennifer Castellow
University of South Carolina

Follow this and additional works at: <https://scholarcommons.sc.edu/etd>



Part of the [Clinical Psychology Commons](#), and the [Community Psychology Commons](#)

Recommended Citation

Castellow, J.(2016). *Getting to Outcomes® in Clinical Practice An Empirical Exploration of a Framework that Supports Quality for Graduate Student Therapy Training*. (Doctoral dissertation). Retrieved from <https://scholarcommons.sc.edu/etd/3838>

This Open Access Dissertation is brought to you by Scholar Commons. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of Scholar Commons. For more information, please contact digres@mailbox.sc.edu.

Getting to Outcomes® in Clinical Practice
An Empirical Exploration of a Framework that Supports Quality for Graduate Student
Therapy Training

by

Jennifer Castellow

Bachelor of Arts
North Carolina State University, 2009

Master of Arts
University of South Carolina, 2012

Submitted in Partial Fulfillment of the Requirements

For the Degree of Doctor of Philosophy in

Clinical-Community Psychology

College of Arts and Sciences

University of South Carolina

2016

Accepted by:

Abraham Wandersman, Major Professor

Bret Kloos, Major Professor

Kimberly J. Hills, Committee Member

Robert Hock, Committee Member

Paul Allen Miller, Vice Provost and Interim Dean of Graduate Studies

© Copyright by Jennifer Castellow, 2016
All Rights Reserved.

ABSTRACT

Getting To Outcomes® in Clinical Practice is an innovation being developed and disseminated in a clinical training center for psychology doctoral students. The innovation is a step-wise framework posited to enhance clinical practice by supporting the planning, implementation, and evaluation of specific evidence-based practices in psychology. The current study introduces and defines the innovation and uses a multiple case study, mixed method analysis to evaluate current innovation use behaviors as well as attitudes about the innovation. The guiding research themes for this study include: (1) innovation use behaviors, (2) attitudes about the innovation, and (3) influential contextual factors that impact adoption and attitudes. Cases studied were student-therapists within the setting where the innovation is being developed and disseminated. Multiple data sources, including therapist interviews, case records, supervisor evaluations, and physical file inventories, were utilized to triangulate innovation use behaviors and organized into a system used to understand variance in adherence to the innovation, called an Innovation Configuration Map (Hall & Hord, 2011). Themes related to relative advantage, compatibility, complexity, trialability, and observability, constructs known to account for innovation adoption (Rogers, 2003), were evaluated during interviews. Cross-case thematic assertions and contextual, case-specific factors were identified that impact implementation and program refinement. Assertions relevant to understanding the program were the following: (1) Behaviors varied in terms of adherence to the model; (2) Therapists developed idiosyncratic ways to adhere to the model and viewed the

framework as implicit rather than an explicit step-by-step guide; (3) Attitudes about the utility of the innovation were mixed; (4) There was an overall reaction to the label of the innovation; (5) The steps were difficult to remember and participants desired steps to be consolidated; (6) Implementation support is necessary for successful implementation; (7) Trialability and observability were difficult to gauge given the implicit use of the framework; (8) Contextual factors, such as program enrollment, caseload characteristics, and the implementation setting, impacted use and attitudes. These findings have implications regarding the refinement of the innovation as well as its measurement system and generate future directions for continued evaluation of this innovation.

TABLE OF CONTENTS

ABSTRACT	iii
LIST OF TABLES	vii
LIST OF FIGURES	viii
LIST OF ABBREVIATIONS.....	x
INTRODUCTION	1
CHAPTER 1 LITERATURE REVIEW	4
1.1 A HISTORY OF GRADUATE TRAINING IN PSYCHOLOGY	4
1.2 THE EMPIRICALLY SUPPORTED TREATMENT MOVEMENT	6
1.3 EVIDENCE-BASED PRACTICE IN PSYCHOLOGY	8
1.4 DEVELOPING EXPERTISE IN CLINICAL PRACTICE.....	10
1.5 GRADUATE TRAINING IN CLINICAL PSYCHOLOGY TODAY	12
1.6 GETTING TO OUTCOMES IN CLINICAL PRACTICE.....	14
1.7 ADOPTION AND APPRAISAL OF AN INNOVATION.....	25
1.8 IMPLEMENTATION AND ADAPTATION	26
1.9 THE CURRENT STUDY.....	28
1.10 POSITIONALITY OF THE PRINCIPAL INVESTIGATOR	28
CHAPTER 2 METHOD.....	31
2.1 SETTING	31
2.2 METHODOLOGY	35
2.3 PARTICIPANTS	36

2.4 MEASURES	38
2.5 PROCEDURE.....	41
2.6 DATA ANALYSIS.....	42
CHAPTER 3 RESULTS.....	47
3.1 CROSS-CASE ASSERTIONS	61
CHAPTER 4 DISCUSSION.....	77
4.1 RESEARCH QUESTIONS	78
4.2 LIMITATIONS	82
4.3 FUTURE RECOMMENDATIONS FOR CONTINUED RESEARCH AND PROGRAM DEVELOPMENT.....	83
4.4 CONCLUSIONS	86
REFERENCES	88
APPENDIX A – GTO IN CLINICAL PRACTICE GRAPHIC.....	101
APPENDIX B – INNOVATION CONFIGURATION MAP	102
APPENDIX C – INTERVIEW PROTOCOL	113
APPENDIX D – WORKSHEET DESCRIPTIONS	118
APPENDIX E – IC MAP ANALYSIS EXAMPLE.....	119
APPENDIX F– CASE REPORT EXAMPLE	132

LIST OF TABLES

Table 1.1 GTO Accountability Questions	16
Table 1.2 Support for GTO in Clinical Practice Steps.....	19
Table 1.3 GTO in Clinical Practice Accountability Questions.....	21
Table 2.1 Important Participant Sampling Variables.....	38
Table 2.2 Case Selection Matrix.....	38
Table 3.1 Overall IC Map Means and Modes.....	65
Table 3.2 GTO in Clinical Practice Step-wise Means from IC Map Profiles.....	65

LIST OF FIGURES

Figure 1.1 GTO in Clinical Practice Logical Model.....	23
Figure 2.1 Worksheet 1: Graphic Design of Case Study	43
Figure 3.1 Worksheet 2: Themes of the Multi-case Study	47
Figure 3.2 Worksheet 3: Analyst's Notes While Reading Case report for Participant 1...	49
Figure 3.3 Worksheet 3: Analyst's Notes While Reading Case report for Participant 2...	50
Figure 3.4 Worksheet 3: Analyst's Notes While Reading Case report for Participant 3...	51
Figure 3.5 Worksheet 3: Analyst's Notes While Reading Case report for Participant 4...	52
Figure 3.6 Worksheet 3: Analyst's Notes While Reading Case report for Participant 5...	53
Figure 3.7 Worksheet 3: Analyst's Notes While Reading Case report for Participant 6...	54
Figure 3.8 Worksheet 3: Analyst's Notes While Reading Case report for Participant 7...	55
Figure 3.9 Worksheet 4: Rankings of Utility and Uniqueness of Each Case for Themes	56
Figure 3.10 Worksheet 5b: Merged Findings	57
Figure 3.11 Worksheet 6: Tentative Cross-Case Assertions	60
Figure 3.12 Worksheet 6: Cross-Case Assertions.....	62
Figure 3.13 Worksheet 6: Multi-Case Assertions for Final Report.....	63
Figure 3.14 Graphical Presentation of All IC Map Scores	64
Figure F.1 Participant 7 IC Map Profile	133
Figure F.2 Participant 7 IC Map Profile: All Clients.....	133
Figure F.3 Participant 7 IC Map Profile: Client 1	134

Figure F.4 Participant 7 IC Map Profile: Client 2134

LIST OF ABBREVIATIONS

ANCOVA	Analysis of Covariance
APA	American Psychological Association
Assmt	Assessment
ATYP	Atypical
CBT	Cognitive Behavioral Therapy
CC	Clinical-Community
CCA	Cross Case Assertion
CL/Clt	Client
CQI.....	Continuous Quality Improvement
Diff.....	Differences
EBP	Evidence-Based Practice
EST	Empirically Supported Treatment
GTO	Getting To Outcomes
GTO in CP	GTO in Clinical Practice
HIPAA	Health Insurance Portability and Accountability Act
I	Interviewer
IC.....	Innovation Configuration
IRB.....	Institutional Review Board
ORS.....	Outcome Rating Scale
P	Participant
PI.....	Principal Investigator

PHI	Private Health Information
RAND	Research and Development
Sch.....	School
Tri.....	Triangulation
Tx	Treatment

INTRODUCTION

The study of therapy training models for students in clinical psychology graduate programs is an area of research that is currently lacking (Boswell & Castonguay, 2007). In graduate-level training, developing professional psychotherapists strive to learn the intricacies of acquiring and refining expertise in clinical practice. This process is complex in that it requires the novice clinician to balance an understanding of empirical research and clinical data within the context of each client (APA Presidential Task Force on Evidence-Based Practice [EBP], 2006).

Getting To Outcomes (GTO®) is a planning, implementation, and evaluation framework that has been used in several settings—including substance abuse prevention, positive youth development, teen pregnancy prevention, homelessness services, and case management programs—to systematize decision-making in program evaluation, organizational, and community change endeavors (Chinman, Imm, & Wandersman, 2004; Imm et al., 2007; Fisher, Imm, Chinman, & Wandersman, 2006; Lesesne et al., 2008; Chinman, Hannah, & McCarthy, 2012; Barbee, Christensen, Antle, Wandersman, & Cahn, 2011). More recently, a research team composed primarily of clinical practitioners has adapted this framework to be used on the clinical-individual level to empower novice therapists to plan, implement, and evaluate the therapy process. *Getting To Outcomes in Clinical Practice*™ (GTO in Clinical Practice™) achieves this by demystifying parts of the therapy process for psychotherapy trainees by making each step in the therapy process *explicit* in order to ensure a certain level of quality.

Therapy is a complex process. Although most seasoned psychologists tend to rely on their previous training, experience, and clinical judgment to ensure quality, accountability support mechanisms are likely to reduce error in complex processes involved in the medical and behavioral health field (Gawande, 2010), and novice professionals are likely to specifically benefit from such a framework as they develop habits that will continue throughout their careers. GTO in Clinical Practice provides that support by prompting the student-therapist to complete 10 essential therapy steps: (1) conducting a strengths-based *assessment* that informs *case conceptualization*, (2) *treatment goal setting*, (3) exploring *best practices* deemed helpful in reaching goals set, (4) exploring *fit* of best practices, (5) considering *capacity* to utilize best practices, (6) *treatment planning*, (7) *therapy process evaluation*, (8) *therapy outcome evaluation*, (9) considering how to *continuously improve quality* of treatment in consideration of previous evaluation processes, and (10) planning for *sustainability* of treatment gains. Although some would argue that most therapists implicitly complete each of these processes and that ensuring that these steps have been taken is superfluous and unnecessary, making these components explicit ensures that developing therapists are being methodical and systematic in the treatment process across all clients.

Given this innovation's¹ early stage in development, developing a fidelity measurement process and exploring its feasibility to be studied further is appropriate (McGinty, 2002). The three aims of this dissertation are to (1) theoretically introduce GTO in Clinical Practice to the field of psychology, (2) study how student-therapists

¹ The term *innovation* is defined as “an idea, practice, or object that is perceived as new by an individual or other unit of adoption” (Rogers, 2003, p. 12).

enact this innovation using a tailored fidelity measurement system, and (3) assess student-therapists' attitudes about the innovation. One major contribution that this dissertation will make is the introduction of the innovation, GTO in Clinical Practice. This framework has potential to support clinical decision-making and training in developing therapists by making essential therapy processes explicit. In turn, GTO in Clinical Practice has the potential to be utilized in clinical training programs and other organizational treatment settings to ensure quality in clinical practice by enhancing accountability to quality. Further, the study will demonstrate how a multiple case study analysis can be used to study innovations in these early stages of development and implementation².

This study explores the complexity and utility of this innovation using a mixed-method, multiple case study analysis that gathers information on behavioral *adherence* to GTO in Clinical Practice components as measured by Hall and Hord's (2011) Innovation Configuration Mapping system (IC Map) as well as student-therapists' *appraisals* and *perceptions* of this innovation's utility in supporting clinical practice during the early phases of organizational adoption and implementation. Specifically, the current study will describe how a group of students behaviorally adhered to the essential components of GTO in Clinical Practice, as measured by a tailored IC Map, as well as how useful they perceive the innovation to be supporting or interfering with clinical practice.

² *Implementation* involves "executing the innovation effectively" after it is adopted (Meyers, Durlak, & Wandersman, 2012, p. 465).

CHAPTER 1

LITERATURE REVIEW

1.1 A History of Graduate Training in Psychology

Following World War II, a time when the mental health field was dominated by psychiatry, the American Psychological Association (APA) organized around an initiative to distinguish and legitimize the field of psychology (Frank, 1984; Baker & Benjamin, 2000). This attempt to professionalize psychology led to a training model that distinguished the field from other mental health paradigms by asserting psychology's professional equivalence to psychiatry by embracing the medical model and its associated research paradigms (Frank, 1984). Spearheaded by David Shakow, the ubiquitous scientist-practitioner model (i.e. the Boulder Model) was proposed in 1949 at the Boulder Conference on Graduate Education in Clinical Psychology in Boulder, Colorado (Raimy, 1950). The Boulder Model has since been widely accepted as the predominant doctoral training model in clinical psychology (Raimy, 1950; Frank, 1984; Baker & Benjamin, 2000).

In theory, the Boulder Model encourages students in psychology to be trained as scientist-practitioners, conducting research and practice with the same amount of rigor and systematic thinking (Baker & Benjamin, 2000). According to this esteemed model, each therapy case should be treated as an experiment, in which the therapist constantly generates and tests hypotheses by tapping into research theory, and each experiment can explore how therapy functions on a larger scale; science and practice should not be

mutually exclusive but rather be used in an iterative and reciprocal fashion (Boswell & Castonguay, 2007; Strupp, 1981). However, many psychologists fail to reference research in practice settings, a longstanding problem in the field (Nathan, 2000; Eysenck, 1992; Barlow, 1981).

Today, psychologists struggle with truly reconciling these two foci in practitioner settings, as research and clinical practice have been argued to involve two vastly different skill sets (Strupp, 1981). The scientist-practitioner model does not always lend itself to effective training in providing therapy. The acceptance of the medical model forces the psychologist to make clinical decisions based on diagnoses, rather than client-centered conceptualizations (Strupp, 1981; Albee, 2000). This emphasis makes it difficult for the psychologist to consider social influence, historical learning mechanisms, and behavioral principles, underemphasizing the larger picture of the client situated within her/his own context. Frank (1984) argues that the problem with the Boulder Model emerges from the “scientist-humanist” discrepancy. Scientists are interested in discovering how treatment functions across groups, whereas the humanist is invested in the client context.

There is a need for a model that builds a bridge between the research-to-practice gap while considering the intricacies involved with implementing a best practice in applied settings. Despite critiques of the model, the Boulder Model has been inaugurated into the psychology field and psychologists can either resist or streamline efforts to improve its contribution (Nathan, 2000). Psychologists must work to create practice guidelines that take all of these challenges into consideration; otherwise, psychologists will ultimately be forced to adhere to more guidelines created by the field of psychiatry (Nathan, 2000).

1.2 The Empirically Supported Treatment Movement

The Boulder Model set the foundation for the Empirically Supported Treatment (EST) movement to take precedent in psychology. In response to the perception that psychological treatment was inferior to pharmacology, the EST movement, a movement already predominant in the medical field, was adopted and mobilized by APA in the 1990's. Under the assumption that empirically supported data are important to clinical practice, this emphasis focuses on identification and dissemination of empirically supported practices. The EST movement posits that current empirical knowledge is critical to client care and staying abreast of the constantly emergent information relevant to practice is difficult for practicing clinicians. Therefore, summaries of evidence and access to information about evidence are critical to quality practice (Chambless & Ollendick, 2001). Activities of task forces appointed by APA included establishing criteria for what comprises an “empirically validated treatment” and devising lists of these supported treatments per problem domain (APA Task Force on EBP, 2006). Various work groups classified “efficacious” treatments by promoting treatments that had been supported by multiple randomized control trials (RCTs), a research design widely endorsed by the medical model. This, in turn, created a platform for manualized treatments to be created, disseminated, and embraced by the field of psychology as “scientific” practice.

Some scholars argue that the use of manuals degrade the quality of therapy (Garfield, 1996; Henry, 1998). However, the findings are mixed, some manualized treatments found to be superior for certain disorders (e.g. exposure therapy for agoraphobia), whereas other problems have less clearly prescribed treatments (Chambless

& Ollendick, 2001). Surveys have shown “cookie-cutter therapy,” or manualized treatment, is not generally utilized or preferred by seasoned psychologists (Jennings, Goh, Skovholt, Hanson, & Banerjee-Stevens, 2003; Smith, 1995; Silverman, 1996; Lambert, 1998; Bohart et al., 1998). In one study, 23% of psychologists in practice had never even heard of treatment manuals, and of those that were aware that they existed, 38% were unclear as to what they were (Addis & Krasnow, 2000; Chambless & Ollendick, 2001). Therapy is viewed as an art to some psychologists, rather than the adherence to a step-by-step protocol (Bohart, O’Hara, & Leitner, 1998). On the contrary, some scholars argue that psychotherapists can use manuals creatively, and that the intricacies of adoption and adaptation need to be studied (Addis, Wader, & Hatgis, 1999). Selecting, administering, and utilizing treatment protocols with quality while simultaneously working to build a therapeutic relationship takes finesse. Perhaps guidelines around adaptations and deviating from the protocol are necessary to make manuals more user-friendly and applicable in real-world clinical settings. Balancing fidelity and flexibility has been under-explored.

Although ESTs set the precedent for ensuring quality treatment in psychology, scholars acknowledge ESTs comprise only one critical part of providing quality care (Chambless & Ollendick, 2001). Selecting treatments solely based on diagnosis is dehumanizing and minimizes the importance of the client context (Chambless & Ollendick, 2001; Bohart et al., 1998). In a survey inquiring about use of a list of ESTs in APA-accredited training and internship sites, several directors commented on the difficulty of simply checking off ESTs (Crits-Christoph, Frank, Chambless, Brody, & Karp, 1995). Some of the written responses were quite telling, respondents refusing to

complete the survey and speaking to the importance of tailoring treatment strategies to the individual client as opposed to using “canned” packages developed in research settings. It should be noted, however, that these controversial responses reflected only a few opinions out of the 138 respondents on the grad program survey. These responses do, however, reflect a general controversy over whether the EST movement is too stringent to be applicable in the every day practice.

1.3 Evidence-Based Practice in Psychology

In response to the EST movement, scholars argue that ESTs are indeed important, but psychologists need to be prepared to deliver evidence-based practices in applied settings (Crits-Christoph et al., 1995). Acknowledging the strengths and limitations of the EST movement, APA outlined the Evidence-Based Practice (EBP) paradigm, a more comprehensive concept which promotes a client-centered approach to reviewing research, or ESTs, with the purpose of reaching outcomes in applied clinical practice (APA Task Force on EBP, 2006). The APA Presidential Task Force on Evidence-Based Practice developed guidelines for best practice in psychology with the caveat that they should be based on research as well as clinical expertise. APA (2006) describes the EBP paradigm as more inclusive, involving activities such as assessment, case formulation, therapy relationships, as well as an overall decision-making process for incorporating research and evidence into clinical practice. Thus, evidence-based practice is not only defined as familiarity and adherence to the research but also the integration of research and clinical expertise in the context of the client’s individual characteristics, culture, and preferences. APA (2006) describes *clinical expertise* as competence attained through training as well

as experience with effective practice that integrates the consideration of best practices with the client context.

Scholars have long argued that therapeutic change can be accounted for by non-specific, common factors across therapy systems (Luborsky, Singer, & Luborsky, 1975; Luborsky & Krause, 2002; Wampold 2001). An analysis of 50 different articles on psychotherapy yielded a list of factors that were not specific to any given treatment orientation, summarized to largely include the establishment of a therapeutic alliance, opportunity for catharsis, acquisition and practice of new behaviors, and the client's positive expectancy (Grencavage & Norcross, 1990). Indeed, the therapeutic alliance has been widely esteemed as an essential ingredient that accounts for client improvement as much as the particular treatment method, and some scholars argue that the therapist's allegiance to a particular treatment is often not accounted for in randomized control trials, the gold standard in psychotherapy research (Wampold, 2001; Luborsky & Krause, 2002). APA sponsored a task force with the endeavor of identifying and disseminating effective practices related to the therapeutic relationship (Norcross, 2010). This paper will herein refer to these factors as *non-specific* EBPs to be distinguished from EBPs *specific* to particular treatment systems. These factors are acknowledged to be pan-theoretical in nature, and are known to contribute to quality practice, regardless of the specific treatment or technique selected, necessary but not necessarily sufficient for therapeutic change. Specific as well as nonspecific factors should be considered in developing expertise in therapy and clinical practice.

1.4 Developing Expertise in Clinical Practice

Scholars have been discussing the definition of clinical “expertise” for over a decade without necessarily pinpointing a specific definition (Skovholt, Rønnestad, & Jennings, 1997; Skovholt & Jennings, 2004; Jennings et al., 2003). There are various stages of professional development (Skovholt et al., 1997). First, the novice integrates external information (ESTs and theory) into practice. Later, the more experienced therapist uses feedback from self, clients, and colleagues to refine and internalize via self-reflective processes in order to refine the implementation of externally informed theory and practice. This process is reciprocal, informed by ideology and how that ideology is then put into practice. Thus, one can assume expertise, or “mastery,” involves experience with EBP, and is likely preceded by professional development leading to overall competence in the psychotherapy field; however, a clear interpretation of what clinical competence, expertise, and mastery are has yet to be determined. Multiple studies have been conducted to demystify these constructs.

Research has shown that therapists’ perceptions of their own competences are correlated with years of experience (Orlinsky, Rønnestad, Willutzki, & Cierpka, 1999). Jennings et al. (2003) argue that years of experience only allow for the therapist to build a schema for more complex conceptualizations and treatment processes, drawing upon accumulated experiences (Jennings & Skovholt, 1999). Assuming the therapist is effective throughout development, this theory would imply that an effective therapist would develop multiple schemas for conceptualization and treatment for a variety of clients. Experience is necessary, but perhaps insufficient, for building expertise in therapy practice. Whereas novice therapists tend to be focused on the “how to” processes in

treatment, more experienced therapists conceptualize cases more broadly and in a more complex way. The more skilled therapist is less concerned about being a “technique wizard” and more concerned about how treatment modalities fit with the therapist’s professional identity. Martin, Slemon, Hiebert, Hallberg, and Cummings (1989) argue that with the necessary training and experience, clinical experience creates deep, meaningful mental representations of clients’ presenting concerns and profiles.

The APA Task Force on Evidence-Based Practice describes various components of clinical expertise that include competence in specific therapeutic processes as well as competence in non-specific EBPs (APA Task Force on EBP, 2006). Developed and demonstrated in all clinical activities, clinical expertise is developed through clinical and scientific training, a working understanding of theory and research, clinical experience, the practice of self-reflection, and the pursuit of continuous professional development. As defined by APA, expertise includes assessment skills, diagnostic judgment, and case formulations; clinical decision making, treatment implementation, and outcome monitoring; interpersonal skills; continual professional development and self-reflection; appropriate integration of research with practice; multicultural sensitivity; seeking support as needed (e.g. consultation, referrals, etc.); and the use of a logical rationale for clinical decisions (APA Task Force on EBP, 2006). Expertise are demonstrated in all clinical activities, including alliance building, assessment and case conceptualization, goal setting, selection of best practices, tailoring treatment to the client, ensuring capacity to administer treatment, treatment planning, monitoring the process of therapy as well as the outcomes, and making informed corrections to the treatment process. The foundation for expertise is built in clinical graduate training.

1.5 Graduate Training in Clinical Psychology Today

There is currently an emphasis on improving training in the human services field. Boswell and Costonguay (2007) argue that there is a deficit in research to ensure quality training in clinical practice and that the Boulder Model should not only guide practice, but also guide the science and practice of clinical training. There is limited evidence that training models utilized in preparation for mental health professions improves trainees' skill levels in delivering effective therapy (Alberts & Edelstein, 1990). Scholars suggest that the long-term application of specific skills allows for developing therapists to generalize specific skills into overall practice (Alberts & Edelstein, 1990; Fuqua, Johnson, Anderson, & Newman, 1984). Given a recent emphasis on clinical outcomes in our health care system, many scholars and policy-makers emphasize evaluating clinical competence in trainees rather than evaluating the completion of various unstandardized credit-hours in training (Alberts & Edelstein, 1990, Institute of Medicine [IOM], 2006).

Given changes in behavioral health services, scholars argue that there is a growing concern that training programs have not kept pace with reforms (Hoge, Huey, & O'Connell, 2004). In the midst of the healthcare reform in the United States that supports effective, efficient, and safe treatment, there seems to be a "training gap" between education and the knowledge and skills required to provide quality care in the midst of healthcare reform. Hoge et al. (2004) argue that in light of advances in the health care systems, students in mental health fields should be taught to *learn* as opposed to subscribe to any one particular treatment modality or school of thought. Students should gain an understanding of how to review, learn, critique, adapt, and implement practices, learning the *process* of electing and implementing practices. By learning the skills

necessary for critically evaluating competing treatment approaches, the student-therapist is equipped to absorb, process, and utilize the ever-growing body of literature around evidence-based practices. By understanding and valuing the utility of their learning objectives, trainees can take initiative in the learning process, utilizing previous experience and current training to inform the application of best practices in applied settings (Hoge et al., 2004; Green, 2001).

A study published by APA reported findings that implied direct practice with clients is an essential component to the training of students in clinical psychology programs (Orlinsky & Rønnestad, 2005). Further, these clinical experiences should be rewarding to the therapist and healing to the client, so as to reinforce positive learning experiences. If student-therapists have several stressful experiences, perceiving themselves as ineffective or unhelpful, this promotes feelings of anxiety and insecurity in the student that not only interfere with the learning process but most likely also translate into how the student-therapist interacts with each of her/his clients. In turn, students should be trained in a way that leads to self-efficacy and overall clinical competence.

With a current emphasis on integrating research and practice consistent with the ubiquitous Boulder Model, scholars argue that students in psychotherapy should be trained to conduct formal assessment batteries on clients, use these findings to inform case formulations and treatment planning, and perform ongoing formative and summative evaluations to assess the effectiveness of therapy, essentially conducting systematic case studies for each individual client (Borkovec, 2004). In order to do so, Borkovec (2004) argues that students need access to manuals and other literature on EBPs as well as updated literature reviews that describe the science supporting each treatment. Treatment

processes can be evaluated by both fidelity observations, i.e. assessing whether the therapist is adhering to the prescribed treatment strategy, as well as systematic feedback during the therapy process. These types of evaluations are essential to providing feedback to the therapist, supervisor, and overall training program, as data can then be compiled and consolidated to inform the therapist as well as the training infrastructure. Indeed, Borkovec (2004) argues that all clinical decisions can be data-informed and that systematic therapy creates the opportunity to bridge the research-to-practice gap.

1.6 Getting To Outcomes in Clinical Practice

This paper proposes that Getting To Outcomes in Clinical Practice might be a framework that can be utilized in training settings to help trainees bridge the research-to-practice gap in providing quality care. This section will be used to conceptually introduce the framework and its potential utility in supporting training in psychotherapy. GTO in Clinical Practice has been adapted from the original GTO framework, a tool that operationalized an evaluation approach called Empowerment Evaluation. The following section will (1) conceptually introduce GTO, (2) briefly describe research and practice supporting GTO's utility in evaluation endeavors, (3) introduce GTO in Clinical Practice, and (4) discuss how GTO in Clinical Practice can advance the literature on psychotherapy reviewed above.

Empowerment Evaluation is a program evaluation approach that is designed to actively engage communities in creating sustainable change (Fetterman & Wandersman, 2005). With an emphasis on equipping communities and organizations with the skills and capacities that are essential to creating lasting change, Empowerment Evaluation is participatory in nature. Stemming from this evaluation approach, Getting to Outcomes

(GTO) is a framework that was developed and has been utilized to support organizational and community change by providing support to planning, implementation, and evaluation processes (Chinman et al., 2004; Fetterman & Wandersman, 2005; Chinman, Acosta, Hunter, & Ebener, 2015). GTO is considered a tool that is used to enact and operationalize these principles. The 10-step framework (see Table 1.1) is often described and taught to the stakeholders in order to *empower* the community to select, implement, and evaluate plans that promote long-lasting change. The founders argue that the entire 10-step model, if completed with fidelity, ensures accountability to a certain level of quality in community change endeavors. Further, the founders argue that completing each step is essential to ensuring the appropriate selection and implementation of any innovation to reach sustainable outcomes. Indeed, the whole of GTO is bigger than the sum of its parts, and completing each step is essential to seeing the overarching benefit of the approach. Hence, if the community participant can answer each of GTO's 10 steps' accountability questions (see Table 1.1), they have planned, implemented, and evaluated that initiative with quality and increased the probability of achieving outcomes.

GTO has been used in a wide variety of domains, including substance abuse prevention, positive youth development, teen pregnancy prevention, homelessness services, and case management programs and has been studied in several settings (Chinman et al., 2015). According to a chapter published by the RAND Corporation, GTO has been adopted and utilized by various national, state, and local organizations; GTO has been used by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC), the New Hampshire Division for Children, Youth and Families (DCYF), the Division of Juvenile Justice

Table 1.1

GTO Accountability Questions

GTO Step	Questions
1. Needs and Resources	What are the needs to be addressed and resources available?
2. Goals	What are the goals and desired outcomes?
3. Best Practices	Which evidence-based practices will be helpful in reaching the goals and desired outcomes?
4. Fit	What adjustments need to be made in order to fit the community context?
5. Capacity	What capacity is necessary to implement the program?
6. Plan	What is the specific plan for this program?
7. Process Evaluation	How will quality implementation be assessed?
8. Outcome Evaluation	How well did the program work to reach outcomes?
9. Continuous Quality Improvement	What adjustments/improvements need to be made to the strategy?
10. Sustainability	How will outcomes be sustained?

(Wandersman, Imm, Chinman, & Kaftarian, 2000; Chinman et al., 2015)

(DJJ), the New York Office of Child and Family Services (OCFS), the Children, Youth and Families Department of State of New Mexico, the Department of Veterans Affairs (VA), and the Department of Defense (DoD) for various behavioral health initiatives (Chinman et al., 2015). GTO is posited to lead to outcomes as such: GTO→ increased program capacity→ increased performance→ individual outcomes (Chinman et al., 2015; Chinman et al., 2005; Florin et al., 2012).

Thus far, four experimental or quasi-experimental studies have been conducted to evaluate GTO (Chinman et al., 2015). A study funded by the CDC using a quasi-experimental design compared drug prevention programs that did or did not receive training in GTO. Over two years, despite no difference between the GTO and control group, those who perceived themselves to be using GTO more were behaviorally more consistent with GTO components, and thus theorized to have higher capacity to plan, implement, and evaluate prevention programs (Chinman et al., 2008). Similarly, an internet-based GTO system, referred to as iGTO, was investigated by comparing coalitions in the iGTO group versus standard practice (Chinman, Tremain, Imm, & Wandersman, 2009). Repeated measures ANCOVAs showed that the iGTO programs demonstrated an increase in performance on GTO activities, as measured by an adapted version of Chinman et al.'s (2008) IC Map. In a study where six substance abuse prevention coalitions were randomized into a GTO group ($n = 3$) or usual practice group ($n = 3$), the groups assigned to GTO demonstrated increased performance in GTO activities and a within-group analyses showed that alcohol merchants in the GTO-assigned communities refused to sell alcohol to minors more than before the introduction of GTO (Imm et al., 2007). A larger randomized control trial showed that there was no significant difference between programs assigned to GTO versus the control group in terms of GTO-related activities; however, within the GTO group, those that reported using GTO more, had higher prevention capacity as measured by GTO activities (Chinman, et al., 2012). In this study, staff reported that GTO facilitated planning and evaluation processes; around two-thirds of the GTO programs began process evaluation and around one-third started measuring outcomes.

The wide adoption of GTO speaks to its utility in empowering communities to plan, implement, and evaluate effective programs. Indeed, the complexity of researching such a framework is vast, but its utility is logical across different levels of intervention and prevention and therefore important to study. This paper introduces a customization of GTO for planning and evaluation support in utilizing EBPs in psychotherapy. GTO in Clinical Practice entails (1) conducting an *assessment* for the purpose of a thorough case conceptualization, (2) setting *treatment goals*, (3) exploring *best practices* for reaching goals, (4) selecting best practices based on client and therapist *fit*, (5) considering *capacity* to implement best practices, (6) developing a detailed *treatment plan*, (7) evaluating the *process* of therapy, (8) evaluating potential therapy *outcomes*, (9) making necessary systematic corrections to treatment or *continuous quality improvement*, and (10) planning for *sustainability* of treatment gains. The 10 steps are displayed in Appendix A as logically sequential and iterative. Although the literature on clinical practice in psychology certainly supports each of these steps (see Table 1.2), a framework organizing and integrating all of these components has yet to have been created.

GTO in Clinical Practice, interestingly, resembles frameworks proposed during the emergence of prescriptive eclecticism. Scholars have long argued that prescriptive eclecticism will infiltrate the mental health system and that these systems are well-suited for data-informed treatment approaches, as they are not theory-based interventions but rather outcome focused (Lazarus, Beutler, & Norcross, 1992; Lambert, 1992). In fact, from the Integrative and Eclectic Therapy approaches, emerged Systematic Treatment Selection, a process utilized for systematically matching and adapting treatments based various dimensions of the case. Dimond, Havens, and Jones (1978) actually proposed a

Table 1.2

Support for GTO in Clinical Practice Steps

GTO Step	References
1. Assessment/Case Conceptualization	Sommers-Flanagan & Sommers-Flanagan, 2009; Haynes, Leisen, & Blaine, 1997; Persons & Tompkins, 2007; Boswell & Castonguay, 2007
2. Treatment Goals	Norcross, 2010; Haynes et al., 1997; Drake et al., 2001; Locke, Shaw, Saari, & Latham, 1980
3. Best Practices	Addis et al., 1999; McHugh & Barlow, 2010; Drake et al., 2001; APA Task Force on EBP, 2006
4. Fit	Beutler & Consoli, 1993; Chorpita, Daleiden, & Weisz, 2005; Norcross & Wampold, 2011; Beutler et al., 2005
5. Capacity	Norcross & Wampold, 2011; Gomes-Schwartz, 1978; Haynes et al., 2007; Beutler et al., 2005
6. Treatment Plan	Beutler et al., 2005; Harkness & Lilienfeld, 1997; Duckworth & Freedman, 2012; APA, 2010; Adams & Grieder, 2005
7. Process Evaluation	Bickman, 2008; APA, 2010
8. Outcome Evaluation	Lambert, Hansen, & Finch, 2001; Lambert, 1998; Lambert, Harmon, Slade, Whippie, & Hawkins, 2005; Duncan, 2012; Bickman, 2008; Bickman Kelley, Breda, de Andrade, & Riemer, 2011; Wells, Burlingame, Lambert, Hoag, & Hope, 1996
9. Continuous Quality Improvement	Wells et al., 1996; APA, 2010
10. Sustainability	Sperry, 2011; Beck, 2011

multi-step framework that included assessment, goal setting, treatment selection, and outcome evaluation. However, the current framework presented is not restricted to this

school of thought; GTO in Clinical Practice can be used within or across different philosophical orientations or schools of thought. Therefore, the developers³ of GTO in Clinical Practice argue that it *can* be utilized by eclectic and integrative psychotherapists but can also be useful to a therapist subscribed to a particular school of thought.

Some would argue that GTO in Clinical Practice is simply a way to strategize one's case formulation, building and testing a theory of change based in specific EBPs. Because a thorough case formulation involves observing, describing, making inferences, and applying strategies (Eells, 2006), GTO in Clinical Practice might be viewed as a way to operationalize the case formulation process within and across various therapeutic orientations. The framework is also consistent with literature on tailoring treatment, the steps encouraging the user to make necessary adaptations collaboratively with the client, preserving evidence-based elements of interventions while making client-centered adaptations (Chorpita, et al., 2005; Hoge et al., 2004). This requires a thorough understanding of the client, a repertoire of EBPs, and a system that assures and accounts for clinical progress. If a therapist were to adhere to each GTO in Clinical Practice step, the client and therapist should be able to answer each of the questions posed in Table 1.3.

There has been a long-standing divide between research and practice in clinical psychology and perpetuating the debate is not helpful to the field (Kazdin, 2008). A system such as this might facilitate bridging the research-to-practice gap by giving therapists a tool for implementing specific EBPs. In the same way that GTO has been used as a tool to empower communities to plan, implement, and evaluate prevention strategies, this paper introduces the possibility that GTO in Clinical Practice empowers

³ Jennifer Castellow, Katie Knies, Jonathan Scaccia, and Abraham Wandersman

Table 1.3

GTO in Clinical Practice Accountability Questions

GTO Step	Client	Therapist
1. Assessment/Case Conceptualization	What are the primary problems I want to work on in therapy? What strengths do I have that will help the work we do?	What needs does my client have that therapy can address? What strengths and supports does my client have? How do I conceptualize this case?
2. Treatment Goals	What long-term changes and desired outcomes do I hope that therapy will lead to?	What long-term goals and desired outcomes are we going to work toward in therapy?
3. Best Practices	What are some of the treatment strategies that can help me reach my goals?	What best practices have been shown to assist reaching the goals and desired outcomes for therapy?
4. Fit	What might interfere with me participating in treatment? Does this treatment make sense to me? Is this treatment consistent with my values (e.g. cultural, spiritual, etc.)?	What are the inclusion/exclusion criteria for the best practices? What are some of the barriers preventing the use of this best practice (e.g. cultural considerations, client preferences, etc.)? How do these best practices fit with my philosophical orientation or school of thought?
5. Capacity	Do I have previous experience with this type of treatment or any of its components? Do I feel capable of participating in this treatment? What general resources do I have that will be helpful in completing treatment?	Do I have the skills necessary for administering these best practices? Do I have resources available to facilitate my administration of these practices (e.g. time, manual, training, supervision, etc.)?
6. Treatment Plan	What steps will we be taking in therapy? What am I responsible for? What does the timeline look like?	What steps need to be taken by whom throughout the treatment process? What is the specific timeline we are aiming for?
7. Process	Am I following my treatment	Are we following the treatment

Evaluation	plan? Do we need to make changes to the plan?	plan? Are we deviating from the plan or its timeline? Do we need to make mid-course corrections?
8. Outcome Evaluation	Is treatment working?	Which desired outcomes have been achieved?
9. Continuous Quality Improvement	Is there anything I feel needs to change about our goals or the specific strategies we are using?	What adjustments need to be made in response to emerging needs, barriers to following our plan, and/or a lack of desired outcomes?
10. Sustainability	How do I sustain the progress I have made in therapy after treatment? What skills have I built and how do I maintain them?	What strategies might be necessary to sustain treatment gains (e.g. booster sessions)? How will my client act as her/his own therapist after treatment? How can my client be transitioned to natural supports?

the student-therapist to plan, implement, and evaluate evidence-based practices in psychotherapy. In doing so, the framework might have the capacity to support the scientist-practitioner training model, the therapist systematically developing and testing hypotheses.

The current study posits an adaptation of the original GTO logic model by revisiting the relationship between performance and capacity as well as adapting the GTO framework to be utilized to reach clinical outcomes. The following logic model represents GTO's utility on the clinical level in psychotherapy as posited by the current author: GTO in Clinical Practice → quality implementation of specific EBPs → client outcomes. Thus, GTO in Clinical Practice might be a useful tool that supports planning, implementation, and evaluation of *specific* EBPs in clinical practice, but perhaps capacity is developed through repeated use of the framework. This study asserts that, as described

in the literature on professional development in psychotherapy, this framework has innovative potential to support professional development of psychotherapy trainees by increasing the amount of positive experiences they have with implementing EBPs successfully during the initial training phases, given the realistic nuances that clinical practice presents. Perhaps the repeated use of GTO in Clinical Practice allows for the student-therapist to build capacity via these successful experiences in implementing EBPs (for theories related to building competence through clinical experience, see Jennings et al., 2003; Orlinsky & Rønnestad, 2005). This, in turn, would theoretically lead to the therapist engaging in more effective clinical practice and lead to more consistent positive client outcomes. The logic for how GTO in Clinical Practice might support the professional development in clinical practice is presented in Figure 1.1.

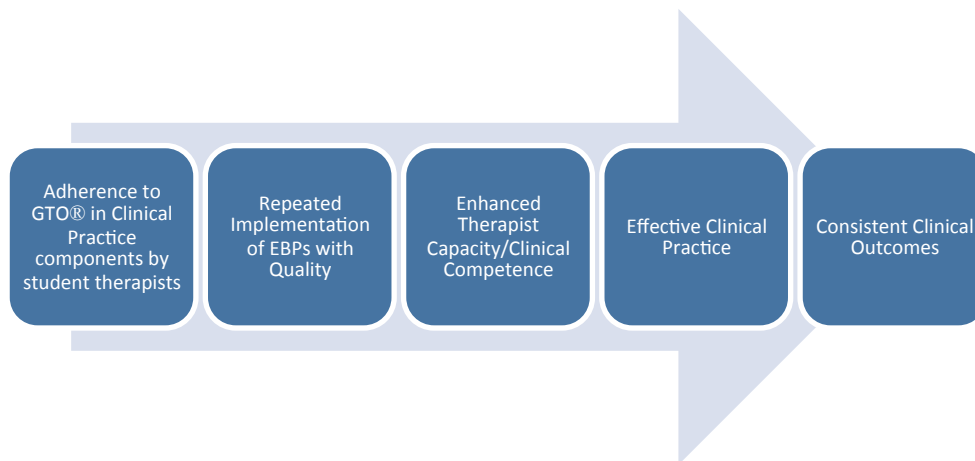


Figure 1.1: GTO in Clinical Practice Logic Model

There is currently a dearth of research on clinical decision-making processes (Kazdin, 2008). This study explores the GTO in Clinical Practice framework, a planning, implementation, and evaluation support tool. Although RCTs are considered the gold standard in clinical practice research and do inform professional training directly, it is essential to follow a programmatic process for building theory and knowledge (McGinty,

2002). These phases are often not linear, but iterative processes (Campbell, Fitzpatrick, Haines, & Kinmonth, 2000).

Studying complex interventions that are subject to more variations than a drug is a difficult task (Campbell et al., 2000). Complex system level interventions, such as GTO in Clinical Practice, are often defined and developed through the process of research and require intentional planning for implementation and appropriate evaluation phases. During the theoretical, or preclinical, phases, researchers are tasked with developing and refining theory that posits why the intervention might have the desired effect (Campbell et al., 2000). Although this phase often does not generate a study, building theory is essential to the first phase of research. This author claims to have done so via the preceding literature review and conceptual introduction of GTO in Clinical Practice.

In the first phase of research, the researcher must identify critical intervention components, often through qualitative case studies, preliminary surveys, and even focus groups (Campbell et al., 2000). This, essentially, defines the first draft of the intervention. These beginning stages are also used to inform potential barriers to implementation, taking a close look at the providers tasked with administering the intervention (Campbell et al., 2000; McGinty, 2002). The current study is dedicated to this phase of research, developing a system for measuring adherence to a model and exploring potential barriers to implementation. Only after the intervention is defined can the researcher begin to test the feasibility of the innovation.

The beginning phases of research are exploratory in nature, often exploring “use-inspired” questions (McGinty, 2002), e.g. “What do student-therapists *do* in treatment with their clients?” This, in turn, systematically develops a theoretical model of change

that can later be tested in small pilot studies. Supporting research in preliminary, exploratory stages is essential to developing good theory, solid interventions, and logical, resource-appropriate research designs that truly measure desired outcomes (Robey, 2004; Rogers, 2009). Although it might be premature to study outcomes related to GTO in Clinical Practice given its early phase of development, studying components of the proposed framework and attitudes around the innovation is feasible and appropriate. Describing interventions and methods utilized to measure fidelity are highly valuable and publishable contributions to research (Robey, 2004). Multiple levels of investigation in psychotherapy training are in order; an exploratory study in a single training site would be a valuable contribution to the literature (Boswell & Castonguay, 2007).

1.7 Adoption and Appraisal of an Innovation

Implementation is a process that is often undermined, often taking 3-5 years or longer (Hall & Hord, 2011; Hall, 2013). Purveyors sometimes rely on the utility of the innovation to speak for itself and work under the assumption that effective innovations will be adopted and implemented based on their merit alone. This is simply not the case (Rogers, 2003). Rogers (2003, p. 11) defines diffusion or dissemination as “the process by which (1) an *innovation* (2) is *communicated* through certain *channels* (3) *over time* (4) among the members of a *social system*.” Perceptions, actions, and appraisals of the front line personnel tasked with implementing the innovation change over time in dynamic ways (Hall, 2013). Depending on how “users” are resisting, appraising, and utilizing the innovation, different types of support can help the process of organizational adoption (Hall, 2013).

Attitudes toward innovations can dictate use versus non-use or trying versus not trying the new way of doing things (Aarons, 2004; Candel & Pennings, 1999; Frambach & Schillewaert, 2002; Rogers, 2003). One of the most important factors related to adoption of an innovation is the perceived attributes of it; most of the variance in the rate of adoption is explained by five attributes involving how the user feels about the innovation: *relative advantage*, *compatibility*, *complexity*, *trialability*, and *observability* (Rogers, 2003). This paper will hereafter refer to this construct as *innovation appraisal*, composed of the aforementioned five components. Relative advantage involves how the user feels the innovation in consideration outplays or exceeds previous practices. Compatibility is the degree to which an innovation is consistent with the user's existing values, experiences, and current needs. Complexity involves how difficult the innovation seems to use. Trialability is the extent to which an innovation can be tried out by the user on a limited basis. Observability is the degree to which the results of an innovation are visible.

1.8 Implementation and Adaptation

Dissemination and implementation efforts must consider the complexity of implementation in applied settings (Aarons, 2004). Although most change initiatives intend to create outcomes, often programs and innovations struggle to reach intended outcomes. Hall (2013) describes the process generally beginning with the identification of a problem, in this case the overarching acknowledgement that therapist activities are not necessarily systematic in psychology training centers. A desired outcome is then identified, e.g., improving student-therapist training and practice. Generally the innovation is launched through a particular ceremony, e.g. training on GTO in Clinical

Practice. Materials are delivered and then there is an assumption that the innovation has been adopted and institutionally accepted. However, oftentimes there is no difference between previous activities and the current activities that take place after the launch (Hallinger & Lee, 2011). Implementation is a process, not an event, and considering how users adopt and implement the innovation is essential to the process.

Adaptations can be part of the implementation process (Durlak & DuPre, 2008; Hall, 2013). Adaptations take place in order for the innovation to meet the need of the implementation context. Mutual adaptations can occur, where the context informs the innovation and the innovation development informs the implementation (Hall, 2013). Scaling up requires adaptations and an understanding of how users are “adhering” to the core components of an innovation (Hall, 2013).

Fidelity when implementing any innovation is not dichotomous in nature; indeed, the construct of fidelity is complex. Often users of an innovation will implement some components of an innovation with fidelity and vary in their implementation of other components. These variations should be an expectation when an innovation is being introduced, especially in early implementation phases. From Hall and Hord’s (2011) Concerns-Based Adoption Model system for implementation support, emerged the Innovation Configuration (IC) construct. All innovations have various components, and these components are all implemented with various levels of fidelity. Different users will produce various configurations of adherence, enacting the innovation in different ways. Thus, fidelity or adherence can be measured with an IC Map, a tool that acts as a rubric for implementation. The IC Map emerged from examining these real world applications of innovations where intended and unintended adaptations took place (Hall, 2013). This

measurement strategy allows measurement of adherence; the IC map also allows for the evaluator to get a sense of what adaptations are made in the implementation process, highlighting “shortcuts” that occur in everyday application of the innovation (Hall, 2013).

1.9 The Current Study

The literature presented thus far has introduced GTO in Clinical Practice as an innovation and discussed how innovation adherence and appraisal are involved in implementation processes. Given the early phase of investigating this innovation, this paper will focus on *innovation configuration* (or how the therapist enacts the innovation) and *appraisal* of GTO in Clinical Practice. The research questions are as follows:

1. How do student-therapists in a setting where GTO in Clinical Practice is being developed actually enact the innovation? What innovation configurations emerge?
2. How do student-therapists in this stage of development feel about GTO in Clinical Practice and how it affects their practice?
3. How might contextual factors (e.g. program enrollment, clinical experience, organizational context, e.g.) influence the student-therapist's experience with this innovation?

1.10 Positionality of the Principal Investigator

My position as principal investigator (PI) is unique because of my involvement with the innovation being investigated as well as my previous roles at the organization within which the innovation is being studied. First, I would like to acknowledge my vested interest in GTO in Clinical Practice. I have spearheaded the initiative to develop this innovation, adapt it to the setting, and integrate it into the organizational setting; therefore, I have contributed time, thought, and resources to promote its success.

However, I would also like to highlight that I am very interested in how this innovation is being enacted and perceived. Although invested, I do not claim that this innovation is flawless and comes without costs. For example, I have often wondered whether the use of GTO in Clinical Practice has iatrogenic costs; by focusing on the implementation of specific EBPs, are student-therapists apt to underemphasize non-specific best practices in psychology? My position and investment in this innovation is a curious and flexible one with an underlying assumption that GTO in Clinical Practice has, indeed, demonstrated utility in enhancing clinical training in this organization and therefore might have the potential to be useful on a larger scale in the mental health system.

My previous roles in the organization present a unique set of experiences through which I have come to understand the context and the need for GTO in Clinical Practice. I served as a Clinical Assistant for one year and was promoted to Associate Director for two years. I have also acted as a therapist in this setting, maintaining a small caseload of clients. In my role as Associate Director, I was positioned with a certain level of clout that allowed for me to integrate GTO in Clinical Practice into various programmatic channels through the development of policies, procedures, and training opportunities. All decisions were supervised, vetted, and approved by faculty and leadership. Due to my involvement with enhancing clinical training through this project, I was also promoted to Clinical Supervisor for my final year before internship. This opportunity allowed me to understand both the strengths and costs of using and promoting GTO in Clinical Practice, as I found myself invested in the overall professional development of my supervisees and understood that training in non-specific practices is crucial to that process. Further, my own professional development as a student-therapist allowed me an insider's perspective

in regards to the changes the introduction of this innovation presented to my workload and practice, the strengths as well as the burdens. This, in turn, gives me a unique internal systems change agent perspective, knowledge about the context as a research-participant, and also created unique ethical considerations in maintaining balance between my role as supervisor, evaluator, and PI during data collection and analyses.

CHAPTER 2

METHOD

2.1 Setting

The setting in which this innovation is being studied is a clinical training center for doctoral students in APA-accredited Clinical-Community Psychology and School Psychology programs at a university in the United States. The primary mission of the organization is to train students to provide evidence-based treatment with quality, and the secondary mission is to provide accessible mental health treatment to the community. Student-therapists receive training and supervision in therapy as well as assessment at the center. They also have access to extensive resources for clinical practice, including psychometric test kits and measures, reference books, treatment manuals, and video resources for psychotherapy training. Over the course of fiscal year 2013-2014 (the time of data collection), 50 student-therapists saw clients at the center and were supervised by 10 different supervisors. Treatment modalities include child and family therapy, adult therapy, couples therapy, and group therapy. Assessments are conducted by student-therapists and licensed faculty for developmental disabilities, psychoeducational evaluation, and psychosocial evaluation. Services are provided on a sliding scale and clients served tend to fall in the low-income range. Primary reasons for treatment and assessment range from sub-clinical adjustment to life stressors to serious and persistent mental health challenges. Given that both Clinical-Community and School Psychology graduate students receive clinical training at this center, general characteristics and

specific requirements for clinical training for each program are described below as presented in each program's respective website and student handbook for the data collection year.

Clinical-Community Program Characteristics. The Clinical-Community Psychology program emphasizes an understanding of how mental health and well-being function within environmental contexts by integrating clinical and community perspectives in psychology. The program embraces a Clinical Scientist training model, a derivative of the Boulder model that emphasizes a scientific epistemology in all clinical and scholarly activities (McFall, Treat, & Simons, 2015). Thus, the program underscores its significant research accomplishments and emphasizes that clinical practice should be grounded in empirical science.

The program was last accredited by APA in 2015. According to outcome data for the academic year of 2013-2014, students took an average of 7.7 years to complete the program including their internship year. Three out of the 5 students applying for internship in 2013-2014 obtained APA/Canadian Psychological Association (CPA)-accredited internships, one obtained an unaccredited paid internship, and one did not obtain an internship. Out of the 77 graduates from this program between 2005 and 2015, 45 (58%) became licensed psychologists, a substantial minority of students focusing on community practice and/or academic research post-graduation.

According to the 2015-2016 handbook, students in the Clinical-Community Psychology program are required to take two year-long sequences (4 semesters) of practica, including community practicum, adult practicum, and child/family practicum. Students are required to complete two years of either adult or child/family practicum, and

are allowed to enroll in the same practicum for multiple years to meet the requirement. They may not meet this requirement by only enrolling in community practicum for 2 years. Students are encouraged to complete practicum requirements in their 2nd and 3rd years in the program. In terms of assessment, students are required to complete a didactic course on assessment. An assessment practicum course is offered for advanced training for those students seeking this specialization, but is not required for graduation.

School Psychology Program Characteristics. The School Psychology doctoral program follows a scientist-practitioner model (i.e., the Boulder Model), emphasizing an iterative relationship between research and practice as well as high impact research. According to the program's mission, the School Psychology program aims to train students for careers in academia as well as practice in prevention, assessment, and intervention with an emphasis on interdisciplinary approaches to research and practice.

The program was last accredited by APA in 2015. In terms of outcome statistics from 2013-2014, students take an average of 5.51 years to complete the program. Two out of the four students that applied to internship in the 2013-2014 academic year went to an APA/CPA-accredited site, the remaining two successfully obtaining non-accredited paid internships.

In terms of clinical practicum requirements in the 2015-2016 academic year, the program encourages clinical practicum and creates opportunities for students to obtain this experience, but does not require it. They allow students to take clinical practicum in lieu of a required introductory course on psychosocial interventions. Generally, students are encouraged to take clinical practicum in their 2nd year (if meeting the requirement for the introductory to psychosocial interventions course) or their 4th year in the program.

Requirements around assessment practicum are more stringent, School Psychology students required to take 3 semesters of assessment practicum during their first and second years of training.

The Impetus for GTO in Clinical Practice. GTO in Clinical Practice is being developed and disseminated in this setting in response to an emergent need to make clinical training more consistent across practica and supervisors. Upon the hire of a new clinical director in January of 2013 and this author's promotion to Associate Director, the training clinic organized efforts to systematize the requirements for student-therapists and enhance the training model. GTO in Clinical Practice was developed and vetted by an implementation team as well as the organization's steering committee and leadership team. Generally, meetings and focus groups indicated that implementing a system such as this would be beneficial to the training program. The organization's clinical staff as well as an implementation team began supporting the development and adoption of GTO in Clinical Practice beginning in the Fall semester of 2013 through development, planning, training, technical assistance, and incorporating quality assurance mechanisms.

Several activities to support the development and dissemination of this innovation have taken place since the Fall semester of 2013. An introductory orientation to GTO in Clinical Practice was held in August of 2013 and a multi-modal training around applying GTO in Clinical Practice was held in September of 2014. Informational resources have been disseminated to staff, students, and faculty, such as checklists and informational resources for each step. GTO in Clinical Practice coaches were invited to attend practicum courses throughout the Spring semester in 2014 and provide 15-minute presentations on how to access resources related to specific steps. Later, coaching was

integrated into the overarching organization's staff responsibilities; clinical assistants were trained to provide tailored, responsive coaching in the Fall semester of 2014. Clinical assistants have also been tracking student-therapist activities to ensure that specific steps have been carried out (e.g., verifying that assessment reports and treatment plans are in place for each client) since August of 2013. The development, refinement, and implementation of GTO in Clinical Practice have occurred in an iterative fashion. As the framework has been introduced, feedback from the supervisors, student-therapists, and the organization's staff has been elicited; translation and implementation have occurred in parallel. This feedback, in turn, has informed the design and refinement of the innovation. The current study will provide rich insight into how this innovation is being enacted and perceived by the student-therapists.

2.2 Methodology

This study investigates the aforementioned research questions with a multiple case study analysis (for an example of similar methodological conventions, see Fernando, 2010). Because the questions are exploratory in nature and this dissertation is primarily an enactment of a sophisticated program evaluation, a multi-case study is appropriate (Stake, 2006). The phenomenon of interest in this study is essentially the student-therapist experience with GTO in Clinical Practice during an early phase of organizational adoption and frontline implementation, focusing primarily on how the student-therapist enacts and appraises the innovation. As such, the analysis must have enough depth to gain an understanding of the student's experience and behavior when "using" or "not using" GTO in Clinical Practice as well as their attitudes and understanding of the innovation. Indeed, this type of inquiry requires a certain level of

depth as well as enough breadth to gain an understanding of how the phenomenon functions across different contexts. Stake (2006) suggests that less than 3 cases do not show enough interactivity between situations and contexts, whereas over 10 cases provide too much uniqueness of interactivity than the readers can comprehend.

2.3 Participants

Participant-cases in this study include 7 student-therapist participants recruited from the clinical training center. Participants were recruited between December 2014 and March of 2015 via email invitation, verbal invitation, and brief recruitment talks during certain courses held on site at the clinic. At the time of recruitment, 35 students-therapists were seeing clients at the center. Of these students, 26 were enrolled in child-family practicum and 11 were enrolled in adult practicum. The population was composed of 11 School Psychology graduate students and 24 Clinical-Community Psychology graduate students. Participants received a \$10 gift card for Amazon.com® for participating in the study, and were informed that they would still receive this gift card even if they refused to participate after beginning the interview. Cases were selected based on the following guidelines posed by Stake (2006) in his multiple case study approach:

- Is the case relevant to the phenomenon that the researcher is attempting to understand (i.e. the activities and perceptions related to GTO in Clinical Practice)?
- Do the cases provide diversity across contexts (e.g. training experience, program enrollment, professional interests, etc.)?
- Do the cases provide good opportunities to learn about complexity and contexts?

(p. 23, questions slightly adapted and qualifiers added)

Demographics. Participants included 5 female graduate students and 2 male graduate students. For the purpose of maintaining confidentiality, race and age of the participants were not recorded during data collection and gender was de-identified for case reports. Program enrollment and level training of the participants included 2 students from the School Psychology program and 5 students from the Clinical-Community Psychology programs, ranging from 2 to over 5 years of enrollment in their respective programs. Participants ranged from .5-4 years of experience in clinical practice at the training center and 2-6 years of overall clinical experience.

Case Selection. This study follows the methodology presented in Robert Stake's (2006) text, *Multiple-Case Study Analysis*. For the sake of quality in analysis, interpretation, and data presentation, the current study explored 7 cases via a multiple case study analysis (Stake, 2006). Although this interferes with generalizability, this study does not claim that the findings can be generalized outside of this given context of each case. This study will allow for a richer understanding of how this innovation is enacted and appraised by different student-therapists influenced by various contextual factors. This level of depth allows the researcher to understand and display how the innovation functions and is influenced by these contexts, rather than ignoring contextual factors altogether. Each student functions in a different context, affected by factors related to her/his cohort, program, school of thought, supervisor, etc. Studying this phenomenon across these case-specific contexts is valuable to understanding the program more fully. As such, students were sampled across the following variables in Table 2.1.

Table 2.1

Important Participant Sampling Variables

<i>Program</i>	<i>Cohort*</i>	<i>Years of Experience**</i>	<i>Focus</i>
Clinical-Community (CC)	Early	< 1	Adult
School (Sch)	Advanced	≥ 1	Child

*Defined by Years of Experience

**Years of Experience is defined by years of enrollment in adult and/or child practicum

The following participants (see Table 2.2) were purposively sampled in an attempt to represent characteristics of the practicing clinicians within the setting and to capture a variety of influential contextual factors (i.e., clinical focus, exposure to the innovation within sequence of training, program enrollment, and level of training):

Table 2.2

Case Selection Matrix

Variable	Sample						
<i>Program</i>	CC	CC	CC	CC	Sch	Sch	CC
<i>Cohort</i>	Early	Advanced	Early	Advanced	Early	Advanced	Internship*
<i>Focus</i>	Child	Child	Adult	Adult	Child	Child	Adult

*Students on internship is “Advanced” but will offer a unique perspective outside of the organization

2.4 Measures

Innovation Configuration Map. The GTO in Clinical Practice IC Map was developed in adherence to Gene Hall and colleagues’ guidelines (Hall, 2013; Hall & Hord, 2011). The IC Map manual was referenced (Hord, Stieglebauer, Hall, & George, 2006) and Gene Hall acted as a key informant and advisor on the development and revision process of the GTO in Clinical Practice IC Map.

The IC Map is comprised of *components*, and each component is operationalized into *variations* of behaviors that demonstrate various levels of adherence to the innovation’s core components. These variations are displayed as word pictures from left-to-right, ranging from A (high adherence) to E (low adherence), ranging from the ideal

versus unacceptable behavior that would be displayed during implementation of GTO in Clinical Practice (See Appendix B). The IC Map essentially acts as a rubric for implementation of GTO in Clinical Practice.

The developers of the innovation were interviewed and tasked with drafting and revising the IC Map. The initial draft was informed by the initial GTO in Clinical Practice accountability questions. The developers of GTO in Clinical Practice as well as developers of the original GTO framework were consulted and engaged in the drafting process. Interviews were conducted with student-therapists as well as supervisors to inform different behavioral variations for each component. This was an iterative process, each draft informed by key informants, interviews, document reviews, and suggestions made by Gene Hall.

Interview. The purpose of this interview protocol (see Appendix C) was to gain understanding of how students are knowingly or unknowingly adhering to the 10 steps of GTO in Clinical Practice and gain an understanding of how they feel the innovation affects their practice. The responses to the interview were ultimately used to (1) inform student-therapist Innovation Configurations (IC) in GTO in Clinical Practice and (2) gain an understanding of student-therapists' appraisal of GTO in Clinical Practice as an innovation. All items inquiring about innovation appraisal were developed based upon Rogers' (2003) theory on perceived attributes of innovations and/or adapted from Aarons' (2004) Evidence-Based Practice Attitude Scale.

The interview was piloted three times for clarity, wording, and to explore whether the inquiries elicited responses that allowed for the IC Map to be scored. Pilot subjects included one novice and one advanced student within the GTO lab as well as one

advanced therapist practicing outside of the development and dissemination context who was not aware of the existence of GTO in Clinical Practice. Upon the third pilot of the interview protocol, the interview seemed to consistently retrieve information related to the components of the IC Map. Responses to the interviews were also used to revise the IC Map, discussed in the preceding section.

Interviews were conducted privately at the training clinic. Written consent was acquired by all participants. Interviews were transcribed by the PI and four undergraduate research assistants for the study. Transcripts were then uploaded into NVivo 10 for Mac.

Document Review. During the interview, participants were asked for permission to review specific client records: written assessment reports, treatment plans, case notes, and client records with the understanding that all Private Health Information (PHI) would be redacted prior to data collection. Further, participants were asked if their personal folders (both physical and electronic) could be reviewed by the PI on site at the training center with the understanding that no PHI would be recorded. Standardized supervisor rating forms that include Likert-scale ratings on clinical competence components as well as sections designated for written feedback to the student on each component were requested from each participant. Some participants provided copies whereas others gave consent to the PI to request these records from previous supervisors. Every participant consented to all documents being retrieved for the study. All records were utilized to triangulate therapist behavior for the purpose of completing the IC Map accurately.

The director of the clinic as well as the director of clinical training provided written authorization to release data to the PI. Client records were de-identified according to HIPAA guidelines by the PI and clinic-staff research assistants. These clinic-staff

research assistants were trained in de-identification and signed forms stating they were aware of both guidelines around client confidentiality as well as confidentiality of the research participants. Student evaluations were released to the PI without the clinical director or supervisors' knowledge of the identity of the participants.

The current study's proposal and detailed application were submitted to the University of South Carolina's Institutional Review Board (IRB) and the study was deemed not subject to the Protection of Human Subject Regulations and no further oversight by the IRB was required.

2.5 Procedure

Each participant was interviewed one-two times and consented for the PI to access supervisor evaluations, assessment reports, treatment plans, case notes, and other client records per availability. All client-level mini-cases were included if (1) the cases had been seen by the student-therapist during or after the roll-out of GTO in Clinical Practice and (2) if all therapists seeing the case during clinical interactions with the student-therapist case (e.g., if the case had also been seen by a co-therapist) also consented to the files being de-identified and incorporated into the analyses. Client case files that were not relevant to the specific student-therapist case being studied (e.g., case records associated with a previous or subsequent therapists) were excluded from analyses. The only exception to the first condition was the intern case; client cases seen before dissemination of the innovation were also included for analysis in this particular case for the purpose of providing unique contextual data.

Students supervised by the this author (i.e., the PI) were given the option to be interviewed by alternative lab members and also allowed to request that further data

collection and analyses for these cases pause until after they were no longer under the PI's supervision. One participant requested another interviewer and was interviewed by lab member Katie Knies. Interviews were transcribed and field notes were written throughout the collection and analysis. All data were organized and analyzed in NVivo 10 for Mac.

2.6 Data Analysis

Data were analyzed using NVivo and Robert Stake's (2006) step-wise analytic process for performing a multiple case study analysis (see Appendix D for description of worksheets). See Figure 2.1 for a template utilized to guide data collection and Figure 3.1 (described and displayed in the proceeding chapter) for a worksheet that guided a priori thematic analyses. Prior to cross-case analyses, all documents for each case were coded and analyzed using NVivo according to a priori themes associated with specific IC Map Components, aforementioned attributes associated with innovation appraisal (i.e., relative advantage, compatibility, complexity, trialability, and observability), and a broad theme for contextual factors. These codes and sub-codes were modified to fit emergent themes that arose from the data during analysis but the broad categories of *Innovation Configurations*, *Attitudes About the Innovation*, and *Participant Context* remained throughout the analysis. Case notes were reviewed until saturation occurred (Seale, 1999), i.e. no new codes emerged from the data source. The analyst then reviewed middle and last notes. If new codes emerged, notes were re-reviewed for new codes. Additionally, updated treatment plans were not re-coded if new codes did not emerge, as most of the findings were redundant; although, this author reviewed all treatment plans

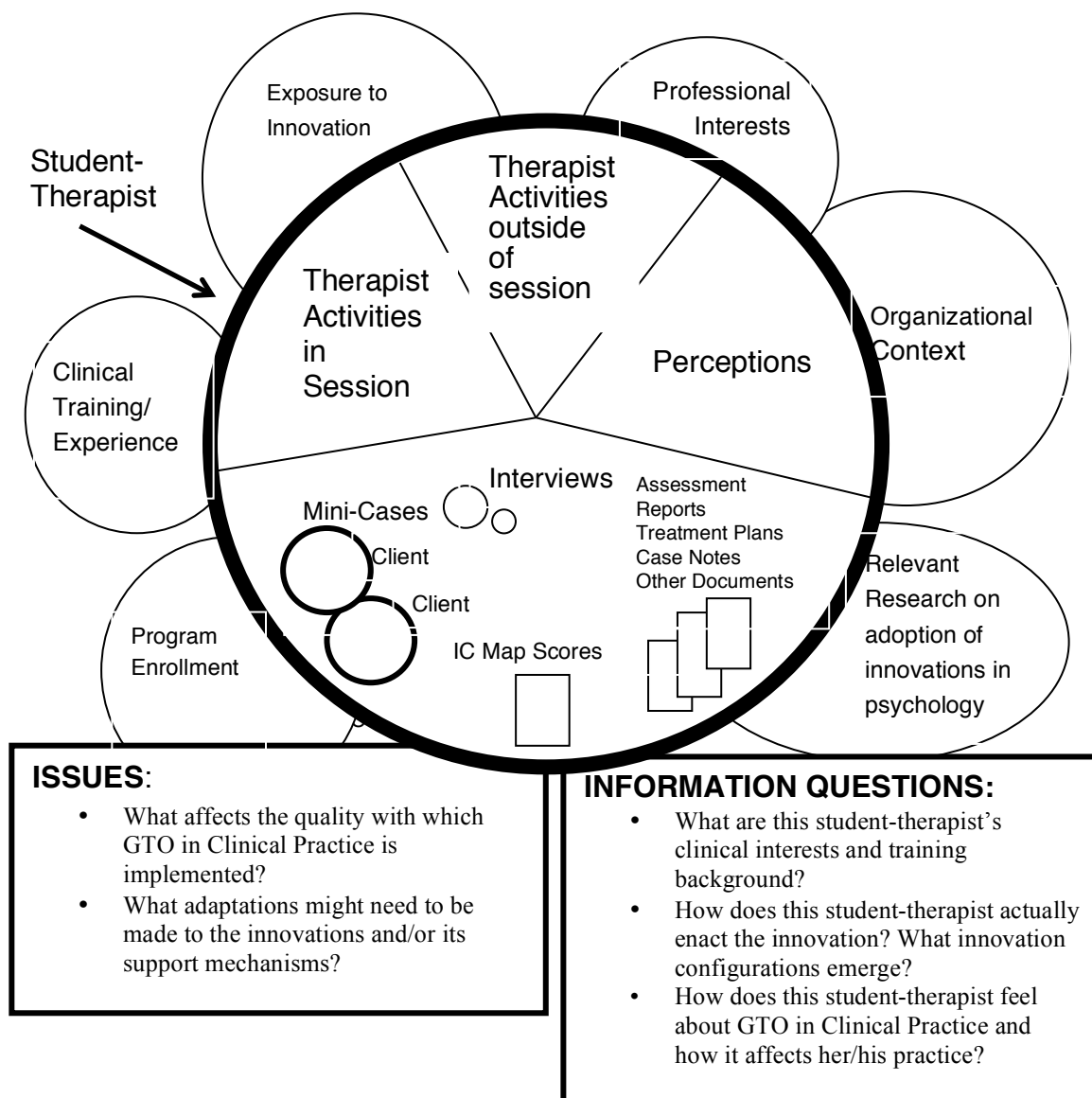


Figure 2.1. Worksheet 1: Graphic Design of a Case Study

fully. Case notes and treatment plans were the only sources of data in which this method of saturation was utilized given the large amount of repetitive data.

After coding within NVivo was finalized for each case, the PI sorted all relevant codes to the IC Map scores within an excel spreadsheet and systematically organized findings for the purpose of score assignment. Data sources, findings, and data source triangulation were noted within this table. See Appendix E for an example of one of these

analytic tables. Scores assigned according to this analytic process were then graphed into graphical presentation of participants' IC Map profiles. All findings were organized within each individual case report. "Gender" was randomly assigned to all case reports by using Google TM Coin Flip (heads: female, tails: male) to enhance confidentiality of participants within the study but to maintain readability of the reports. Findings related to attitudes about the innovation were systematically analyzed within NVivo and reported in each individual case report.

Follow-up interviews were conducted with 6 of the 7 participants, one participant refusing to participate due to time demands of the interview. The purpose of the follow-up interviews were to (1) verify findings with the participant and resolve any discrepancies (Miles & Huberman, 1994) and (2) to ensure the participant felt they had not been inadvertently identified by the quotations and findings reported within each case report. Notes were taken during the follow-up interviews and incorporated into final analyses. Minor discrepancies were resolved and quotations that the participants believed might be identifying were removed or modified with redactions. No major discrepancies were identified within these phone calls. This credibility check procedure, as perceived by this author, enhanced the credibility of the findings by shedding light on areas that were unable to be understood without follow-up inquiry. Several participants described the process as interesting, stating that the feedback was helpful to their clinical work.

Following development of preliminary case reports and follow-up interviews, the PI then engaged in a reliability check by auditing interview transcripts and follow-up interview notes for findings that clarified innovation configurations as well as additional themes related to attitudes about the innovation and contextual factors (e.g., program

influences, level of training, etc.) that influenced the use and/or attitudes about the innovation (for example of similar qualitative data auditing convention, see Kloos et al., 2005). The PI took this opportunity to re-evaluate any innovation configurations and check any findings that had been noted to be questionable by this author during analyses. The culmination of these findings was then incorporated into finalized individual participant case reports. A total of 7 case reports were created with this process. See Appendix F for an example of one of these case reports.

After each case report was finalized with the aforementioned dependability and credibility check processes, the PI (this author; also referred to as “analyst” in subsequent worksheets) utilized Stake’s (2006) Worksheets 3-5 to determine themes and assertions for the final case report, which the reader will find within the Results section of this paper. Thus, the this author participated in multiple activities, acting as PI and analyst, during the course of this study:

1. Conducting interviews and collecting data.
2. Overseeing research assistants during data collection.
3. Conducting individual case studies.
4. Conducting within-case analyses, and creating individual case study reports.
5. Conducting cross-case analyses to make assertions about the findings, and outlining these findings in the final report.

Multiple Case Study Analysis Worksheets. Stake’s analytic worksheets are intended to help the analyst organize in-depth individual case studies in a way that allows for cross-comparisons and assertions about the entire study in the final report. This process allows the analyst to draw relationships between granular themes that relate to

the overall understanding of the innovation across the various case-level contexts. The purpose of the multiple case study analysis is to view each case within its own context, highlighting how the innovation operates across contexts. The worksheets described in Appendix D allow for the researcher to organize findings for a cross-case analysis (Fernando, 2010).

CHAPTER 3

RESULTS

Individual case reports were produced for each participant (for an example, see Appendix F) according to the aforementioned procedures. Each case report described IC Map profiles, findings associated with a priori themes described in Worksheet 2 (see Figure 3.1), as well as any emergent findings relevant to the research questions. Worksheet 2 served as a guiding lens for the analyses, always within reach of the PI/Analyst (i.e., this author) for analytic decision-making processes.

Worksheet 2. The Research Questions or Themes of the Multi-case study
<i>Theme 1:</i> How do students enact GTO in Clinical Practice as measured by the IC Map?
<i>Theme 2:</i> How do student-therapists perceive the relative advantage of GTO in Clinical Practice versus other ways of structuring therapy?
<i>Theme 3:</i> How do student-therapists perceive GTO in Clinical Practice to be compatible with their needs, beliefs, and values?
<i>Theme 4:</i> How complex do student therapists perceive GTO in Clinical Practice to be?
<i>Theme 5:</i> How have student-therapists felt they could try out using GTO in Clinical Practice?
<i>Theme 6:</i> How visible are the results of using the innovation?
<i>Theme 7:</i> How do contextual factors seem to impact the student-therapist's understanding of the innovation?

Figure 3.1. Worksheet 2: Themes of the Multi-case Study

Worksheet 3 was utilized to further engage in case-level data reduction process, guiding the author in synthesizing and generating findings within each case. See Figures 3.2-3.8 to review the findings from these completed worksheets for all seven participants.

Worksheet 4 (see Figure 3.9) was then utilized to determine the uniqueness of each case and the prominence of themes within each case study, this author reflecting upon impressions while developing case reports as well as the relevance and uniqueness sections of Worksheet 3 to systematically inform that decision process. Uniqueness was noted in the first row, “U” indicating a highly unusual case and “u” indicating a somewhat unusual case. For example, Participant 2 was noted to be highly unique given that the case was an intern during the time of interview. Prominence of each theme was noted in the proceeding rows, “M” indicating high manifestation of that theme within the given case, “m” indicating the presence of the theme, and an empty box indicating low relevance to the theme for that given case. This worksheet is utilized to determine the weight of various findings during cross-case analyses.

Findings from each case synopsis were then listed in one document with the Participant number attached to each finding. For example, one finding listed included: “P02: I. As an advanced student, the participant does not value the system because she describes having her own system.” Each finding was cut into “findings strips” which were then spread across a large surface. Findings were spatially sorted according to relevance to one another and sorted sequentially in accordance to the importance and relevance to understanding the program/phenomenon. This was a thoughtful process that involved sorting and pondering, this author able to spatially sort and place themes closer and further from one another to begin drawing meaningful connections. Mismatched or

Worksheet 3: Analyst's Notes While Reading Case Report Case ID: Participant 1 (P01)	
<p>Synopsis of case: P01 is a 2nd-year Clinical-Community Psychology doctoral student with a child and family focus. He has had a total of 3 years of clinical experience with less than 1 year at the training clinic. He tends to focus on adolescents and has previous and current experience in external settings, including settings that he describes as lacking structure. Total mean for IC Map was B and mode was A. Participant demonstrates strengths in exploring best practices and weaknesses in process evaluation. Overall, P01 seems to value the innovation for providing structure and holding himself accountable, but desires more innovation-specific capacity to carry out the innovation with fidelity. Generally, this innovation seems compatible with his perception of good practice. He describes the innovation as time-intensive and also describes feeling ill-equipped to use the innovation with fidelity. He describes having been able to try out the innovation in his perception. He is not able to pinpoint observable benefits because he can not necessarily pinpoint when he is using versus not using the innovation. The nature of his case load is the main contextual factor discussed. He mentions also the implementation context, emphasizing resources available at the training clinic and describing treatment plans being a "formality" in other settings. A need for more training and support to use GTO in CP was emphasized.</p>	<p>Case Findings: I. The participant seems to use the treatment plan to plan for outcome evaluation or just to complete requirements. Outcome evaluation plan is interesting, but without using a plan for treatment, process evaluation is nearly impossible. II. The participant finds it more difficult to follow through with GTO in CP steps with more complex case. III. In external settings, some of the steps are formalities, i.e., treatment planning. IV. The participant is unable to note when "using" the innovation as though the implicit ideology of the framework is more salient than the actual steps. V. Unable to remember steps. VI. The participant emphasizes the importance of getting more training in order to effectively implement GTO in CP. VII. Participant describes believing that this is what he would have already done. VIII. The participant values the innovation for structure and accountability.</p>
<p>Uniqueness of case situation for program/phenomenon: Previous experience in "unstructured" settings, preferences for more training.</p>	
<p>Relevance of case for cross-case Themes: Theme 1: H, Theme 2: M, Theme 3: M, Theme 4: H, Theme 5: M Theme 6: H, Theme 7: H</p>	<p>Possible excerpts for cross-case report: Page: 4, Complexity Page: 4, Relative Advantage Page: 4, Compatibility Page: 3, Relative Advantage (what I would have done) Page 5: relative advantage Page 5: case complexity</p>
<p>Commentary: The main take-away I pull from this case is the repeated request for more training while discussing the value of the innovation.</p>	

Figure 3.2. Worksheet 3: Analyst's Notes While Reading Case Report for Participant 1

Worksheet 3: Analyst's Notes While Reading Case Report Case ID: Participant 2 (P02)	
<p>Synopsis of case: P02 is a Clinical-Community Psychology intern and provides contextual information. She attended both orientations. Further, her level of training at the time she was introduced to GTO in CP is unique. Notably, she is and acknowledges being largely non-adherent to GTO in CP, with an average of C and a mode of E for her IC Map scores. She scored lowest on process evaluation and highest on fit and CQI. Interestingly, her scores seem to be impacted by the timeline of implementation, the only client seen after trainings having higher scores especially relevant to Steps 1 and 8. The salience of the interview is neutral-negative, the participant seemingly annoyed with the innovation due to “being told what to do” and extra “paper work.” She mentions that the innovation is consistent with her values, specifically mentioning some program evaluation concepts.</p>	<p>Case Findings: I. As an advanced student, the participant does not value the system because she describes having her own system. II. Plans are largely considered a formality. Generally, the participant described GTO in CP as added “paper work” III. Participant describes thinking this is what people should already be doing. IV. The participant denied using the innovation “very much” V. Unable to remember steps. VI. The participant seems to have an aversion to the labeling of the innovation as well as being “told what to do.” VII. The implementation context has a large impact on utilization, being on internship impacting use of treatment plans, for example. VIII. Participant increased adherence after rollout of innovation, specifically mentioning an impact on assessment and a marked difference in outcome evaluation.</p>
<p>Uniqueness of case situation for program/phenomenon: on internship, non-adherent, cases pre-GTO in CP roll out, non-use</p>	
<p>Relevance of case for cross-case Themes: Theme 1: H, Theme 2: H, Theme 3: H, Theme 4: H, Theme 5: L Theme 6: L, Theme 7: H</p>	<p>Possible excerpts for cross-case report: Page: 4-5, Relative Advantage Page: 5, all stuff should be doing Page:5, prog eval exposure Page: 5, already had a system Page 5-6: non-use Page 6: paper work Page 6-7, implementation context Page: 7, resistant quotes</p>
<p>Commentary: The main take-away I pull from this case is the negative salience toward the innovation. Also, despite this attitude, the roll out of the innovation did seem to have an impact on how the therapist conducted therapy and continues to do so (See comment about ORS).</p>	

Figure 3.3. Worksheet 3: Analyst's Notes While Reading Case Report for Participant 2

Worksheet 3: Analyst's Notes While Reading Case Report Case ID: Participant 3 (P03)	
<p>Synopsis of case:</p> <p>Participant is a 2nd-year Clinical-Community Psychology student with a focus on adults and previous clinical experience. She has experience in external settings, including residential settings, homeless services, and inpatient programs. Her previous expertise were in psychoanalytic framework and she now utilizes 2nd and 3rd wave CBT approaches. Largely, she averaged a B score on the IC Map across clients and the mode was A. She exhibited highest scores for exploring best practices and outcome evaluation. Her lowest scores were associated with process evaluation. She tended to perform assessment in a progressive and reciprocal fashion, continuing to assess as different aspects emerged. She described ambivalence about the innovation, valuing the framework ideologically, but also curious about the value of autonomy as a therapist.</p>	<p>Case Findings:</p> <p>I. Lack of clarity on goal-setting seemed to impact treatment planning and process evaluation.</p> <p>II. Emphasizes flexibility in the innovation for the purpose of nurturing alliance.</p> <p>III. Therapist wonders whether some of the steps would be naturally occurring without the framework.</p> <p>IV. Therapist wonders about consolidating steps to simplify the framework</p> <p>V. Ambivalent about the value of accountability versus value of autonomy.</p>
<p>Uniqueness of case situation for program/phenomenon: psychoanalytic orientation, ambivalence about the innovation</p>	<p>VI. She describes a need for more training in order to fully implement the model.</p> <p>VII. She describes a negative salience impacting the training.</p> <p>VIII. The participant weaved treatment plans and assessments throughout the therapy process in a fluid way.</p> <p>IX. Could not remember the steps.</p>
<p>Relevance of case for cross-case Themes: Theme 1: H, Theme 2: H, Theme 3: H, Theme 4: H, Theme 5: M Theme 6: M, Theme 7: L</p>	<p>Possible excerpts for cross-case report: Page: 4-5, ambivalence Page: 5, complexity Page: 6, contextual</p>
<p>Commentary: The largest take-away from this case report was the ambivalence expressed. She was outwardly ambivalent in her report and seemed to follow the steps in a strange fashion. Treatment plans were weaved throughout notes and assessments were done throughout therapy. Outcome evaluation was interesting because she questioned the validity of ORS, but wrote in detail about findings of the ORS in her notes.</p>	

Figure 3.4. Worksheet 3: Analyst's Notes While Reading Case Report for Participant 3

Worksheet 3: Analyst's Notes While Reading Case Report Case ID: Participant 4 (P04)	
<p>Synopsis of case: Participant is a 3rd year Child/Family focused Clinical-community psych student with external experiences in health settings. Largely, he is adherent, scoring a mean of B and mode of A on his IC Map scores across cases. He had particular strengths in assessment, goal-setting, exploring best practices, assessing fit, and outcome evaluation. Low scores were associated with planning for sustainability. He had a tendency to utilize EB protocols in therapy. The participant was self-aware, acknowledging strengths and weaknesses in using GTO in CP. He values the innovation, but acknowledges that with being more "purposeful" comes more work. He inquires about eliminating or consolidating steps in order to internalize steps, and acknowledges an inability to remember all of the step upon follow-up. He describes needing different types of support in more advanced stages. He also mentions the importance of considering how this framework would be applied in fast-paced settings where the clinician sees the client once or twice.</p>	<p>Case Findings: I. This participant believes that the innovation will help him be a stronger clinician and more marketable. II. Describes GTO in CP as an "ideal" way to function. III. Participant describes goals/plans changing, like moving targets and struggling with this process. IV. He describes the innovation as cumbersome and mentions a need to consolidate steps. V. Cannot remember steps VI. Desires a checklist to support innovation use. VII. Has noticed being more accountable since beginning to use this innovation.</p>
<p>Uniqueness of case situation for program/phenomenon: exposure to fast-paced settings, value of the innovation</p>	<p>VIII. He describes a need to consider how this innovation would be used in short-term treatment, fast-paced settings.</p>
<p>Relevance of case for cross-case Themes: Theme 1: H, Theme 2: H, Theme 3: H, Theme 4: H, Theme 5: M Theme 6: H, Theme 7: H</p>	<p>Possible excerpts for cross-case report: Page: 4, relative advantage (marketable) Page: 5, "ideal sense of self," "married" Page: 5, "so many steps" Page: 6, "burdensome" Page 6: context, fast-paced</p>
<p>Commentary: This participant was very enthusiastic about the innovation and its ability to force the therapist to be accountable. He emphasized the difficulty with internalizing the steps in the throes of clinical work. Further, he posed interesting questions about how the innovation could be adapted to fast-paced contexts.</p>	

Figure 3.5. Worksheet 3: Analyst's Notes While Reading Case Report for Participant 4

Worksheet 3: Analyst's Notes While Reading Case Report Case ID: Participant 5 (P05)	
<p>Synopsis of case: Participant is an advanced student enrolled in the Clinical-Community Program with an emphasis in individual adult therapy. She has seen multiple clients in the program development setting and has had multiple clinical experiences in external placements. Her adherence to the innovation is relatively high, scoring mean of B on the IC Maps across clients with a mode of A. High scores were associated with exploring best practices and assessing fit. Lower scores were associated with sustaining treatment gains. The participant's attitude about the innovation largely had a positive salience, seeming to believe that the more she has "used" GTO in CP, the more comfortable she has become with the innovation. She particularly values the beginning steps and values the flexibility of the innovation. She does mention this notion that the innovation seems redundant in some ways; "It seems like we're already doing a lot of this stuff." She also acknowledges the added benefit of the innovation. She also reacts to the labeling of the innovation to some extent. She describes the innovation as "face valid" and consistent with her "client-centered" approach to therapy. She describes the use of the innovation abstractly rather than explicitly following steps. She describes that the innovation might not be appropriate with high-risk clinical situations (e.g. suicidality or acute substance use).</p>	<p>Case Findings: I. Participant values the innovation and claims to "use" the innovation in an abstract way rather than step-by-step II. She finds utility in the earlier steps. III. Participant highlights the benefit of using/practicing GTO in CP to see the benefits IV. Participant uses color-coding system with her treatment plan to plan for CQI V. Cannot remember steps VI. Participant describes being unable to use the innovation in clinical crisis situations VII. Negative reaction to the labeling of the innovation VIII. Believes flexibility is essential to the innovation working well. IX. Participant describes a need for more maintenance of the training provided at the beginning of the year for GTO in CP.</p>
<p>Uniqueness of case situation for program/phenomenon: high number of cases, exposure to both trainings, external settings exposure, use of innovation</p>	
<p>Relevance of case for cross-case Themes: Theme 1: H, Theme 2: H, Theme 3: H, Theme 4: M, Theme 5: M, Theme 6: H, Theme 7: M</p>	<p>Possible excerpts for cross-case report: Page: 5, relative advantage Page: 5, compatibility Page: 6, innovation support Page: 6, observability</p>
<p>Commentary: This participant has high adherence and positive attitudes about the innovation. She does, however, speak to embracing the model abstractly rather than step-by-step.</p>	

Figure 3.6. Worksheet 3: Analyst's Notes While Reading Case Report for Participant 5

Worksheet 3: Analyst's Notes While Reading Case Report Case ID: Participant 6 (P06)	
<p>Synopsis of case: This participant is a 3rd year, advanced School Psychology student with a professional goal to work in schools. His clinical focus is on young children and he has had experience in external settings, including schools and a homeless shelter. He is tenuously adherent to the steps, scoring an overall mean of C on the IC Map and a mode of C. The participant's behaviors in relation to clinical work highlight the flexibility in the assessment and inquiry process, as he was able to collect data on multiple dimensions without a formal assessment process. Further, this participant demonstrates that building capacity and exploring evidence-based practices seems to occur simultaneously through the use of PracticeWise. He also emphasizes behavioral strategies, which he describes as applicable to many cases and "ingrained" in his classes. Superficially, the participant describes valuing the innovation but also speaks to how GTO in CP's longer format might be less relevant to a school psychologist trainee and describes many of the steps as "paper work," describing an aversion to documentation overall. He compares the innovation to a "consultation framework" taught in School Psych program. He emphasizes the importance of not rigidly following steps. He admits he cannot remember the steps and wonders if there are "too many steps." He describes needing more "practice" with the innovation and expresses a desire for supervisors to hold therapists accountable for using the framework. He describes "use" abstractly as opposed to explicitly following steps. Contextually, the therapist describes that his level of experience at the time of trainings was ideal. He also describes supervision in Child/Fam stretched thin during his time of enrollment in practicum.</p>	<p>Case Findings: I. Framework might be less relevant to School Psych students due to brevity of clinical interactions. II. The steps are viewed as "paper work" III. There are too many steps. IV. The framework might be similar to a consultation framework taught in School Psych. V. Cannot remember steps VI. Therapist desires supervisors to be more involved with innovation support. VII. The IC related to step 1 is interesting given that clinical interview was not necessary for relevant conceptualizations. VIII. Seemed to build capacity while exploring best practices through use of PracticeWise. IX. Flexibility is important. X. Use of the innovation is abstract rather than explicit step-by-step. XI. Desire for supervisors to hold therapists accountable for steps.</p>
<p>Uniqueness of case situation for program/phenomenon: school psych, less clinically oriented</p>	
<p>Relevance of case for cross-case Themes: Theme 1: H, Theme 2: M, Theme 3: H, Theme 4: M, Theme 5: L, Theme 6: L, Theme 7: H</p>	<p>Possible excerpts for cross-case report: Page: 1, IC Page: 4, Aren't we supposed to do this Page: 4, less relevant to School Page: 4, too many steps Page: 5, context</p>
<p>Commentary: This participant seems a bit ambivalent, superficially describing benefit of the innovation, but also describing it as lengthy and overwhelming. He attributes this partially to his program enrollment.</p>	

Figure 3.7. Worksheet 3: Analyst's Notes While Reading Case Report for Participant 6

Worksheet 3: Analyst's Notes While Reading Case Report Case ID: Participant 7 (P07)	
<p>Synopsis of case: Participant is 2nd year School Psychology student with less than one year of experience at the training clinic. Interestingly, however, this participant has approximately 4 years of clinical experience due to external experiences. The participant is very interested in a clinical role in his career. He was largely adherent to the model, scoring an overall mean of B and mode of A across cases on the IC Map. He has higher scores on assessment and exploring best practices. Lower scores are associated with assessing capacity, process evaluation, and planning for sustainability. Interestingly, this participant's analysis highlights the discrepancy of collaboration with child/fam clients versus adults. Further, he acknowledges difficulty with setting concrete goals with clients with emotional disturbance rather than disabilities or behavioral problems, but noted he had improved upon this in follow-up. The participant expresses positive attitudes about the innovation overall. He describes the model as consistent with the data-driven, evidenced based themes in his program as well as his own needs. He did, however, acknowledge a need for more support in using the innovation, not being able to remember all of the steps, and suggested consolidating the steps if possible. He described his use as "fluid" rather than step-by-step. He does acknowledge adherence to the model is impacted by the clinical setting, some external settings, e.g., the homeless shelter, making it difficult to follow the model and others, i.e., a residential program, making it easier. He also acknowledges different cases calling for different levels of complexity for some steps. Previous training, he states, impacted his value of being systematic and data-driven.</p>	<p>Case Findings: I. There may be discrepancies in terms of the utility of collaborating on goal-setting and evaluation with child/fam versus adult cases. II. The use of the model is "fluid" rather than explicitly step-by-step III. This participant had very high regard for the innovation IV. Need for support to use the innovation more effectively. V. Cannot remember steps. VI. Contextual factors, including setting and previous experiences, impact ability to utilize the model. Therapist mentions some settings that are more/less conducive. VII. Previous training in behavioral therapy contributed to value of data-driven decision-making.</p>
<p>Uniqueness of case situation for program/phenomenon: external experiences, previous training, value of the innovation</p>	
<p>Relevance of case for cross-case Themes: Theme 1: H, Theme 2: H, Theme 3: H, Theme 4: H, Theme 5: M, Theme 6: H, Theme 7: H</p>	<p>Possible excerpts for cross-case report: Page: 1, IC Page: 3-4, relative advantage Page: 4-5 compatibility Page 5, complexity Page 5, trialability Page 6-7, context</p>
<p>Commentary: This participant seemed both adherent and supportive of the innovation. His values and previous clinical experiences seemed to impact this.</p>	

Figure 3.8. Worksheet 3: Analyst's Notes While Reading Case Report for Participant 7

**Worksheet 4. Estimates of Ordinariness of the Situation of Each Case and
Estimates of Manifestation of Multicase Themes in Each Case**

U = highly unusual situation, u = somewhat unusual situation, blank = ordinary situation

M = high manifestation, m = some manifestation, blank = almost no manifestation

	P01	P02	P03	P04	P05	P06	P07
Ordinariness of this Case's situation:		U	u		u		u
Original Multicase Themes							
Theme 1 Innovation Configuration	M	M	M	M	M	M	M
Theme 2 Relative Advantage	m	M	M	M	M	m	M
Theme 3 Compatibility	m	M	M	M	M	M	M
Theme 4 Complexity	M	M	M	M	M	m	M
Theme 5 Triability	m		m	m	m		m
Theme 6 Observability	M		m	M	M		M
Theme 7 Contextual Factors	M	M		M	m	M	M

High manifestation means that the Theme is prominent in this particular case study.

A highly unusual situation (far from ordinary) is one that is expected to challenge the generality of themes.

Figure 3.9. Worksheet 4: Rankings of Utility and Uniqueness of Each Case for Themes

stray findings were clustered together and put to the side for reference later in the analysis. Once the sorting process was completed, each cluster of findings was renamed and listed on Worksheet 5b (see Figure 3.10). Cases associated with the finding were listed in the second column of the worksheet 5b and weight of the finding was designated for each theme as “H” for high, “M” for medium, and “L” for low. When a finding had a high weight for a particular theme and was associated with 2 or more findings from one particular case that had been noted as prominent in Worksheet 4 for that particular theme, the finding was notated as “(H),” and this merged finding was considered important for determining cross-case assertions. Also, if the merged finding included two or more findings from a case notated as highly unusual in Worksheet 4, that theme’s relevance

Worksheet 5b. A Map on which to make Assertions for the Final Report

		Themes						
<u>Merged Findings</u>	<u>Cases</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>
Finding I Participants described the use of the innovation as implicit rather than explicitly following each step.	P01, P07, P05, P06	H	L	M	M	H	H	L
Finding II The innovation is valued due to providing strategic guidance and an emphasis on accountability.	P01, P04, P04, P04, P05, P05, P07	L	(H)	(H)	L	L	L	M
Finding III Negative attitudes were associated with a reaction to the labeling of the innovation, threats to autonomy, and perceived tediousness of paper work associated with the steps.	ATYP P02, P02, P02, P02, P03, P05, P06,	L	(H) ATY P	(H) ATY P	L	L	L	M
Finding IV Therapists develop idiosyncratic ways in which they follow the steps, tailoring the innovation to their personal needs and situations.	P01, P03, P05, P06, P06	(H)	L	(H)	L	L	L	M
Finding V Participants specifically struggled with goal-setting and treatment planning due to client needs changing or being unclear.	P04, P03	M	L	L	H	L	L	L
Finding VI In order to implement GTO in CP with fidelity, therapists believe they need implementation support (e.g. ongoing training, checklists, coaching, technical assistance, supervision, etc.)	P01, P03, P04, P05, P06, P07	L	L	M	H	H	L	H
Finding VII The way the innovation is	P04, P06,	L	M	(H)	M	L	L	(H)

being taught currently might be less relevant to child/family cases, school settings, and fast-paced, brief clinical interactions (e.g., hospital settings). Further, other external settings might be more conducive to implementation of GTO in CP (e.g., residential programs).	P07, P07							
Finding VIII The innovation cannot be applied to complex and high risk cases.	P01, P05	L	L	M	M	L	L	H
Finding IX Treatment plans are a formality in some external settings.	P01, P02	L	L	M	M	L	L	H
Finding X Therapists identify that flexibility in using the innovation is essential for its successful implementation	P03, P05, P06	L	M	H	M	L	L	L
Finding XI Therapists believe there are too many steps and that they should be consolidated.	P03, P04, P06	M	M	L	H	L	L	L
Finding XII None of the participants could remember the steps.	P01, P02, P03, P04, P05, P06, P07	L	L	L	H	L	L	L
Finding XIII Therapists speculate that they would have done most of these steps anyway or that this is how therapy should be done.	P01, P02, P03, P05, P06	L	H	H	M	L	L	M

A High mark means that the Theme is an important part of this particular case study and relevant to the theme.

Note. H = High Importance; M= Middling Utility; L= Low Importance

Figure 3.10. Worksheet 5b: Merged Findings

was notated with “ATYP” to prompt the analyst to consider the atypicality of that particular finding given the context of the case. Next, rows in these worksheets were re-sorted based on relevance to each theme, e.g., all merged findings relevant to Theme 1 are re-sorted so highly relevant themes were listed first, then medium, and then low. This re-sorting process allows the analyst to consider merged findings that are particularly relevant to pinpointing cross-case assertions, the ultimate goal for the multiple case study. Given that seven themes exist, seven individual, re-sorted copies of Worksheet 5b were created, saved, printed, and reviewed by this author. Notably, the aforementioned analyses maintain data sources as well as transparency of all analytic decisions, allowing the analyst to re-trace steps to data sources and therefore make data-informed interpretations while making cross-case assertions using Worksheet 6.

The final step of the multi-case analysis includes generating cross-case assertions based primarily upon preceding worksheets. Preliminary or “tentative” assertions are generated based upon findings on the thematically sorted versions of Worksheet 5b (see Figure 3.11). Stake (2006) defines this process as the most interpretive step in the multiple case study, although sources of data are recorded and maintained throughout the process.

Stake (2006) suggests the analyst take this opportunity to reflect upon emergent themes and assertions that were perhaps eliminated during the data reduction process. This involves re-reading case reports, synopses, field notes, and reflecting upon memorable findings. This author also took this opportunity to review and important themes within NVivo relevant to the understanding of the program/phenomenon. This process involves the expansion of themes and assertions as well as further data reduction.

Worksheet 6. Tentative Cross-Case Assertions

#	Assertion	Evidence in Which Cases
1	CCA1-1: Therapists have developed nuanced ways to implement the innovation, viewing the innovation as an implicit framework rather than a step-by-step process.	1, 3, 5, 6, 7
2	CCA2-1: There are mixed reactions in terms of the added benefit of the innovation, some therapists reporting a value in relation to the structure and accountability, others relating negative reactions to extra paper work and requirements. Several participants describe suspicion that they would be carrying out most of the steps independently.	1, 2, 3, 4, 5, 6, 7
3	CCA3-1: The innovation seems to be meeting the specific needs of therapists for the most part as it relates to structure, guidance, and consistency with views on best practices.	1, 2, 3, 4, 5, 7
4	CCA3-2: The innovation might be incompatible with some needs in regards to specific settings and cases. Some therapists adapt the framework to fit their needs and most emphasize a need for the innovation to be flexible around those needs.	1, 2, 3, 4, 5, 6, 7
5	CCA4-1: Specific struggles identified included goal-setting and treatment planning due to client needs changing constantly or client needs being unclear.	3, 4
6	CCA4-2: Implementation support is necessary for successful implementation of GTO in CP. Trainings/orientations are not sufficient. Suggestions were made for ongoing training, checklists, technical assistance, and for GTO in CP to be included/discussed in supervision.	1, 3, 4, 5, 6, 7
7	CCA4-3: The model is difficult to remember. None of the participants can remember the steps and some suggested they be consolidated or some steps be eliminated to simplify the model.	1, 2, 3, 4, 5, 6, 7
8	CCA5-1: There is not a strong perception of use versus non-use, therefore trialability was not clear. This was partially attributed to the therapists following the framework implicitly versus explicitly following the model step-by-step as well as participants feeling somewhat ill-equipped to use it with fidelity.	1, 3, 4, 5, 6, 7
9	CCA6-1: Most of the participants were not able to identify use versus non-use, so they were not able to articulate any observable characteristics of the innovation. Most related an inability to know if they were using the innovation.	1, 5, 6, 7
10	CCA7-1: Child/family and school-focused students note that due to fast-paced settings and brief intervention models, the framework as it is taught does not fit their needs.	4, 6, 7
11	CCA7-2: Case load characteristics impact implementation, specifically high-risk or complex cases making it difficult for therapists to follow through with steps.	1, 5
12	CCA7-3: The implementation setting also impacts implementation. Treatment planning is considered a formality in external settings	1, 2

Figure 3.11. Worksheet 6: Tentative Cross-Case Assertions

The analyst takes this opportunity to re-order and merge themes. See Figure 3.12 for the list of expanded cross-case assertions.

These assertions are then finalized and merged during the last data reduction process, the analyst considering how assertions should be merged for the final report. The final version of Worksheet 6 (see Figure 3.13) produces the finalized cross-case assertions, including columns that track the source of each assertions as well as a column that captures which themes relate to each assertion. This final version of Worksheet 6 will be used as the analyst provides expansive and contextual descriptions of each assertion, including specific quotes and contextual factors attributed to particular cases. These many layers of data reduction, triangulation, and organization lead to an organized foundation of findings related to the program/phenomenon for the analyst to re-engage in case-level analyses.

3.1 Cross-Case Assertions

Descriptions and findings associated with each aforementioned final cross-case assertion will be demonstrated below. Methods used to demonstrate these findings include a mix of quantitative as well as qualitative analyses. Qualitative methods utilized will include review of individual case study reports, multiple case analytic worksheets, NVivo queries, as well as previously generated excel spreadsheets used in prior analyses. Please note that linguistic fillers—e.g., “like,” “um,” “you know,” “so,” etc.—have been redacted from certain quotations below in order to improve readability. Please also note that although relevant themes stemming from the research questions are noted in parentheses below, given that findings were merged to make assertions about the

Worksheet 6. Cross-Case Assertions

	Assertion	Evidence in Which Cases
1	CCA1-1: IC Map Profiles vary greatly across participants and sub-cases. Five participants exhibited high adherence, one medium, and one low. Scores and averages are demonstrated graphically and numerically.	1, 2, 3, 4, 5, 6, 7
2	CCA1-2: Therapists have developed nuanced ways to implement the innovation, viewing the innovation as an implicit framework rather than a step-by-step process. E.g. one participant uses treatment plans to plan for outcome evaluation.	1, 3, 5, 6, 7
3	CCA2-1: There are mixed reactions in terms of the added benefit of the innovation, some therapists reporting a value in relation to the structure and accountability, others relating negative reactions to extra paper work and requirements. Several participants describe suspicion that they would be carrying out most of the steps regardless of familiarity with GTO in CP.	1, 2, 3, 4, 5, 6, 7
4	CCA2-2: Enrollment in the Clinical-Community program impacted the value of the innovation because these students were exposed to program evaluation concepts. These participants were able to articulate the ideological benefit of the innovation.	1, 2, 3, 4 (all CC students)
5	CCA2-3: Trainings and dissemination of GTO in CP seemed to impact P02's technique as evidenced by assessment-oriented activities were evident in paper work following the orientation.	2 (ATYP)
6	CCA3-1: The innovation seems to be meeting the specific needs of therapists in relation to desire for structure, guidance, and consistency with views on best practices. The innovation is incompatible with some needs in regards to specific settings and cases. Some therapists adapt the framework to fit their needs and most emphasize a need for the innovation to be flexible around those needs.	1, 2, 3, 4, 5, 6, 7
7	CCA3-2: Reactivity to the innovation's label, "GTO in Clinical Practice," seems to be salient across participants. Attitudes seemed neutral to negative.	2, 3, 4, 5, 7
8	CCA4-2: Implementation support is necessary for successful implementation of GTO in CP. Trainings/orientations are not sufficient. Suggestions were made for ongoing training, checklists, technical assistance, and for GTO in CP to be included/discussed in supervision.	1, 3, 4, 5, 6, 7
9	CCA4-3: The model is difficult to remember. None of the participants can remember the steps and some suggested they be consolidated or some steps be eliminated to simplify the model.	1, 2, 3, 4, 5, 6, 7
10	CCA4-1: Specific struggles identified included goal-setting and treatment planning due to client needs changing constantly or client needs being unclear. Further, participants were not clear about the distinction between treatment planning and goal-setting, as though these two activities happen in parallel rather than sequentially.	3, 4, 5
11	CCA5-1: There is not a strong perception of use versus non-use, therefore trialability was not clear. This was partially attributed to the therapists following the framework implicitly versus explicitly following the model step-by-step as well as participants feeling somewhat ill-equipped to use it with fidelity.	1, 3, 4, 5, 6, 7
12	CCA6-1: Most of the participants were not able to identify use versus non-use, so they were not able to articulate any observable characteristics or benefits of using the innovation. Most related an inability to know if they were using the innovation. The highly supportive participants described noticing being more accountable, outcome-oriented, and data-driven in their clinical practice.	1, 4, 5, 6, 7
13	CCA7-1: Child/family and school-focused students note that due to fast-paced settings and brief intervention models, the framework as it is taught does not always fit their needs in external settings.	4, 6, 7
14	CCA7-2: Case load characteristics impact implementation, specifically high-risk or complex cases making it difficult for therapists to follow through with steps.	1, 5
15	CCA7-3: The implementation setting also impacts implementation. E.g., treatment planning is considered a formality in external settings.	1, 2

Figure 3.12. Worksheet 6: Cross-Case Assertions

Worksheet 6. Multi-Case Assertions for the Final Report

Designator	Assertion	Related to Which Themes	Evidence in Which Cases
CCA1-1	1. IC Map Profiles vary greatly across participants and sub-cases. Five participants exhibit high adherence, one medium, and one low. Scores and averages can be demonstrated graphically and numerically.	1	1, 2, 3, 4, 5, 6, 7
CCA1-2	2. Therapists have developed nuanced ways to implement the innovation, viewing the innovation as an implicit framework rather than a step-by-step process.	1, 2	1, 3, 5, 6, 7
CCA2-1	3. There are mixed reactions in terms of the added benefit of the innovation, some therapists reporting a value in relation to the structure and accountability, others relating negative reactions to extra paper work and requirements. Several participants describe suspicion that they would be carrying out most of the steps regardless of familiarity with GTO in CP.	2, 3	1, 2, 3, 4, 5, 6, 7
CCA3-2	4. Reactivity to the innovation's label, "GTO in Clinical Practice," seems to be salient across participants. Attitudes about the label range from neutral to negative.	3, 2	2, 3, 4, 5, 7
CCA4-3	5. The model is difficult to remember. None of the participants can remember the steps and some suggest steps be consolidated or reduced to simplify the model.	4	1, 2, 3, 4, 5, 6, 7
CCA4-2	6. Implementation support is necessary for successful implementation of GTO in CP. Trainings/orientations are not sufficient. There is a need for ongoing training, checklists, technical assistance, and for GTO in CP to be included/discussed in supervision. Participants feel ill-equipped to use the innovation.	4, 5	1, 3, 4, 5, 6, 7
CCA5-1 CCA6-1	7. There is not a strong perception of use versus non-use, therefore trialability and observability cannot be easily identified. The highly supportive participants attribute being more accountable, outcome-oriented, and data-driven in their clinical practice to the innovation.	6, 5	1, 3, 4, 5, 6, 7
CCA2-2 CCA7-1 CCA7-2	8. Contextual factors impact implementation, including program enrollment, case load characteristics, and the setting in which the clinician is practicing.	7, 3, 2	1, 2, 3, 4, 5, 6, 7

Figure 3.13. Worksheet 6: Multi-Case Assertions for Final Report

overarching understanding of the innovation across cases, there is certainly more overlap than a categorical designation to each research question can capture.

Assertion 1: *IC Map Profiles vary greatly across participants and sub-cases. Five participants exhibit high adherence, one medium, and one low. Scores and averages can be demonstrated graphically and numerically. (Theme 1: Innovation Configurations)*

Various IC Map profiles emerged from this study, indicating that the current IC Map is sufficient in capturing variance across participants. Largely, variance is evident by the graphical presentation of all case and mini-case presentations of IC Map scores (see Figure 3.14). Findings appear to cluster around Steps 4 (Fit), 5 (Capacity), and 10 (Sustainability); otherwise, scores vary across cases.

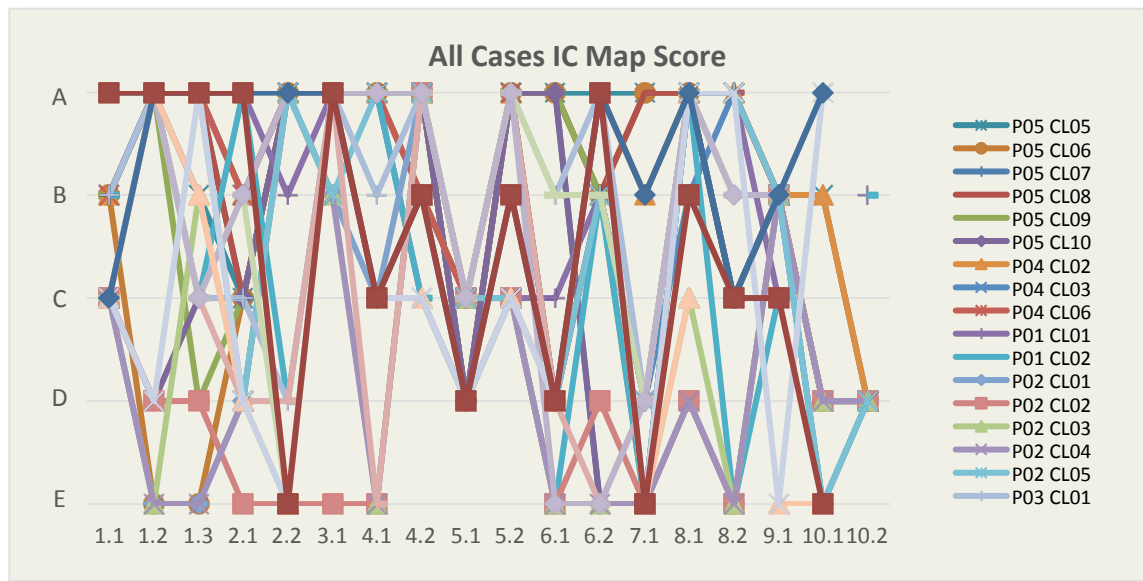


Figure 3.14. Graphical Presentation of All IC Map Scores

IC Map findings were transformed from letter to numerical scores (A = 4, E = 0, etc.) for the purpose of graphically presenting the data and calculating simple statistics. Findings presented in Table 3.1 involve finalized calculations being rounded to the nearest whole number prior to being re-transformed into letter scores. Means and modes for each participant indicate a range of adherence across participants.

Step-wise averages were also calculated in numerical format for the purpose of gaining insight into whether there is any consistent pattern related to high-adherence

Table 3.1

Overall IC Map Means and Modes

Participant	Overall Mean	Overall Mode
P01	B	A
P02	C	E
P03	B	A
P04	B	A
P05	B	A
P06	C	C
P07	B	A

steps versus low-adherence steps. Calculations presented in Table 3.2 indicate that there was a pattern of high adherence in Step 3: Exploring Best Practices and there were patterns of low adherence in the Step 7: Process Evaluation.

Table 3.2

GTO in Clinical Step-wise Means from IC Map Profiles

	P01	P02	P03	P04	P05	P06	P07	Total
<i>Step 1</i>	3.33	1.67	2.75	3.78	2.67	2.67	3.67	2.93
<i>Step 2</i>	3.00	2.00	1.88	3.50	3.00	0.50	3.00	2.41
<i>Step 3</i>	4.00*	2.40	4.00*	4.00*	4.00*	4.00*	4.00*	3.77*
<i>Step 4</i>	3.00	2.60*	3.38	3.50	4.00*	2.00	2.50	3.00
<i>Step 5</i>	1.50	2.00	3.00	3.00	2.50	1.50	2.00	2.21
<i>Step 6</i>	2.00	0.50	1.75	2.17	3.08	2.50	2.50	2.07
<i>Step 7</i>	0.50**	0.20**	1.00**	1.67	2.00	0.00**	1.50**	0.98**
<i>Step 8</i>	3.00	1.30	3.50	3.83	3.17	3.00	2.75	2.94
<i>Step 9</i>	2.00	3.00	3.00	3.00	3.00	0.00**	2.50	2.36
<i>Step 10</i>	3.00	0.80	missing	1.17**	1.17**	2.00	2.00	1.69

*high scores; **low score

Assertion 2: *Therapists have developed nuanced ways to implement the innovation, viewing the innovation as an implicit framework rather than a step-by-step process.* (Theme 1: Innovation Configuration; Theme 2: Relative Advantage)

Some of the steps within GTO in Clinical Practice are followed in idiosyncratic ways. Upon review of electronic files, it seems the formal treatment plan included goals and listed best practices, but these best practices were not always enacted with actionable

items. Instead, it appears Participant 1 primarily used treatment plans to plan for outcome evaluation rather than to plan for steps in therapy, short term goals including symptom reduction and other goal-related outcomes, e.g., “reduce [client’s] anxiety scores by week 10.” Although this likely enhances his use of outcome evaluation, this makes the feasibility of process evaluation low/nil. Notably, this participant reported working in other settings in which treatment plans were considered formalities, seemingly perceived as paper work rather than workable documents.

Participant 3 weaves assessment and goal-setting throughout therapy. The participant describes struggling with moving into an active treatment phase. She states during the interview, “I think that’s something I need to improve on ...as a result of the assessment process being extended for the clients I’ve had so far ... It almost feels like I’ve not fully arrived at the, ‘Right now we’re entering treatment.’” Notably, case records corroborate this, the participant seemingly engaging in assessment, goal-setting, and treatment planning throughout the entirety of treatment. These steps are more iterative than sequential for this particular participant. This participant’s previous training in process-oriented therapy might have influenced this finding.

Participant 5 describes a review of her treatment plan and even mentions a color-coding system to conduct evaluations for CQI. She states in her interview:

I think it’s useful to just look through what we wrote down that week and see if we are making progress on it, and if we are, then you put down some dates, cross it off or make it a different color or whatever, and if you’re not, then you sort of ask those questions about, well, why? You know, is it the strategies we are using aren’t good? Is this not a good goal? Is this not a priority for you right now? Are

you not motivated? Asking those questions to figure out—and then making sure that your treatment plan is dynamic. You move things around, you cross goals off, you put goals on hold, you add new goals that weren't on there, but your client achieved them over the weeks. So, just keeping in mind I guess that its dynamic but also I think just making sure to reference it pretty often with them kind of face to face instead of it kind of just being this thing I have and they never see.

This is a very nuanced and systematic way to engage in process evaluation that can lead to CQI decisions, but seemingly this system was developed independently by this therapist, as evidenced by how she describes this system and the lack of evidence of this system in other cases. Notably, this participant had multiple versions of her treatment plans on file for two of her clients and most of her clients seen long-term had very detailed treatment plans. This participant did acknowledge being unable to develop and utilize a treatment plan for cases with acute risk.

Participant 6 seemed to build capacity and explore best practices simultaneously. He describes utilizing a program, PracticeWise, as well as consulting with peers and supervisors to explore best practices for the problem identified. He seemingly builds expertise and capacity to complete the intervention throughout this process, rather than these two steps being explicit and separate from one another. Notably, although not captured in analyses, it is possible this is true for all of the child/family-focused therapists, as this system was available and heavily utilized by all participants with a child/family focus.

Participants 1, 5, 6, and 7 describe an implicit use of the innovation rather than following the framework step-by-step. Participant 1 states, “[W]hen I'm working with a

client, I don't think I'm actively thinking about the GTO process.” Similarly, Participant 5 denies referencing the specific steps:

I don't bring up like the-the graphics or whatever and be like, “Oh am I doing these things?” So I feel like I think more about the ideas in general but I don't necessarily like... access the detailed written information as much. ‘Cause part of me sort of is like well...is that necessary to like write it all out in terms of like the step one, step two, step three, and um, i-that's also just not really modeled for us I guess—

Similarly, participant 7 states, “I don't know that I was really thinking of it in terms of-of the steps themselves,” and goes on to describe conceptualizing the model as a “framework” rather than a step-by-step process.

Flexibility in the use of the innovation seems essential to successfully using it in therapy. Participants 1, 3, 4, and 5 describe “flexibility” or the framework being “flexible” as essential to successfully using the innovation. Participant 5 states that she believes the “flexibility makes sense,” seeming to imply that she believes the model to be inherently flexible. Participant 6 describes a situation in which he believes being rigid in the use of GTO in Clinical Practice might interfere with doing quality therapy as though the model does not allow for flexibility. Similarly, Participant 3 specifically references believing she “would have missed the mark” with one of her cases if she had rigidly moved through the steps as she was particularly attuned to maintaining the therapeutic alliance in therapy. Notably, Participant 3 has previous exposure and training in process-oriented therapy, which might lead the structured step-by-step nature of the innovation

being less compatible with her previous perception of how therapy is conducted. Other participants, however, all subscribe to CBT and other structured approaches.

Given the value of flexibility and the perception that the framework is more of an ideological framework rather than a step-by-step process, the nuanced use of various steps seems logical. This nuanced use, however, makes measurement with a system, such as the IC Map, difficult. Further, the nuanced use of the innovation makes “use” versus “non-use” less of a clear distinction.

***Assertion 3:** There are mixed reactions in terms of the added benefit of the innovation, some therapists reporting a value in relation to the structure and accountability, others relating negative reactions to extra paper work and requirements. Several participants describe suspicion that they would be carrying out most of the steps regardless of familiarity with GTO in Clinical Practice. (Theme 2: Relative Advantage; Theme 3: Compatibility)*

Attitudes about the utility of the innovation above and beyond other ways of conducting therapy are mixed, ranging from highly supportive to ambivalent to outright dismissive and resistant. Despite the salience of these beliefs, many of the participants question whether most of these steps would have taken place regardless of the dissemination of GTO in Clinical Practice in the training clinic.

Many of the attitudes are positive in salience, supporters of the innovation speaking to the benefits of “structure,” “accountability,” and being data-driven. Participant 7 describes that the framework prompts therapists to keep “outcomes in mind” which the participant describes as “helpful.” Participant 4 states, “I feel like GTO forces me a little bit to really ask myself tougher questions about am I seeing improvements, is this working and what could I maybe do differently with this client to make sure I’m getting the outcomes that I want.” Similarly, Participant 5 explains:

I think it's made me do more work on the front end to kind of set myself up to be successful later on. So, thinking about all this stuff beforehand that might influence treatment, whereas dealing—whereas before I felt like I was dealing with it as it came up. So I think that's especially useful because I feel like the more work you do in the beginning the better chance you have of helping your client meet their goals better. So I think that's how I see it's been beneficial is like-like doing more in the beginning to be more successful later on.

Other participants have very negative reactions to the framework, Participants 2, reacting to “being told what to do,” and both Participants 2 and 6 describing the framework primarily as extra “paper work.” This seemingly indicates the innovation is a nuisance and administrative requirement, rather than beneficial to conducting quality therapy. This seems congruent with how Participant 2 completed treatment planning after GTO in Clinical Practice began rolling out, seemingly fulfilling a paper work requirement rather than investing thought in the document, and Participant 6 did not have formal assessments or treatment plans for his cases despite the requirement. Even the most supportive participants acknowledge the time-intensive nature of using the innovation.

Participant 3 describes conflicting values during the interview, reflecting on her process-oriented tendencies as well as her belief that systems such as GTO in Clinical Practice are helpful in moving toward outcomes. She states, “I wonder... if in some cases if someone's doing effective work is—maybe the fundamental elements of GTO are already kind of embedded in what they're doing... in terms of their process.” She describes that the innovation might perhaps interfere with the value of autonomy:

“Maybe... a value that feels like sometimes it interferes with is independence... I say that but I have, like, three counterarguments for it in my head.” This provides helpful contextual information given this participant’s previous proclivity for process-oriented therapies.

Many of the participants mention at some point a belief that either they “would” or “should” be carrying out the steps in GTO in Clinical Practices anyway. One participant asks, “Aren’t these all the things that we’re already supposed to be doing in a circle written down?” Another participant says when asked about the framework, “That probably is what I would have done regardless.” These statements and others reflect suspicion about the real advantage of the framework as an innovation. Despite Participant 2’s largely negative reaction to the innovation and stated belief that the steps are things everyone “should be doing as therapists” regardless of the innovation, she admitted that “the importance of needs assessment” was impressed upon her as a result of the roll out of the innovation which was corroborated by her IC Map profiles. Her IC Map profiles also demonstrated she engaged in more outcome evaluation after being exposed to the innovation.

Assertion 4: *Reactivity to the innovation’s label, “GTO in Clinical Practice,” seems to be salient across participants. Attitudes about the label range from neutral to negative. (Theme 3: Compatibility; Theme 2: Relative Advantage)*

Participants 2, 3, 4, 5, and 7 all mentioned the labeling of the innovation as GTO in Clinical Practice unprompted. Participant 4 references saturation, describing external exposure to Getting To Outcomes in other classes, so with the roll-out at the clinic, the labeling is overwhelming; he states, “[I]t’s so integrated here is that it’s pervasive, I can’t stop, like, it’s so everywhere which can be annoying.” A few participants mention

believing that many of these steps are a “naturally occurring” processes that should be carried out in therapy and that, as one participant describes it, “[S]omebody’s just, like, putting a name on it...” Another participant describes feeling neutral about the label of the innovation, but states, “I guess what would be the most important, I guess you know—Are we hitting all of these important parts and making sure that they are accomplished?” One of the more resistant participant states, “You can call it whatever you want. You’re just keeping track of what you’re supposed to be doing.” Notably, there were no positive reactions to the labeling of the innovation, and this finding emerged even though inquiries did not specifically ask about reactions to the name, *Getting To Outcomes in Clinical Practice*.

Assertion 5: *The model is difficult to remember. None of the participants can remember the steps and some suggest steps be consolidated or reduced to simplify the model.*
(Theme 4: Complexity)

Every participant mentioned either during initial interview or at follow-up an inability to remember the steps in the GTO in Clinical Practice model. Participant 7 states, for example, “I’ll be very honest, I don’t remember the names to all of the steps... I just remember the beginning ones and the end ones.” Participant 6 actually brought a printed version of the steps to reference during the interview and referenced it as a “cheat sheet” at one point during the interview.

Many of the participants also specifically describe a need to simplify the model. Participant 4 describes concern about being able to internalize all of the steps:

Sometimes I feel like it’s unreasonable you know... Oh there’s so many steps that how am I really going to be ever able to really internalize all of these steps so that

it's a n-part of my process as a therapist every day? Because it's so, it feels like so many steps sometimes.

Other participants inquire about whether there need to be “so many steps,” Participant 1 asking, “[I]s there a way of making it seem less cumbersome?” after referencing the amount of steps in the model. Participant 6 also mentions the amount of steps but admitted, “I can’t think of a step that you can take out that would make it as effective as it is right now.”

Assertion 6: *Implementation support is necessary for successful implementation of GTO in CP. Trainings/orientations are not sufficient. There is a need for ongoing training, checklists, technical assistance, and for GTO in CP to be included/discussed in supervision. Participants feel ill-equipped to use the innovation.* (Theme 4: Complexity; Theme 5: Trialability)

Every participant except Participant 2—the unique intern case that claimed not to value or utilize the innovation—described a need for ongoing support in using the innovation. Participant 1 articulates frustration with being told to use GTO in Clinical Practice without the necessary support to do so: “I think it’s more of, like, you know, ‘GTO, GTO, GTO,’ ... [W]e keep being told that we need to do this... and that this is... important.” He goes on to say, however, that he feels students are not necessarily adequately trained to use the framework, despite positive messaging about the innovation. He states outright, “I just don’t know enough.” He states, “I wish that I had more training in it and felt more confident with it...” Similarly, Participant 5 describes how the training in GTO in Clinical Practice and general training in practicum seem exclusive from one another: “[I]t’s this other... mysterious thing that we keep talking about once in a while.” Participant 4 mentions at follow-up that a “checklist” might be helpful to support use and Participant 6 emphasizes the importance of the concepts being

incorporated into supervision. Participant 7 describes feeling the post-orientation support as lacking: “I definitely like the-the trainings that you did at the beginning of the [redacted] was helpful and I definitely, um...kind of used that and, um, at the same time, it didn’t really come up as much as I thought it would during courses.”

***Assertion 7:** There is not a strong perception of use versus non-use, therefore trialability and observability cannot be easily identified. The highly supportive participants attribute being more accountable, outcome-oriented, and data-driven in their clinical practice to the innovation. (Theme 6: Observability; Theme 5: Trialability)*

As mentioned in previous assertions, most of the participants identify the use of the innovation as implicit versus explicit, therefore they were not able to identify explicitly when they were “trying out” using the innovation or able to articulate anything observable associated with the use of the innovation. Notably, however, participants that were seemingly supportive of the innovation were able to describe how they think use of the innovation has changed their clinical work. Participant 5, for example, emphasizes that practicing using GTO in Clinical Practice has been helpful: “I kind of draw this parallel between what I talk about with my—with my clients is things become more beneficial and easier the more routine they become and I just, you know, I think that as that happens we’ll all become an army of little GTO-ers.” She also describes believing that since the roll-out of GTO in Clinical Practice, her conceptualizations have become stronger and she creates more “workable” treatment plans. Participant 4 also describes how he believes the innovation has impacted his work:

I think I probably am turning into and will be a better clinician for it I mean, uh, I- I think that’s how the real world works and I think particularly that’s how we’re going is to be more accountable for the outcomes that we have in therapy... You know, from a practical stand point of, like, I want to make sure that I am

competitive for a job and that I know how to do that well and to show that I'm getting outcomes with my clients. I like that.

Assertion 8: *Contextual factors impact implementation, including program enrollment, case load characteristics, and the setting in which the clinician is practicing.* (Theme 7: Contextual Influences; Theme 3: Compatibility; Theme 2: Relative Advantage)

Participants 1-4, all enrolled in the Clinical-Community program, mentioned understanding the ideology associated with rolling out GTO in Clinical Practice. This seemed to impact their sense of compatibility with their previous values. Participant 3, for example, states:

Bill Gates spent so much I think... hundreds of millions of dollars trying to identify this way, a good way of evaluating effective teaching. And it seems like that with therapy, there are some similarities there, part of it's difficult to describe what it means to be an effective therapist and s-so it's s-such a big um, idea and so having, I think, a strength of GTO is it demystifies that a bit, and it's just like follow these steps and [chuckles] um, you know, the odds of you being ineffective are decreased [laughs].

Other participants reference "program evaluation" and the "Checklist Manifesto." All of these statements are within the context of understanding the purpose of the innovation.

Child/family and school focused students also seem to be impacted by their context, describing how interactions in hospitals and schools with children tend to be brief and therefore less conducive to the use of GTO in Clinical Practice. Participant 6 describes how school psychology students might find the framework less relevant in school settings:

I mean normally we bounce from different cases. It's just a shift in thinking, um, and these kinds of cases are longer and more in depth than when we go to school we have a case, we see them that day and then do the feedback meeting, you know, two weeks later and that's it.

Similarly, Participant 4, during follow-up, describes that it is important for the developers of GTO in Clinical Practice to consider how therapists function outside of the training setting, referencing one-time clinical interactions and/or brief interventions.

Participants 1 and 5 describe difficulty implementing GTO in Clinical Practice when cases are complex and/or in crisis. Participant 1 describes that with a complex case, “[I]t's been so difficult to get assessments done with this client,” so moving on to proceeding steps has been challenging. During follow-up interview, when reviewing IC Map findings for one of the less adherent cases, Participant 5 admitted that the GTO in CP steps were not being considered for one client because of an acute crisis and the therapist felt compelled to manage that crisis day-to-day without considering the bigger picture of clinical outcomes.

Being within the training center also impacts implementation. Participants 1, 4, and 6 all specifically mention access to the library or clinical resources (e.g. assessment tools) available in the training center. They also reference access to the program used by child/family students within the training center to support selection and implementation of evidence-based practices, PracticeWise. Other participants also mention utilizing interview forms that have been developed and disseminated within the training center to support the clinical interview process.

CHAPTER 4

DISCUSSION

This dissertation introduced an innovation, Getting To Outcomes in Clinical Practice, a framework posited by this author and developers to support clinical practice specifically with therapist trainees. The innovation was developed and has begun to be disseminated in a naturalistic setting; therefore, studying how this innovation is being enacted and how it is being perceived by its users was a critical first step to understanding the feasibility of continuing research on the model as well as understanding necessary adaptations for its successful dissemination (Hall, 2013; Rogers, 2003). Thus the following questions were investigated with this study:

1. How do student-therapists in a setting where GTO in Clinical Practice is being developed actually enact the innovation? What innovation configurations emerge?
2. How do student-therapists in this stage of development feel about GTO in Clinical Practice and how it affects their practice?
3. How might contextual factors (e.g. program enrollment, clinical experience, organizational context, e.g.) influence the student-therapist's experience with this innovation?

This section will address how findings relate to each research question/theme as well as how these findings contribute to the understanding of the innovation and relate to research on implementation. Limitations to this study will also be described.

4.1 Research Questions

Innovation Configurations. Notably, despite the small sample size that a multiple case study permits, variance in Innovation Configuration profiles emerged from the findings. This indicates, first, that the current IC Map is sufficient in capturing variance in behavior which is essential to conducting quality research on how fidelity to the innovation impacts various outcomes in future research (Robey, 2004). However, it should be noted that measurement using this system was not perfect. In fact, this author made multiple notes on IC Maps for the first several participants that related to suggested revisions of the IC Map. As described in the results, participants oftentimes engaged in nuanced adherence to the steps. The IC Map developed and utilized within this dissertation will function as a meaningful outline for future revisions, but the tool did not necessarily capture all of the variations of behavior. Further, findings suggest that some of the steps may be less exclusive from one another than the model suggests. A theme emerged regarding the overlap of the exploration of best practices and enhancing capacity, trainees perhaps using the phase of information gathering to also acquire materials to support use of evidence-based practices. Similarly, goal-setting, treatment planning, and planning for outcome evaluation seemed less exclusive from one another than the model indicates. Thus, it might be beneficial to consider which steps converge more than they are divergent from one another.

Further, participants commented on how the framework, as it was taught and as it is measured, does not capture the experience of how the ideology of GTO in Clinical Practice would be manifested in brief therapy models. Perhaps this speaks to the relevance of the innovation to those clinical experiences, but it might also relate to how

the training and measurement of the steps would need to be adapted based on the need of the setting. Brief one-to-two session therapy models will follow the steps much differently than long-term cases. This finding is essential to adapting the innovation to the needs of its users (Hall, 2013).

These findings relate to context-informed innovation adaptations, a process that often occurs during implementation and can be used to inform adaptations (Hall, 2013). Similarly, Rogers (2003) also writes at length about innovations that are more likely to be perceived as “compatible” and therefore adopted when being partially informed by the users. This balance is delicate, however, and should be informed by experts in the field, innovation development stakeholders, as well as the users of the innovation. Inclusion is essential to successful changes in programming.

Innovation Appraisal. Findings indicate that Getting To Outcomes in Clinical Practice has relevance to supporting therapist trainees, many participants speaking to how the innovation supports their clinical practice. Innovations appraisal was evaluated based on a priori themes about the diffusion of innovations Rogers (2003): relative advantage, compatibility, complexity, trialability, and observability. Rogers (2003) describes that these attributes have been shown to account for 49-87 percent of variance in rate of adoption.

In terms of relative advantage, participant attitudes ranged from valuing the innovation for its emphasis on structure, accountability, and outcomes to ambivalence about its advantage above and beyond other models. Interestingly, there was a theme that emerged where many participants wondered whether the steps would have been carried out regardless of the innovation’s dissemination. The intern participant provides some

insight around this suspicion, her behaviors indicating that the dissemination impacted her behavior in relation to assessment and conceptualization as well as outcome evaluation. Further, many of the policies that participants described, the requirements and support for assessments, treatment plans, and outcome measurement, all were instated due to the roll-out of the innovation. Notably, however, this seemingly negative reaction seems more consistent with the theory behind GTO than the participants seem to realize, as the developers are not claiming that any one step is unique but rather that the framework as a whole has potential to support clinical decision making.

Participants wrestled with compatibility, some describing the innovation as a representation of their “ideal self” as though the innovation was incredibly consistent with pre-existing values and beliefs. Others argued that the innovation might interfere with the value of autonomy. Some participants described valuing the flexibility of the framework and others mentioned worry about the rigidity of the framework. GTO is generally intended to be flexible and iterative, so perhaps this finding reflects a misunderstanding of the innovation rather than an issue with goodness of fit (Chinman et al., 2004). Although the framework will likely inherently provide structure, the steps are not meant to be followed in a rigid and inflexible manner. Further, there was a reaction to the labeling of the innovation, an aspect of compatibility that Rogers (2003) emphasizes should not be undermined by purveyors.

There were many issues in terms of complexity. Users could not remember the steps and many suggested the steps be simplified or reduced. Although one might disregard this as resistance, the overarching prominence of this theme is notable and existed even across highly supportive participants. Some participants viewed the

innovation as requiring more “paper work” and nearly everyone acknowledged the time-intensive nature of the innovation. Further, many participants requested ongoing support in order to feel like they could adequately use the innovation. There were requests for more training, technical assistance, support tools, and support from supervisors. Innovation support is essential to quality implementation (Wandersman, Chien, & Katz, 2012).

Trialability and observability were somewhat unclear due to the overarching perspective that the use of the innovation was mostly implicit rather than a step-by-step process. Some therapists acknowledged they noticed their skills improving since the roll-out of the innovation, but most spoke to being unable to necessarily detect use versus non-use. Thus, without *knowing* whether the innovation is being used, it is difficult to know whether users felt they had an opportunity to try out using the innovation on their own. Further, the use of the innovation was not observable by others and not even necessarily noticeable by the users themselves.

Contextual Factors. The consideration of contextual factors will likely be extremely important to ensuring this innovation’s successful roll-out. The individual case study analysis allowed for a level of depth that uncovered some contextual factors that might impact how the innovation is used and perceived. Clinical-Community students were more apt to acknowledge the organizational benefit of the innovation given their exposure to program evaluation concepts within their training. School Psychology and child-focused students emphasized that brief psychology models might not be conducive to GTO in Clinical Practice in that the steps have insofar been designed to inform long-term therapy cases. Similarly, the implementation context certainly impacts use. First,

many of the policies, procedures, and resources within the training center contributed to use. Child/family students noted the use of PracticeWise and many mentioned the use of scholarly inquiry including a treatment and assessment library within the training center. Further, it was noted that treatment plans are considered formalities in outside settings and that the emphasis on treatment planning within the training center changed how this process was conducted. The intern case was incredibly helpful in highlighting how the innovation was more abrasive to someone who had already established habits in clinical practice whereas less experienced students seemed to have difficulty teasing GTO in Clinical Practice apart from practice as usual.

4.2 Limitations

This study was not without limitations. First and foremost, the case study analysis interferes with the generalizability of findings beyond the cases studied; however, the provision of a thick description of the setting as well as the contextual information highlighted from the case-level analyses provides enough context that can assist readers drawing conclusions about how this innovation might be utilized and perceived in other settings. Further, although this study sampled only seven participants during a specific time period, the richness of the findings have provided information that can inform fruitful recommendations for both the specific context as well as the innovation as a whole. Also, this project was conducted as a dissertation and lacked funding that would support a larger research team. Although research assistants were utilized in the data collection and preparation processes, there were no resources to include inter-rater reliability checks. This author attempted to enhance dependability or reliability of the data and conclusions by conducting repeated audits throughout the analysis. Last, this

author would like to acknowledge the subjectivity and interpretative nature of this type of analysis. Qualitative analyses by nature tend to be more subjective and subject to interpretation. The thick description of this author's positionality and the context of the research should provide some assurance to the readers regarding the transparency of that bias, but mostly the truth and credibility of the data and findings should be enhanced by the auditing processes, triangulation, and transparency of the systematic analytic process.

4.3 Future Recommendations for Continued Research and Program Development

Although one might perceive findings related to the use of the framework as an ideology rather than a step-by-step process as dissemination failure, resistance, or the result of inadequate innovation support, it is important to acknowledge the differences between program evaluation and community-level change endeavors and psychotherapy. Getting To Outcomes has been well-established as a beneficial tool for empowerment evaluation on these higher levels (Chinman et al., 2015). However, during community-level change endeavors, stakeholders involved in community planning are not often dealing with imminent suicidality or acute substance use, the maintenance of a strong working alliance, in-session maladaptive behaviors, and day-to-day crises. Although these can sometimes be distracting from overall plans and even framed as avoidance, it is only ethical that the therapist respond and ensure beneficence and reduce potential for harm during those incidents. Thus, the therapist might essentially be forced to make clinical decisions and implement interventions within a span of 5-10 minutes or less. One could argue that the therapist is then required to walk through each of the 10 steps implicitly rather than explicitly. Thus, it is essential that innovation developers focused on this model consider the benefits of both explicit use as well as implicit internalization

of the model, as it is likely beneficial for the therapist to be outcome-oriented as a therapist even when faced with day-to-day needs, complaints, demands, and crises that take place in therapy.

Participatory research methods that include various stakeholders, including senior and novice therapists, experts in the field of psychology, innovation support members, administrators, and supervisors, would likely inform the refinement of the model, the measurement system, and the name of the innovation in a way that would enhance utility of the model and allow this innovation to truly thrive. Further, including clients in the process to begin defining how this model might impact a consumer's perception of treatment would be beneficial in sustaining this innovation's development and dissemination. This not only relates to implementation science in that the model would become more compatible to the users tasked with adoption (Rogers, 2003), but gaining input from this array of stakeholders would likely enhance expectancy in both the therapist and the client, a non-specific factor that has been identified to relate to clinical outcomes (Grencavage & Norcross, 1990; Tracey, Lichtenberg, Goodyear, Claiborn, & Wampold, 2003). Clearly, Getting To Outcomes has provided a meaningful foundation for planning, implementing, and evaluating clinical practice, but the design and implementation team might benefit from adapting the label and the model components to the users' and stakeholders' needs and preferences so the users truly embrace the innovation. Although the current label and form of the innovation has a long-standing positive reputation in the community psychology field, its use in clinical psychotherapy might require adaptations.

Wandersman et al. (2012) propose a model for innovation support that is consistent with many of the participants' requests regarding implementation support, the model emphasizing tools, training, technical assistance, and quality assurance mechanisms. In this particular example, tools were being developed as the innovation was being defined. Further, Hall and Hord (2011) emphasize that during early stages of dissemination, concerns of the users should continue to be understood and addressed, and support around those concerns should be communicated through multiple channels in small doses. The culmination of these theories on dissemination and implementation lead this author to recommend a multi-faceted approach. Simple tools, i.e. checklists, one-page handouts, posters, would likely be helpful to be provided and discussed within multiple sources of innovation support, including the innovation support team, the training organization, and supervisors. This process will likely be most beneficial after the model is finalized through a participatory research approach. Given findings from this study, this should only be conducted after the users have taken some ownership of the innovation in terms of the specific ordering, clustering, and labeling of the innovation and steps. Continued training, technical support, and quality assurance mechanisms are also recommended by this author after the innovation is adapted by stakeholders.

As mentioned by one participant during follow-up, research focused on how GTO in Clinical Practice truly impacts outcomes in therapy is essential. The importance of this endeavor is two-fold: (1) Users have acknowledged that the use of the innovation takes time, a precious resource for clinicians that is often not reimbursed or incentivized outside of face-to-face clinical contact, and therefore ensuring that the innovation truly contributes to outcomes is an ethical next step prior to focusing on dissemination efforts;

(2) Findings that support the innovation's utility in enhancing client outcomes or essential dimensions of clinical practice will likely enhance attitudes toward use given the proclivity for graduate student trainees to value empirical research.

This author would like to caution future purveyors with an investment in this innovation in regards to solely addressing innovation use through the installment of more policies and procedures. Indeed, implementation research supports the use of policies and procedures in contributing to innovation adoption (Meyers et al., 2012; Rogers, 2003); however, this is only one facet of supporting an innovation's use. Treatment planning for example, is often considered a formality in clinical settings, a treatment plan required within a certain time-frame for each client; however, these formalities are often completed, deemed useless by the clinician, and thus never referenced beyond getting requirements met. Even accountability mechanisms cannot ensure that the users truly *value* and *utilize the* innovation fully, thus considerations around requirements should be considered delicately and thoughtfully.

In summary, given the nature of this innovation's development, this author suggests the sequence of foci around future research, evaluation, and dissemination to be (1) refining the innovation and measurement system using an inclusive participatory method, (2) piloting and testing the innovation's utility in enhancing clinical competence/practice within the innovation development setting, and (3) focusing on larger-scale dissemination efforts.

4.4 Conclusions

This study has demonstrated that GTO in Clinical Practice likely has utility for clinicians in training and given that variance in adherence to the model was evident in

such a small sample size, there is potential to study how high versus low fidelity to the model impacts various outcomes. Further, this study's methodological approach was unique, providing an example of how innovations being developed and disseminated in naturalistic settings can be explored during preliminary phases. Largely, findings highlight that the model is perceived as beneficial but that adaptations and support mechanisms are likely essential to its success. Given that this study is the first to investigate this innovation, there is great potential for future scholars to continue to investigate the use and outcomes associated with this innovation.

REFERENCES

- Aarons, G. A. (2004). Mental health provider attitudes toward adoption of evidence-based practices: The Evidence-Based Practice Attitude Scale (EBPAS). *Mental Health Services Research, 6*(2), 61–74.
- Adams, N., & Grieder, D. M. (2005). *Treatment planning for person-centered care: The road to mental health and addiction recovery*. Burlington, MA: Elsevier Academic Press.
- Addis, M. E., & Krasnow, A. D. (2000). A national survey of practicing psychologists' attitudes toward psychotherapy treatment manuals. *Journal of Consulting and Clinical Psychology, 68*(2), 331.
- Addis, M. E., Wader, W. A., & Hatgis, C. (1999). Barriers to dissemination of evidence-based practices: Addressing practitioners' concerns about manual-based psychotherapies. *Clinical Psychology: Science and Practice, 6*(4), 430–441.
- Albee, G. W. (2000). The Boulder Model's fatal flaw. *American Psychologist, 55*(2), 247–248.
- Alberts, G., & Edelstein, B. (1990). Therapist training: A critical review of skill training studies. *Clinical Psychology Review, 10*(5), 497–511.
- American Psychological Association (APA). (2010). Understanding anxiety disorders and effective treatment. Retrieved June 30th, 2016 from <http://www.apa.org/helpcenter/anxiety-treatment.aspx>.

- APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *The American Psychologist*, 61(4), 271.
- Baker, D. B., & Benjamin, L. T. (2000). The affirmation of the scientist-practitioner: A look back at Boulder. *American Psychologist*, 55(2), 241–247.
- Barbee, A. P., Christensen, D., Antle, B., Wandersman, A., & Cahn, K. (2011). Successful adoption and implementation of a comprehensive casework practice model in a public child welfare agency: Application of the Getting to Outcomes (GTO) model. *Children and Youth Services Review*, 33, 622-633.
- Barlow, D. H. (1981). On the relation of clinical research to clinical practice: Current issues, new directions. *Journal of Consulting and Clinical Psychology*, 49(2), 147–55.
- Beck, J. S. (2011). Termination and relapse prevention. *Cognitive behavior therapy: Basics and beyond* (2nd edition, pp. 316-331). New York, NY: Guilford Press.
- Beutler, L. E., & Consoli, A. J. (1993). Matching the therapist's interpersonal stance to clients' characteristics: Contributions from systematic eclectic psychotherapy. *Psychotherapy*, 30(3), 417–422.
- Beutler, L. E., Consoli, A. J., & Lane, G. (2005). Systematic treatment selection and prescriptive psychotherapy: An integrative eclectic approach. In *Handbook of psychotherapy integration* (2nd edition, pp.121-143). New York, NY: Oxford University Press, Inc.
- Bickman, L. (2008). A measurement feedback system (MFS) is necessary to improve mental health outcomes. *Journal of the American Academy of Child and Adolescent Psychiatry*, 47(10), 1114–1119.

- Bickman, L., Kelley, S. D., Breda, C., de Andrade, A. R., & Riemer, M. (2011). Effects of routine feedback to clinicians on mental health outcomes of youths: Results of a randomized trial. *Psychiatric Services*, 62(12), 1423–1429.
- Bohart, A. D., O'Hara, M., & Leitner, L. M. (1998). Empirically violated treatments: Disenfranchisement of humanistic and other psychotherapies. *Psychotherapy Research*, 8(2), 141–157.
- Borkovec, T. D. (2004). Research in training clinics and practice research networks: A route to the integration of science and practice. *Clinical Psychology: Science and Practice*, 11(2), 211–215.
- Boswell, J. F., & Castonguay, L. G. (2007). Psychotherapy training: Suggestions for core ingredients and future research. *Psychotherapy: Theory, Research, Practice, Training*, 44(4), 378–83.
- Campbell, M., Fitzpatrick, R., Haines, A., & Kinmonth, A. L. (2000). Framework for design and evaluation of complex interventions to improve health. *British Medical Journal*, 321(7262), 694.
- Candel M. J., Pennings, J. M. (1999). Attitude-based models for binary choices: A test for choices involving an innovation. *Journal of Economic Psychology*, 20, 547–569.
- Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology*, 52, 685–716.
- Chinman, M., Acosta, J., Ebener, P., Burkhart, Q., Clifford, M., Corsello, M., ... Tellett-Royce, N. (2012). Establishing and evaluating the key functions of an interactive

systems framework using an assets-getting to outcomes intervention. *American Journal of Community Psychology*, 50(3-4), 295–310.

Chinman, M., Acosta, J., Hunter, S., & Ebener, P. (2015). Getting To Outcomes®: Evidence of empowerment evaluation and evaluation capacity building at work. In D. Fetterman, S. Kaftarian, & A. Wandersman (Eds.), *Empowerment evaluation: Knowledge and tools for self assessment, evaluation capacity building, and accountability* (2nd ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Chinman, M., Hannah, G., & McCarthy, S. (2012). Lessons learned from a quality improvement intervention with homeless veteran services. *Journal of Health Care for the Poor and Underserved*, 23, 210–224.

Chinman, M., Hannah, G., Wandersman, A., Ebener, P., Hunter, S., Imm, P., & Sheldon, J. (2005). Developing a community science research agenda for building community capacity for effective preventive interventions. *American Journal of Community Psychology*, 35(3-4), 143-157.

Chinman, M., Hunter, S. B., Ebener, P., Paddock, S. M., Stillman, L., Imm, P., & Wandersman, A. (2008). The getting to outcomes demonstration and evaluation: an illustration of the prevention support system. *American Journal of Community Psychology*, 41(3-4), 206–24.

Chinman, M., Imm, P., & Wandersman, A. (2004). *Getting To Outcomes: Promoting accountability through methods and tools for planning, implementation, and evaluation*. Santa Monica, CA: RAND Corporation.

- Chinman, M., Tremain, B., Imm, P., & Wandersman, A. (2009). Strengthening prevention performance using technology: a formative evaluation of interactive Getting To Outcomes. *The American Journal of Orthopsychiatry*, 79(4), 469–81.
- Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2005). Identifying and selecting the common elements of evidence based interventions: A distillation and matching model. *Mental Health Services Research*, 7(1), 5–20.
- Crits-Christoph, P., Frank, E., Chambless, D. L., Brody, C., & Karp, J. F. (1995). Training in empirically validated treatments: What are clinical psychology students learning?. *Professional Psychology: Research and Practice*, 26(5), 514–522.
- Dimond, R. E., Havens, R. A., & Jones, A. C. (1978). A conceptual framework for the practice of prescriptive eclecticism in psychotherapy. *The American Psychologist*, 33(3), 239–48.
- Drake, R. E., Goldman, H. H., Leff, H. S., Lehman, a F., Dixon, L., Mueser, K. T., & Torrey, W. C. (2001). Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services*, 52(2), 179–182.
- Duckworth, K., & Freedman, J. (2012). Psychosocial treatments. *National Alliance on Mental Illness (NAMI)*. Retrieved June 6th, 2014 from <http://www.nami.org/>
- Duncan, B. L. (2012). The Partners for Change Outcome Management System (PCOMS): The Heart and Soul of Change Project. *Canadian Psychology/Psychologie Canadienne*, 53(2), 93–104.

- Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology*, 41(3-4), 327–50.
- Eells, T. D. (Ed.). (2006). *Handbook of psychotherapy case formulation* (2nd edition). New York, NY: Guilford Press.
- Eysenck, H. J. (1992). The effects of psychotherapy: An evaluation. *Journal of Consulting and Clinical Psychology*, 60(5), 659–663.
- Fernando, S. (2010). *Implementing response to intervention: Use of innovation configuration maps within a multiple-case study analysis* (Doctoral dissertation). Retrieved from ProQuest. University of South Carolina, Columbia, SC.
- Fetterman, D. M., & Wandersman, A. (Eds.). (2005). *Empowerment evaluation principles in practice*. New York, NY: Guilford Press.
- Fisher, D., Imm, P., Chinman, M., & Wandersman, A. (2006) *Getting To Outcomes with developmental assets: Ten steps to measuring success in youth programs and communities*. Minneapolis, MN: Search Institute.
- Florin, P., Friend, K. B., Buka, S., Egan, C., Barovier, L., & Amodei, A. (2012). The Interactive Systems Framework applied to the strategic prevention framework: The Rhode Island experience. *American Journal of Community Psychology*, 50, 402–414.
- Frambach R. T., Schillewaert N. (2002). Organizational innovation adoption: A multi-level framework of determinants and opportunities for future research. *Journal of Business Research*, 55,163–176.

- Frank, G. (1984). The Boulder Model: History, rationale, and critique. *Professional Psychology: Research and Practice*, 15(3), 417–435.
- Fuqua, D. R., Johnson, A. W., Anderson, M. W., Newman, J. L. (1984). Cognitive methods in counselor training. *Counselor Education and Supervision*, 24(1), 85-95.
- Garfield, S. L. (1996). Some problems associated with “validated” forms of psychotherapy. *Clinical Psychology: Science and Practice*, 3(3), 218–229.
- Gawande, A. (2010). *The checklist manifesto: How to get things right*. New York: Metropolitan Books.
- Gomes-Schwartz, B. (1978). Effective ingredients in psychotherapy: Prediction of outcome from process variables. *Journal of Consulting and Clinical Psychology*, 46(5), 1023–1035.
- Green, M. L. (2001). Evidence-based medicine training in internal medicine residency programs: A national survey. *Journal of Geriatric Internal Medicine*, 15, 129–133.
- Grencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice*, 21(5), 372–378.
- Hall, G. E. (2013). Evaluating change processes: Assessing extent of implementation (constructs, methods and implications). *Journal of Educational Administration*, 51(3), 264–289.
- Hall, G. E., & Hord, S. M. (2011). *Implementing change: Patterns, principles and potholes* (3rd edition). Upper Saddle River, NJ: Pearson.

- Hallinger, P. and Lee, M. S. (2011), Assessing a decade of education reform in Thailand: broken promise or impossible dream?. *Cambridge Journal of Education*, 41(2), 139-158.
- Harkness, A. R., & Lilienfeld, S. O. (1997). Individual differences science for treatment planning: Personality traits. *Psychological Assessment*, 9, 349-360.
- Haynes, S. N., Leisen, M. B., & Blaine, D. D. (1997). Design of individualized behavioral treatment programs using functional analytic clinical case models. *Psychological Assessment*, 9(4), 334–348.
- Henry W. P. 1998. Science, politics, and the politics of science: The use and misuse of empirically validated treatments. *Psychotherapy Research*, 8(2),126–40.
- Hoge, M. A., Huey, L. Y., & O’Connell, M. J. (2004). Best practices in behavioral health workforce education and training. *Administration and Policy in Mental Health*, 32(2), 91–106.
- Hord, S. M., Stiegelbauer, S. M., Hall, G. E., & George, A. A. (2006). *Measuring implementation in schools: Innovation configurations*. Austin, TX: Southwest Educational Development Laboratory.
- Imm, P., Chinman, M., Wandersman, A., Rosenbloom, D., Guckenburg, S., & Leis, R. (2007). Preventing Underage Drinking: Using Getting to Outcomes with the SAMHSA Strategic Prevention Framework to Achieve Results. RAND Technical Report. *RAND Corporation*.
- Institute of Medicine (IOM). (2006). *Improving the quality of health care for mental and substance-use conditions* (pp. i–504). Washington, DC: The National Academies Press.

- Jennings, L., Goh, M., Skovholt, T. M., Hanson, M., & Banerjee-Stevens, D. (2003). Multiple factors in the development of the expert counselor and therapist. *Journal of Career Development, 30*(1), 59–72.
- Jennings, L., & Skovholt, T. M. (1999). The cognitive, emotional, and relational characteristics of master therapists. *Journal of Counseling Psychology, 46*(1), 3–11.
- Kazdin, A. E. (2008). Evidence-based treatment and practice: new opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. *The American Psychologist, 63*(3), 146–59.
- Kloos, B., Gross, S. M., Meese, K. J., Meade, C. S., Doughty, J. D., Hawkins, D. D., ... & Sikkema, K. J. (2005). Negotiating risk: Knowledge and use of HIV prevention by persons with serious mental illness living in supportive housing. *American Journal of Community Psychology, 36*(3-4), 357-372.
- Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In *Handbook of psychotherapy integration* (pp. 94–129). New York, NY: Basic Books.
- Lambert, M. J. (1998). Manual-based treatment and clinical practice: Hangman of life or promising development?. *Clinical Psychology: Science and Practice, 5*(3), 391-395.
- Lambert, M. J., Hansen, N. B., & Finch, A. E. (2001). Patient-focused research: Using patient outcome data to enhance treatment effects. *Journal of Consulting and Clinical Psychology, 69*(2), 159–172.
- Lambert, M. J., Harmon, C., Slade, K., Whipple, J. L., & Hawkins, E. J. (2005). Providing feedback to psychotherapists on their patients' progress: Clinical results and practice suggestions. *Journal of Clinical Psychology, 61*(2), 165–74.

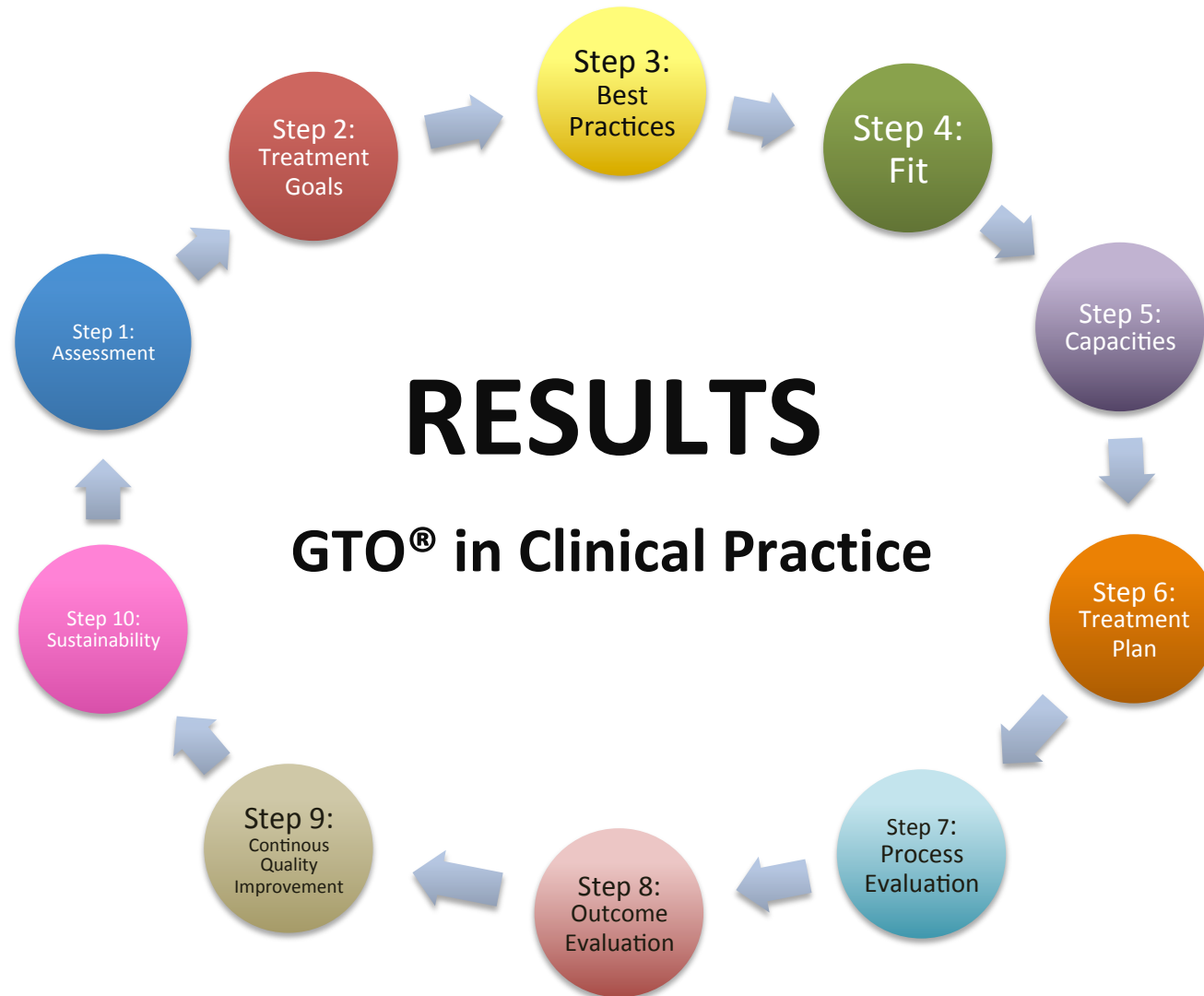
- Lazarus, A. A., Beutler, L. E., & Norcross, J. C. (1992). The future of technical eclecticism. *Psychotherapy*, 29(1), 11–20.
- Lesesne, C. A., Lewis, K. M., White, C. P., Green, D. C., Duffy, J. L., & Wandersman, A. (2008). Promoting science-based approaches to teen pregnancy prevention: Proactively engaging the three systems of the interactive systems framework. *American Journal of Community Psychology*, 41(3-4), 379-392.
- Locke, E. A., Shaw, K. N., Saari, L. M., & Latham, G. P. (1981). Goal setting and task performance: 1969-1980. *Psychological Bulletin*, 90(1), 125-152.
- Luborsky, L., & Krause, E. D. (2002). The Dodo Bird Verdict is alive and well — Mostly. *Clinical Psychology: Science and Practice*, 9(1), 2–12.
- Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that everyone has won and all must have prizes?. *Archives of General Psychiatry*, 32(8), 995-008.
- Martin, J., Slemon, A. G., Hiebert, B., Hallberg, E. T., & Cummings, A. L. (1989). Conceptualizations of novice and experienced counselors. *Journal of Counseling Psychology*, 36, 395–400.
- McFall, R. M., Treat, T. A. & Simons, R. F. (2015). Clinical science model. *The Encyclopedia of Clinical Psychology*. 1–9.
- McGinty, A. S. (2002). A programmatic approach to clinical research. *American Speech-Language-Hearing Association*. Retrieved February 28, 2014 from <http://www.asha.org/Academic/questions/A-Programmatic-Approach-to-Clinical-Practice-Research/>

- McHugh, R. K., & Barlow, D. H. (2010). The dissemination and implementation of evidence-based psychological treatments: A review of current efforts. *The American Psychologist*, 65(2), 73–84.
- Meyers, D. C., Durlak, J. A., & Wandersman, A. (2012). The quality implementation framework: A synthesis of critical steps in the implementation process. *American Journal of Community Psychology*, 50(3-4), 462–80.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook*. Thousand Oaks, CA: Sage.
- Nathan, P. E. (2000). The Boulder model: A dream deferred--or lost? *American Psychologist*, 55(2), 250–251.
- Norcross, J. C. (2010). *Evidence-based therapy relationships* (pp. 1–31). Retrieved from http://www.nrepp.samhsa.gov/pdfs/norcross_evidence-based_therapy_relationships.pdf
- Norcross, J. C. & Wampold, B. E. (2011). What works for whom: Tailoring psychotherapy to the person. *Journal of Clinical Psychology*, 67(2), 127–32.
- Orlinsky, D. E. & Rønnestad, M. H. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth*. American Psychological Association.
- Orlinsky, D., Rønnestad, M. H., Willutzki, U., & Cierpka, M. (1999). Psychotherapists' assessments of their development at different career levels. *Psychotherapy*, 36(3), 203–215.
- Persons, J. B., & Tompkins, M. A. (2007). Cognitive-behavioral case formulation. In T. D. Eells (Ed.), *Handbook of psychotherapy case formulation* (2nd edition, pp. 306–332). New York, NY: Guildford Press.

- Raimy, V. (Ed.). (1950). *Training in clinical psychology*. New York, NY: Prentice-Hall.
- Robey, R. R. (2004). A five-phase model for clinical-outcome research. *Journal of Communication Disorders*, 37(5), 401–11.
- Rogers, E. M. (2003). *Diffusion of innovations* (5th edition). New York, NY: Free Press.
- Rogers, M. A. (2009). What are the phases of intervention research?. *American Speech-Language-Hearing Association*. Retrieved February 28, 2014 from <http://www.asha.org/academic/questions/PhasesClinicalResearch/>
- Seale, C. (1999). *The quality of qualitative research: Introducing qualitative methods*. London: Sage.
- Silverman, W. H. (1996). Cookbooks, manuals, and paint-by-numbers: Psychotherapy in the 90's. *Psychotherapy: Theory, Research, Practice, Training*, 33(3), 207.
- Skovholt, T. M., & Jennings, L. (2004). *Master therapist: Exploring expertise in therapy and counseling*. New York, NY: Pearson Education, Inc.
- Skovholt, T. M., Rønnestad, M. H., & Jennings, L. (1997). Searching for expertise in counseling, psychotherapy, and professional psychology. *Educational Psychology Review*, 9(4), 361–369.
- Smith, E. W. L. (1995). A passionate, rational response to the “manualization” of psychotherapy. *Psychotherapy Bulletin*, 30(2), 36-40.
- Sommers-Flanagan, J., & Sommers-Flanagan, R. (2009). *Clinical interviewing* (4th edition). Hoboken, NJ: John Wiley & Sons.
- Sperry, L. (2011). *Core Competencies in Psychotherapy: Becoming a Highly Competent and Effective Therapist*. New York, NY: Routledge.
- Stake, R. E. (2006). *Multiple case study analysis*. New York, NY: Guilford Press.

- Strupp, H. H. (1981). Clinical research, practice, and the crisis of confidence. *Journal of Consulting and Clinical Psychology, 49*(2), 216–219.
- Tracey, T. J. G., Lichtenberg, J. W., Goodyear, R. K., Claiborn, C., & Wampold, B. E. (2003). Concept mapping of therapeutic common factors. *Psychotherapy Research, 13*(4), 401–413.
- Wampold, B. E. (2001). Specific effects: Weak empirical evidence that benefits of psychotherapy are derived from specific ingredients. In *The Great Psychotherapy Debate: Models, Methods, and Findings* (pp. 119–148). Mahway, New Jersey: Lawrence Erlbaum Associates.
- Wandersman, A., Chien, V. H., & Katz, J. (2012). Toward an evidence-based system for innovation support for implementing innovations with quality: Tools, training, technical assistance, and quality assurance/quality improvement. *American journal of community psychology, 50*(3-4), 445-459.
- Wandersman, A., Imm, P., Chinman, M., & Kaftarian, S. (2000). Getting to outcomes: A results-based approach to accountability. *Evaluation and program planning, 23*(3), 389-395.
- Wells, M. G., Burlingame, G. M., Lambert, M. J., Hoag, M. J., & Hope, C. A. (1996). Conceptualization and measurement of patient change during psychotherapy: Development of the Outcome Questionnaire and Youth Outcome Questionnaire. *Psychotherapy: Theory, Research, Practice, Training, 33*(2), 275.

APPENDIX A – GTO IN CLINICAL PRACTICE GRAPHIC



APPENDIX B – INNOVATION CONFIGURATION MAP

Getting To Outcomes® in Clinical Practice: Innovation Configuration Map Version C

Developed by Jennifer Castellow, Robert Markle, and Katie Knies

What is the IC Map for Getting To Outcomes® in Clinical Practice?

This Innovation Configuration (IC) Map is intended to describe both ideal and non-ideal ways that Getting To Outcomes (GTO®) can be used in clinical practice. It can be used as a guide to assess the extent to which student-therapists are using GTO in Clinical Practice as originally intended by the developers.

Potential Uses:

Supervisors and student-therapists can use this tool to gain an in-depth understanding of how GTO in Clinical Practice is intended to be implemented and where student-therapists may fall along the continuum of implementation. Potential uses include: supervisors who use the map to assess student-therapists' adherence to GTO processes, individual students who use this map for self-assessment, or a class exercise in which students observe their peers and evaluate their level of fidelity to GTO practices.

How to Read the Map:

For each of the components in this map, there are several variations that are written in descending order of fidelity to GTO in Clinical Practice from left to right. The variations depict scenarios in decreasing order of fidelity such that the “A” variations are more adherent to GTO in Clinical Practice than the “B” variations, “B” variations are more adherent than “C” variations and so on. Thus, the “A” variation depicts the most ideal use of the innovation and is what student-therapists should strive to accomplish in implementing GTO into their practice.

Cite as: Castellow, J., Markle, R. S., & Knies, K. (2014). Getting To Outcomes® in Clinical Practice: Innovation Configuration Map, Version B. *Department of Psychology, University of South Carolina, Columbia, SC.*

Table of Contents

Cluster 1: Strengths-Based Needs and Resources Assessment	3
Cluster 2: Treatment Goal Setting	4
Cluster 3: Identifying Best Practices	5
Cluster 4: Selecting Best Practices Based on Fit with Therapist and Client Context	5
Cluster 5: Selecting Best Practices Based on Capacity	6
Cluster 6: Developing Treatment Plan	7
Cluster 7: Implementation/Process Evaluation	8
Cluster 8: Outcome Evaluation	8
Cluster 9: Continuous Quality Improvement (CQI)	9
Cluster 10: Sustainability	10

Cluster 1: Strengths-Based Needs and Resources Assessment

<i>Component 1.1: Therapist identifies client needs and strengths through interview process. (Interview structure, Information obtained)</i>				
A	B	C	D	E
Therapist conducts thorough, semi-structured interview(s) (i.e., a standard interview form is utilized) that collects comprehensive information on client needs, strengths, and supports.	Therapist mostly completes semi-structured clinical interview(s) and collects some information on client needs, strengths, and supports.	Therapist conducts unstructured clinical interview(s) (i.e., no standard interview form utilized) and collects incomplete information on client needs, strengths, and supports.	Therapist identifies needs and strengths based on clinical judgment, intuition, and client session-to-session verbal report.	Therapist conducts therapy without gaining a complete understanding of the client's needs, strengths, and supports. Uses standard approach that is basically the same for all clients.
<i>Component 1.2: Therapist identifies client needs and strengths through supplemental assessment tools. (Relevance of supplemental assessment materials)</i>				
A	B	C	D	E
Therapist administers supplemental assessment materials relevant to their understanding of the presenting problem(s). The assessment battery is tailored to the specific client.	Therapist administers supplemental materials that are moderately relevant to their understanding of the problem. The assessment battery is moderately specific to the individual client.	Therapist administers supplemental materials based upon a common battery of assessments utilized. The battery is comprehensive, but not necessarily tailored to the individual client.	The therapist administers one or two measures that are commonly utilized to gauge common symptoms in therapy clients.	Therapist gathers supplemental information through clinical judgment and client session-to-session verbal report.
<i>Component 1.3: Therapist develops case conceptualization based on integrated findings (Integration of assessment findings, Identification of etiological factors)</i>				
A	B	C	D	E
Therapist conceptualizes	Therapist integrates	Therapist interprets	Therapist conducts	Therapist proceeds

the client's case based on an integration of the preceding assessment process. Therapist attempts to pinpoint specific etiological factors and/or diagnoses that might contribute to an array of problem behaviors.	information gathered from assessment process but case is not conceptualized in full . Therapist identifies multiple problem behaviors without identifying specific etiological factors or diagnoses .	assessment findings but does not integrate findings. Therapist conceptualizes case or gives diagnoses based on clinical judgment, intuition, and client session-to-session verbal report .	assessment but does not interpret any findings , and therefore, does not conceptualize case.	with therapy with limited consideration of assessment findings .
--	---	---	---	---

Cluster 2: Treatment Goal Setting

<i>Component 2.1: Therapist formulates treatment goals based on case conceptualization. (Utilization of assessment to inform goals).</i>				
A	B	C	D	E
Therapist utilizes all findings from assessment to inform the treatment goal-setting process.	Therapist utilizes diagnoses from assessment to inform the treatment goal-setting process.	Therapist partially references assessment findings to inform treatment goal-setting.	Therapist asks client to set treatment goals .	Therapist independently determines client goals . Therapist uses clinical judgment to determine goals for therapy.
<i>Component 2.2: Therapist formulates treatment goals based client input. (Discussion of goals with client).</i>				
A	B	C	D	E
Therapist presents case conceptualization and engages client in a discussion about treatment goal-setting. Any discrepancies	Therapist presents treatment goals to client and asks client for feedback . Any discrepancies between case conceptualization	Therapist informs client about treatment goals without addressing discrepancies . Feedback from the	Therapist independently determines client goals and begins therapy without explicitly discussing	Therapist conducts therapy without discussing treatment goals with the client . Treatment goals are considered flexible

between case conceptualization and client's stated goals are discussed and reconciled with client.	and client's stated goals are discussed and reconciled with client.	client is discussed and acknowledged in therapeutic way.	treatment goals with the client.	entities.
---	--	---	---	-----------

Cluster 3: Identifying Best Practices

<i>Component 3.1: Therapist explores best practices based on case conceptualization and client's goals (Consideration of evidence-based practices, Consultation with colleagues)</i>				
A	B	C	D	E
Therapist considers evidence-based practices (e.g. texts, journal articles, manuals, etc.) related to case conceptualization and treatment goals. Therapist consults with colleagues (e.g. supervisors, problem-related specialists, fellow therapists) regarding best practices.	Therapist either considers evidence-supported practices (e.g., texts, journal articles, manuals, etc.) related to case conceptualization and treatment goals OR consults with colleagues (e.g. supervisors, problem-related specialists, fellow therapists) regarding best practices for specified problems, but does not do both.	Therapist considers evidence-supported practices (e.g., texts, journal articles, manuals, etc.) that are not related to case conceptualization and treatment goals.	Therapist selects practices that are not evidence-based.	Therapist conducts therapy without identifying practices beforehand.

Cluster 4: Selecting Best Practices Based on Fit with Client and Therapist Context

<i>Component 4.1: Therapist selects and/or adapts best practices based on fit with client's needs, background, and preference. (Consideration of client context and barriers).</i>				
A	B	C	D	E
Therapist ensures fit of best practices based on client context (e.g., client's issues, preferences and background).	Therapist partially considers fit of best practice based on client context (e.g., client's issues, preferences and background).	Therapist considers fit of best practice based on parts of the client's context (e.g., client's issues, preferences, and background).	Therapist adjusts fit of best practices while implementing therapy without proactively planning for the process.	Therapist selects practices irrelevant of fit of particular client.
<i>Component 4.2: Therapist selects and/or adapts best practices based on fit therapist's orientation. (Consideration of therapist's preference and orientation).</i>				
A	B	C	D	E
Therapist also ensures fit of best practices based on therapist's own therapeutic orientation .	Therapist partially considers her/his own therapeutic orientation in the selection process.	Therapist considers fit of best practice based on her/his initial appraisal of the strategy without considering her/his therapeutic orientation .	Therapist does not systematically consider her/his therapeutic orientation or preference in selection process.	Therapist selects best practices that are in conflict with her/his therapeutic orientation in order to meet the client's needs.

Cluster 5: Selecting Best Practices Based on Capacity

<i>Component 5.1: Therapist selects and/or adapts best practices based on capacity of client, (Consideration of client's strengths).</i>				
A	B	C	D	E
Therapist leverages specific strengths of client to select best	Therapist considers specific strengths of client to select best	Therapist partially considers specific strengths of client to	Therapist only considers client capacity to fulfill	Therapist conducts therapy without considering capacity

practices.	practices.	select best practices, but selects the treatment most relevant to the treatment goals.	treatment when treatment objectives are not met.	of client to fulfill treatment activities.
<i>Component 5.2: Therapist selects and/or adapts best practices based on her/his own capacity. (Consideration of therapist's skills and Utilization of specific therapy resources).</i>				
A	B	C	D	E
Therapist selects best practices for which she/he has particular skills . Therapist utilizes specific resources for each best practice (e.g., manuals, training, colleagues, supervision, etc.) to ensure quality implementation.	Therapist selects best practices for which she/he has necessary skills to complete . Therapist utilizes specific resources for each best practice (e.g., manuals, training, colleagues, supervision, etc.) to ensure quality implementation.	Therapist selects best practices that she/he is mostly familiar with . Therapist demonstrates a general understanding of best practices selected. Therapist attempts to implement treatment with incomplete support (e.g. manual without proper supervision).	Therapist selects best practices that she/he is unfamiliar with . Therapist attempts to implement best practice without support of resources (e.g. manuals, training, supervision, etc.). Therapist generalizes other therapeutic skills to the utilization of best practices selected .	Therapist selects best practice that she/he has demonstrated incompetence carrying out in the past in order to match the appropriate treatment to the needs of the client. Therapist generalizes other therapeutic skills to the utilization of best practices selected .

Cluster 6: Developing Treatment Plan

<i>Component 6.1: Therapist collaborates with client to develop treatment plan that can guide the therapy process (Collaborate with client on objectives, timeline, and responsible parties).</i>				
A	B	C	D	E
Therapist and client agree on objectives that will help them reach and	Therapist independently sets objectives that are relevant to client's goals.	Therapist independently decides upon treatment plan ,	Therapist independently develops and finalizes	Therapist does not develop a treatment plan .

measure goal attainment. Therapist collaborates with client to determine timeline and responsible parties for each objective.	Therapist consults with client about proposed timeline and responsibility for each objective.	including timeline and responsible parties, and presents treatment plan to client for feedback.	treatment plan.	
<i>Component 6.2: Therapist develops a treatment plan that is informed by case conceptualization, treatment goals, and practices selected (Connection of plan to case conceptualization, goals, and best practices).</i>				
A	B	C	D	E
Therapist develops treatment plan objectives that are informed by case conceptualization, goals, and best practices. Best practices are operationalized by the treatment plan. Each objective logically connects with best practices selected.	Therapist develops treatment plan objectives that are informed by case conceptualization and goals. Action steps seem logically connected to treatment goals, but do not necessarily enact best practices.	Therapist develops treatment based on treatment goals. Therapist determines action steps that are logically linked to described goals, but do not appear informed by the broader case conceptualization of the client. Best practices are not described.	Therapist develops a treatment plan based on intuition and clinical judgment. Action steps seem logical, but are not linked to the case conceptualization, identified goals, or best practices selected.	Therapist does not develop a treatment plan.

Cluster 7: Implementation/Process Evaluation

<i>Component 7.1: Therapist implements treatment according to treatment plan (Complete treatment objectives, Collaboratively monitor adherence, Update treatment plan).</i>				
A	B	C	D	E
Therapist completes each objective according to	Therapist completes each objective	Therapist begins by implementing	Therapist utilizes treatment plan to	Therapist never references treatment

timeline. Therapist and client monitor and measure adherence to treatment plan and timeline. Therapist updates treatment plan throughout therapy process.	according to timeline. Therapist independently monitors adherence to treatment plan sporadically throughout treatment. Therapist updates treatment plan as she/he feels necessary.	treatment plan according to proposed timeline. Therapist keeps treatment plan in mind as she/he moves through treatment process, but this process is not systematic. Treatment plan is never updated.	create cognitive map for therapy. Therapist rarely, if ever, references treatment plan throughout therapy process.	plan throughout therapy process.
---	---	--	---	---

Cluster 8: Outcome Evaluation

<i>Component 8.1: Therapist and client measure progress being made toward selected goals (Develop outcome measurement strategy, Utilize repeated measurement consistently).</i>				
A	B	C	D	E
Therapist monitors progress toward goals with outcome measurement strategies , including client verbal report. Therapist utilizes repeated measurement strategies , measuring at pre-determined time points.	Therapist utilizes outcome measurement strategies sporadically. Some measures are utilized only once or twice to get a sense of whether treatment gains are being made.	Therapist measures outcomes at the beginning and end of therapy. Therapist relies primarily on client report to determine progress.	Therapist relies on clinical judgment to determine progress toward treatment gains.	Therapist inconsistently or never considers monitoring client progress.
<i>Component 8.2: Therapist documents components responsible for goal attainment (Documentation of factors responsible for goal attainment).</i>				
A	B	C	D	E
As progress toward goals	As progress toward goals	Progress toward change	Therapist does not	Therapist does not

is accomplished, therapist documents contributing factors in case notes.	is being accomplished, therapist is able to describe contributing factors, but does not document these contributing factors .	can be attributed to various factors , but therapist is not able to explicitly state what these factors are .	attribute progress toward goals to any specific factors , but rather conceptualizes change as a result of the therapy process.	consider any factors responsible for goal attainment.
---	---	---	---	--

Cluster 9: Continuous Quality Improvement

<i>Component 9.1: Therapist makes necessary mid-course corrections to plan or strategy (Mid-course corrections, Rationale for therapy adjustments).</i>				
A	B	C	D	E
Therapist discusses outcome and process evaluations with client . Therapist and client mutually determine whether adjustments need to be made, based on these findings as well as the client's stated preference . Therapist provides rationale for adapting treatment strategy, treatment plan, or measurement process.	Therapist makes mid-course corrections based on client feedback as well as outcome findings . Therapist uses clinical judgment to determine what changes need to be made.	Therapist only makes mid-course corrections to therapy when client is not being compliant with treatment. Otherwise, the therapy relies on the rationale of the treatment model to guide the therapy process.	The therapist remains consistent with the treatment plan, despite any feedback that treatment gains are not being made. Mid-course corrections are arbitrary .	Therapist never makes any changes to treatment plan or strategies.

Cluster 10: Sustainability

<i>Component 10.1: Therapist plans for the cessation of treatment (Rationale for ending treatment, Consideration of treatment cessation, Discussion of cessation with client).</i>				
A	B	C	D	E
Therapist ends treatment after the client and therapist determine treatment goals have been . Therapist considers various treatment cessation strategies (e.g. booster sessions, skills building groups, etc.). Therapist discusses options with client .	Therapy ends after the client and therapist determine treatment goals are met . Treatment cessation strategies are not discussed . The treatment cessation process is not discussed with the client until final session.	The therapist ends treatment when she/he believes treatment goals have been accomplished without consulting with the client .	Treatment ends arbitrarily . The therapist ends treatment when she/he is no longer able to serve the client .	Treatment ends arbitrarily . Therapist never plans to end treatment. Therapy ends as a result of no-shows .
<i>10.2 Therapist plans for maintaining treatment gains (Exit interview, Discussion of skills and supports).</i>				
A	B	C	D	E
Therapist conducts exit interview focusing on identifying and sustaining treatment gains . Therapist and client outline skills that have been learned in therapy as well as natural supports in client's environment that can be accessed to maintain treatment gains.	Therapist conducts exit interview focusing on identifying and sustaining treatment gains . Therapist solely discusses skills that have built throughout therapy.	Therapist encourages client to discuss what skills she/he has learned from therapy. There is little to no discussion around how to maintain these skills.	Therapist ends treatment under the assumption that treatment has instilled permanent skills.	Treatment ends arbitrarily without consideration of treatment gains .

APPENDIX C – INTERVIEW PROTOCOL

GTO in Clinical Practice IC Map and Appraisal Interview Protocol

Revised: 1/23/15

Would it be okay to record this? [If participant consents, begin recording if participant consents. If participant refuses, ask if you can take notes on your laptop. If participant refuses note-taking, end interview]

[Interviewer should state all of these points casually, ensuring all points of information are covered.]

*Thanks for taking the time to sit down and do this interview. I know you are all really busy, so I really appreciate it. Just to let you know what we're up to with this interview, **this is part of a study for a measurement tool for GTO in Clinical Practice**, an innovation that's being implemented here at the [CLINIC]. As you probably know, our group has a **vested interest in this innovation**, but we're honestly curious about **how using GTO has affected your practice and what it's been like to manage it**. Here we are. We've been developing this thing, we've been planning its rollout, and it's taken a lot of time and work on both the developers and the users. Now we want to pause and really **get a sense of what people are actually doing in therapy, what's useful about GTO in this setting, and what gets in the way**. We really need to know what it's like for you, a student therapist on the ground in classes, in practicum, a busy person using it.*

*Even though we are interviewing you, we are really interested in evaluating the innovation. This is **not an evaluation of your competence or your skill level**. This is more about how evaluating the program, rather than any individual.*

*If at any time you'd like to stop the interview, just let me know, and we can certainly stop. If you feel confused or uncomfortable and would like to ask something about the interview process, please feel free. I'm happy to discuss that with you. **This will not affect your grade, how you are perceived by your supervisor, or anything of the like**. In fact, this interview is **anonymous, meaning that this interview will be transcribed and de-identified before it is analyzed and I will not be sharing that you've participated in this interview or identify you if I ever discuss the interview with my lab members**. For the purpose of anonymity, I encourage you to refrain from discussing with others how you responded to this interview for that purpose.*

I'm going to ask you some questions about your clinical work, what you normally do, and what it's like for you doing clinical work at the [CLINIC]. I'll also be asking you

*about your **perception of an innovation that's being rolled out here**. How does that sound? So let's begin with just some basic stuff.*

1. What program are you in?
2. What year are you in the program?
3. How many years have you been doing some sort of clinical work, including any experience outside of grad school?
4. How many years of experience do you have doing clinical work at the [CLINIC]?
(If participant has not had any clinical experience whatsoever, end interview.)
5. What practicums have you been enrolled in?
6. What practicums are you currently enrolled in?
7. How many clients do you think you've seen at the [CLINIC]? (Prompt to estimate if they are unsure of the exact number)
8. What populations do you tend to work with? (Prompt for adults, couples, children, families, group)
9. What type of settings have you worked in?
10. What treatment modalities have you primarily used?
11. What type of clinical work do you most enjoy doing?
12. What would say your school of thought or philosophical orientation is, if you had to name it?
13. What has been challenging or frustrating about doing clinical work?
14. Do you see yourself doing clinical work later in your career after you've graduated?
 - a. (If **yes**) What kind of work might you see yourself doing?

*Now I'd like to ask you some things about **how you do therapy and what you do in therapy**. Try to **really imagine what you actually DO with your clients rather than what you wish you did or think you're supposed to do**. We understand that therapy is complex, it's time-consuming, and sometimes a lot messier than we'd really like it to be. Would you feel comfortable with that? If you could, **picture one or two clients that you've been working with lately while you answer these questions** and answer the questions I ask by telling me what you've done in these scenarios. Would that be okay?*

[Some standard probes:

- *Can you say more about that?*
- *Tell me more about that.*
- *How does (reflect language) look?*
- *What does that process look like?*
- *(If participant mentions meeting with supervisor as an activity) And what did you two discuss or do during supervision?]*

15. When working with a client, how do you gather information that helps you understand their needs and resources?
16. Do you usually do an assessment of some sort? (Clarify, if necessary: An assessment might involve administering some measures, asking some questions to get to know your client, or maybe something else)

- a. (If **yes**) What does that assessment process look like?
 - b. (If **yes**) Do you write a report or a summary of the assessment?
 - i. (If **yes**) Would you be okay with me taking a look at examples of these in your records to get a sense of how they're written? Again, this will not be used to evaluate you, but rather get a sense of how things are being done. (Refer to consent form)
 - ii. (If **no**) How do you summarize your findings?
 - c. (If **no**) Okay, so how do you gather information when you first start seeing a client?
17. Do you have an interview process for these beginning sessions?
- a. (If **yes**) What do you use to guide the interview?
 - b. (If **no**) What kinds of questions do you ask your client to get to know them in this beginning phase?
18. How do you go about making sense of your case? In other words, how do you use the information that's gathered in those beginning sessions?
19. Do you generally set treatment goals in therapy?
- a. (If **yes**) What does this process look like?
 - b. (If **yes**) How do you decide what the goals are?
 - c. (If **no**) Okay. How do you decide what direction therapy needs to go in the early stages?
20. How do you decide what treatment or treatment strategies you will use to work with your clients?
21. Let's think of a one of those example clients we mentioned before. Tell about how you decided what treatment or strategy to use?
- a. (If they have example) How did you find out about the practices you ended up using?
 - b. (If they have example) How did you decide whether that treatment strategy was appropriate?
22. Do you have a general repertoire or "clinical tool kit" that you tend to use when you think about selecting treatment strategies? What is it?
23. How have you considered specifying treatment to your particular clients in the past?
24. Can you describe a time when a treatment strategy you were considering did not seem to fit your client very well?
- a. (If **yes**) How did you know?
 - b. (If **yes**) What did you do?
25. When have you been were worried about your own ability to administer a specific treatment?
- a. (If **yes**) What happened?
 - b. (If **yes**) What did you do?
26. When have you thought that maybe your client didn't have the ability or the capacity to complete a treatment you were considering?
- a. (If **yes**) Can you tell me how you dealt with that?
27. What do you do to plan for the treatment process?
28. What kinds of things go into your plan?
29. Do you have any written treatment plans?

- a. (If **yes**) Would you be okay with me looking at examples of your treatment plans for the same purpose I mentioned earlier? (Refer to consent form)
- 30. How do you know when you're following your plan for treatment?
- 31. How do you know if you're meeting treatment objectives that you've set for therapy?
- 32. How do you keep track of how your client is doing?
- 33. How do you know your clients are making progress toward their goals for therapy?
- 34. How would you or your client know that you'd reached your goals for therapy?
- 35. When you see progress in therapy, do you generally feel like you have an understanding of what led to that progress or does it feel kind of ambiguous?
 - a. (If **yes**) How do you keep track of that?
 - b. (If **no**) So when you see change, what do you think is happening?
- 36. Are there ever times that you've made strategic changes to your plan for therapy?
 - a. (If **yes**) How do you go about deciding what to change?
 - b. (If **yes**) When you've made changes to your plan, what kinds of changes have you made?
 - c. (If **no**) How does your plan change? Or does it remain pretty consistent?
- 37. How does therapy generally end with your clients? For example, who initiates ending treatment and why?
- 38. If there was progress in therapy, how do you make sure your client maintains that progress beyond treatment? How do you sustain progress?
- 39. Do you mind if I review examples of your notes and other records to see how you record the therapy process? May I review electronic as well as physical files? This would include maybe documents on the client files drive, in Titanium, in your clients' physical files, files in your student folder, etc. No identifiers will be recorded whatsoever. (Refer to consent form)
- 40. Would you mind if I request records from your current and previous supervisors that might tell me about how you've done and currently do therapy? (Refer to consent form)

*Now, I'd like to ask you just a few questions about how you feel about GTO in Clinical Practice and how it affects your life and your practice. **[Be sure to clarify that we are asking about GTO in Clinical Practice, not GTO in general]***

- 41. Have you heard about "Getting to Outcomes, or GTO, in Clinical Practice"? (If yes, proceed with following questions. If no, follow up to make sure they are completely unaware of the innovation, and proceed to question 64.)
- 42. How did you learn about GTO in Clinical Practice?
- 43. How did you feel about it when you first heard about it? (Prompt to discuss both positive and negative feelings)
- 44. What is your understanding as to what GTO in Clinical Practice is?
- 45. Do you feel like you've been adequately trained to use GTO in Clinical Practice?
- 46. Have you had a chance to try out using GTO in Clinical Practice in any way? How did that look?

47. How do you feel GTO in Clinical Practice has changed how you do clinical work?
Does it feel different from “treatment as usual”?
48. What benefits do you get from GTO in Clinical Practice? Or do you?
49. How do you feel like you avoid it?
50. Which parts do you feel like you struggle with?
51. How do you think it compares to other ways of structuring therapy?
52. In what ways does GTO in Clinical Practice help you work with your clients?
53. What ways does it get in the way in doing clinical work?
54. What have you noticed since you’ve started using it?
55. How well does GTO in Clinical Practice fit with your values and needs as a practitioner?
56. How does it interfere with your values and needs as a practitioner?
57. How does GTO in Clinical Practice appeal to you? What do you like about it?*
58. What don’t you like about it?*
59. What “makes sense” about it?*
60. What doesn’t seem to make so much sense?*
61. How do you think your fellow students feel about it? What do they think?*
62. Can you decide not to use GTO in Clinical Practices?*
- a. (If yes) What would happen?
63. What would you change about GTO in Clinical Practice?

Okay, great. I really appreciate you taking the time to answer all of these questions. Now, I know we’ve been here for a while, but I was wondering if you could share how this interview went.

64. Did you feel confused about what I was asking about?
65. Any questions that you didn’t really feel comfortable answering?
66. Is there some piece that you feel like I’ve missed?
67. Is there anything else you’d like to share about any of this?
68. Are there any other students or informants that you feel would help give us information about how people use GTO in Clinical Practice in different ways that you would be willing to share after we stop recording? Anyone that you know that does things differently? Anyone that you know that has strong positive or negative opinions about it? We will use this list of names on a list for the purpose of recruiting participants without identifying which participant suggested these names. [If yes, stop recording while you collect names of potential participants]

Okay, great. Thank you again for being a part of this. I know you are very busy and this has been really helpful. I’ll be scheduling a follow-up with you via email to review how I’ve interpreted this interview and other sources of data about your clinical work and your perception of GTO in Clinical Practice. Would that be okay?

APPENDIX D – WORKSHEET DESCRIPTIONS

Adapted Descriptions of the Multiple-Case Study Analysis Worksheets (Stake, 2006)

	Description
<i>Worksheet 1</i>	When balancing multiple cases, creating a visual outline for gathering data in each case can be useful. Figure 1 represents a template for a therapist as a case. The worksheet takes an ecological approach by including contexts affecting the case, key issues to be aware of during the case study, and an area for detailing the key activities to understand, interviews, and documents to be reviewed. This worksheet informed data collection for individual case reports.
<i>Worksheet 2</i>	Once all the individual case studies have been completed, this worksheet is the first step in the cross-case analysis. The themes in the worksheet represent the research questions for the study. Worksheet 2 should always be easily within reach when reading all of the case studies individually.
<i>Worksheet 3</i>	The majority of the case analyst's notes can be found on the third worksheet. These include the analyst synopsis of the case, uniqueness of the case among the other cases. An important use of this worksheet is for determining the prominence of each theme in the case and the expected utility of the case for developing the theme.
<i>Worksheet 4</i>	After judging the utility for each case to develop the theme, the analyst gives the case a rating of high, middling, or low. These ratings are entered in Worksheet 4.
<i>Worksheet 5</i>	Robert Stake created three different tracks for conducting the multiple-case analysis in order to accommodate the overall aims of the researcher. Track I maintains the case findings and emphasizes the situationality of the cases, Track II merges similar findings, while maintaining some situationality from each case, and Track III is the most quantitative track that shifts the focus from Findings to Factors. This study utilized Track II.
<i>Worksheet 6</i>	The Assertions made from the case studies are placed in the sixth worksheet. The Assertions about the study results are based on the merged Findings from Worksheet 5. "Each Assertion needs to have a single focus, an orientation for understanding the phenomenon of interest, and evidence to support it" (Stake, 2006, p.62).
<i>Worksheet 7</i>	When planning the final report, worksheet 7 acts as a graphical representation of the data gathered from each case, which led to the Findings and Assertions. This worksheet was not necessary given the use of excel spreadsheets and NVivo to organize findings.

Adapted from *Implementing response to intervention: Use of innovation configuration maps within a multiple-case study analysis* by Sheara Fernando, 2010. Retrieved from ProQuest.

APPENDIX E – IC MAP ANALYSIS EXAMPLE

P07 IC Map Analysis

IC Comp	Case Referenced	Codes Reviewed	Data Sources	Findings	Tri*	IC Map Score	Clt Diff**	Quotes
1.1	P07	Clinical Interview	Interview, Physical Files Inventory	The therapist describes doing open-ended as well as structured interviews. Participant describes interviewing the parent with young children and doing naturalistic observations to gain understanding. There is evidence of the use of the clinical interview with Client 2 in the files inventory. Therapist describes using this as a "skeleton."	yes		yes	<p>“What’s the primary concern?” um and kind of get those “who’s in the home home” um “What strengths or behaviors are you seeing?” “What strengths are you seeing?” and really try to emphasize those— I: Uh-huh P: --um, and try to get that picture of just the current level, then kind if dive in to more developmental history. Um, milestones, school history, social, emotional, um history that way um so I guess start at the beginning and then kind of—or I guess start at the present level beginning— I: Yeah. P: --and then work</p>

								from— I: And then go back a little later. P: -- Exactly. Yeah.
1.1	P07	Dimension IDed about Clt	Coding Tree Analysis, Case Notes, Treatment Plans, Assessment Report	Multiple dimensions IDed about Client 2, and only presenting problem and referral information IDed about Client 1. Client 1 was brought in with a full assessment report completed with conceptualization and treatment recommendations.	yes	CL01-C, CL02-A	yes	
1.2	P07	Assmt Battery, Supplemental Data	Physical Files Inventories, Case Notes, Treatment Plans,	Supplemental assessment measures are tailored to the clients. Batteries are tailored to the individual clients.	yes	A	no	

			Interview					
1.3	P07	Integration of Findings and Case Conceptualization	Case Notes, Treatment Plans, Assessment Report	Both cases were fully conceptualized based on preceding findings. Both provide a thorough conceptualization that pinpoints etiological factors within the context of the client.	yes	A	no	But then also just like, you know, um, during the day when I'm getting my normal work done I'll try to build in some time to look at that data and just really kind of the information that I've got so far.
2.1	P07	Source of Goals Set	Treatment Plans, Interview	Goals are seemingly related to primary problems in client documents. Interview sheds light that these were also based on therapist's conceptualization. Participant also describes discussing goal-setting with the client/family in the goal-setting process. It seems that a lot takes place behind the scenes for this	yes	A	no	

				process.				
2.2	P07	Assessment feedback for client	N/A	There was no evidence of assessment feedback for either client	N/A		no	
2.2	P07	Setting Goals Collaboratively with Client	Interview, review of records	There was no evidence of collaborative goal-setting in the record. Participant states upon follow-up that mom and dad came in with conceptualization for CL01 and that was very collaborative..	no	CL01-A, CL02-E	no	
3.1	P07	Step 3 Exploring Best Practices	Physical Files Inventory, Transcript	There is evidence of the participant consulting with supervisors, reading literature (manuals), reading online materials, listening to peers present on approaches. Participant also discusses seeking out materials that relate to	yes	A	?	And what do you guys talk about when you talk about this; the treatment strategies? P: Sure, um, asking them you know what-what strategies they might have used in the past, for similar circumstances,— I: Uh-huh P: --“What has been

				goals/conceptualization.				effective?” “What hasn’t been effective”— I: Sure. P: --Um, just trying to kind of build up those skills definitely. Borrow a manual or borrow a book or something and try to— I: Yeah. P: -- look through.
4.1	P07	Fit for Clt	Case Notes	Participant did not report tailoring fit of treatment, but there is evidence of tailoring fit of treatment to Client 1 in the case notes, considering dosage of tx given assessment findings. Best practices are relevant to presenting problems	no	C	?	

4.2	P07	Fit for Therapist	Interview	Therapist discusses being aware of her tendency toward behavioral approaches and describes also branching out to learn CBT approaches when appropriate for the case.	no	B	?	I think with my background in behavior I'm automatically looking for, well let's implement or reinforcement schedule unless you know just those very kind of concrete things that you can do to help identify, um, the target behavior and figure out how to reinforce it. And so kind of automatically going to that um which is, I mean, I think it applies to many different situations— I: Yeah. P: --I think it's kind of a universal helpful thing, but at the same time, I'm starting to try to get more comfortable in, um, CBT approaches that I'm working on right now
5.1	P07	Capacity of Clt	Interview	There are several examples of considering the client's capacity after treatment	no	D	?	

				begins to go awry. These assessments are retrospective and thoughtful.				
5.2	P07	Capacity of Therapist	Interview	Therapist describes an awareness of his own capacity. He also describes building capacity by referencing literature and consulting with supervisors.	no	B	?	trying to prepare myself—I try to research as much as possible, honestly, I think that’s how I try to make myself feel better is read things and find articles... that’s definitely one of the strategies um, and then just try to um talk to supervisors as much as possible about, um--these same things are coming up over and over again—but um about you know, “What does this look like?” “Is this—you know am I saying this the right way? How do I phrase this?” um— I: So, kind of like, “Am I doing this right?”— P: --Mhm. I: -- “What-how can I change

								what I'm doing?" P: Right, exactly. Um, I'm very—I very frequently ask for feedback, especially um—and I guess my supervisors don't really view my therapy sessions as much, but in feedback sessions, after evaluations with parents, I really enjoy getting feedback about what I could've done better—
6.1	P07	Collaboration with Clt in Tx Planning, Treatment Plan Existence	Physical Files Inventory, Electronic Files Inventory	No evidence of collaboration in treatment planning process. There is evidence that the plans exist.	N/A	D	no	
6.2	P07	Development of Plan	Treatment Plans, Assessment Report	Evidence that plan is informed by conceptualization, goals, best practices, and EBPs.	yes	A	no	

7.1	P07	Step 7 Process Evaluation	Electronic Files Inventory, Case Notes, Treatment Summaries, Interview	Evidence that a plan was heavily utilized for CL01, noted throughout chart. For CL02, the therapist notes motivation and insight and does not reference treatment plan.	yes	CL01-B, CL02-E	yes	I try to—I try to have written outline of what I’d like to cover and a little bit of a schedule, I guess for the session, um, and I try to make sure that, you know, I’m hitting on whatever goals that we’ve specified during that time—
8.1	P07	Step 8 Outcome Evaluation	Physical Files Inventory, Electronic Files inventory, Case Notes, Transcript	There was a lot of evidence of therapist gathering both qualitative and quantitative data in CL01 on a regular basis. There was evidence of use of ORS repeatedly for CL02. Upon follow-up, participant stated he did consider ORS for CL02.	yes	CL01-A, CL02-B	yes	we collected progress monitoring data every two weeks, um, with that child, and so we kind of administered the same standardized [method of intervention] to see how she was doing. Um, and we noticed—we made some qualitative notes about [progress towards goals], and so that was a thing that we went back and, “Okay, we’re going to have a day where we just primarily work on these skills”— I:

								Right. P: --based on that qualitative data.
8.2	P07	Reason for Goal Attainment Known Unknown	Transcript	The participant describes hoping that skills are enhancing treatment gains, but expresses a bit of uncertainty.	no	C	no	I mean [Laughs] [Inhale] um, I think that there's something that we set for just you know coming to therapy and talking to someone who listens to you is probably helpful in— I: Yeah. P:--itself so I think you're going to see some progress, just— I: Right. P: --you know if I'm being a good listener, I hope that there's just some kind of natural progress off of that but and then at the same time over and above that ideally the—you know the skills that we've been working on, um, have-have

								influenced that and let to those outcomes—
9.1	P07	Step 9 CQI	Case Notes, Treatment Summaries, Interview	There is evidence of therapist doing systematic evaluation and making changes to plan for CL01. There was a lack of evidence of CQI for CL02 and appeared therapist relied solely on the model of therapy. The therapist describes in the interview making adjustments when the client is not compliant.	yes	CL01-B, CL02-C	yes	we just said you know, she-she's just kind of shutting down, she's you know, leaning back in her chair and saying, "I don't want to do that." Kind of silent and so, you know, it's just-it's not being productive right now. What do you think we should do? I: Uh-huh P: And so kind of then kind of trying to figure out exactly—work with them and figure out what that should look like and how we can still take the meat of the treatment but present

								it in a way that she's going to enjoy more, or engage with more.
10.1	P07	Step 10	Coding Tree Analysis, Treatment Summaries, Transcript	Evidence that the therapist discussed treatment ending and referral with CL01. It appears CL02 stopped coming to treatment.	yes	CL01-A, CL02-E	yes	
10.2	P07	Step 10 Skills and Supports Reviewed	Interview	Therapist states that he has not had this opportunity to try to maintain gains	no	N/A		I unfortunately haven't had a situation where I have really been able to work on that, um, I guess we probably could have done some follow up um, with the [redacted] case. We did, um, well you know, we kind of ended—we did say, “You know, if you ever feel like you went over the summer and you

								<p>want some boost sessions, we are more than happy to kind of figure that out”</p> <p>um... I: Yeah. P: We haven’t-we haven’t heard from any-from her as far as wanting to start the sessions, so, that’s the only case where I’ve really gotten that far.</p>
--	--	--	--	--	--	--	--	---

*Tri = Triangulation

**Clt Diff = Client Differences in IC Map Scores

APPENDIX F – CASE REPORT EXAMPLE

Case Report: Participant 7

Background/Contextual Data at time of interview

- Program: School
- Years in Program: 2
- Focus: Child
- Orientation Attendance: Only attended 2nd orientation
- Total years of clinical experience: 4
- Years of clinical experience at [CLINIC]: <1 (early)
- Estimated # clts at [CLINIC]: 2
- Pop of Interest: Children with Disabilities
- External Settings: Private Practice, Hospital, Residential, Homeless Shelter
- Therapeutic Orientation: Behavioral and CBT
- Interest in Clinical role in future: Yes

Innovation Configuration

Both of the participant's clients were analyzed. Both clients were opened after the second orientation.

Participant's scores ranged from A to E depending on the client and step, with an average of B for Client 1 and an average of C for client 2. There were some aspects of the IC Map that could be parsed apart per client, and others were either consistent across clients or only evident through interview and other general sources regarding how the participant performs therapy. On average, the participant scored a B for cross-client scores and the mode for the entire IC map across cases was A. The participant showed highest scores for assessment and exploring best practices. Lower scores related to exploring capacity, process evaluation, and planning for sustainability.

IC Map scores are presented below in graphical format (See Figures A.1-A.4).

Findings call into question these major themes: (1) Implementation of the GTO in CP steps seems to vary based on the length of the case. (2) Collaboration seemed to be a challenge with child cases, and the therapist describes reasons this was not clinically appropriate. (3) Planning for outcome measurement is much easier for structured cases, whereas emotion-focused therapy is less concrete. This therapist was thorough with assessment and planning. Evaluating the process was nearly impossible with the client that had less concrete goals and plan.

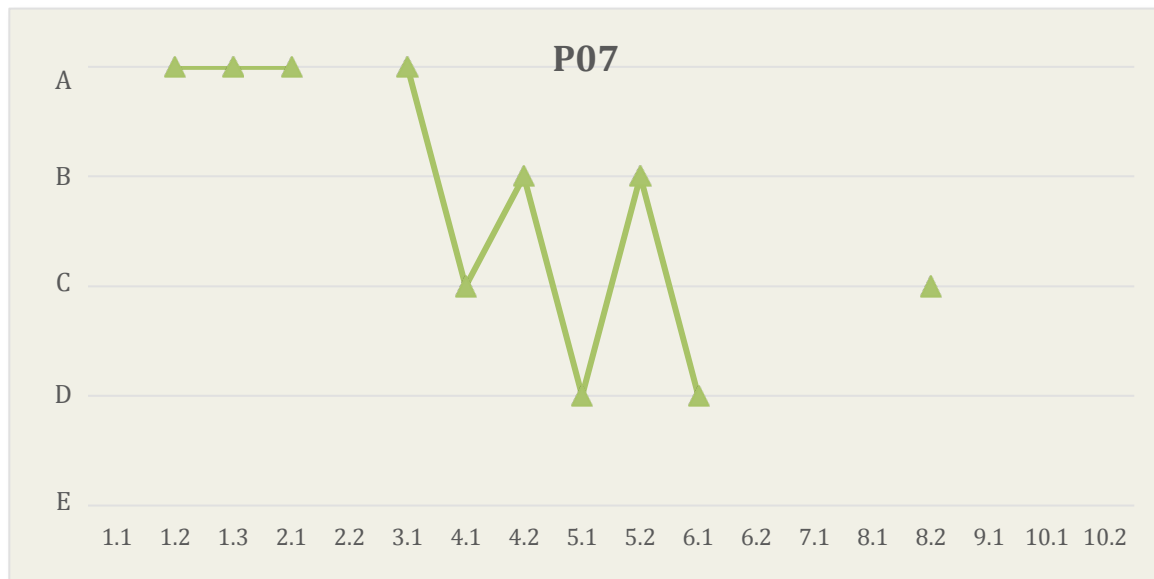


Figure F.1. Participant 7 IC Map Profile

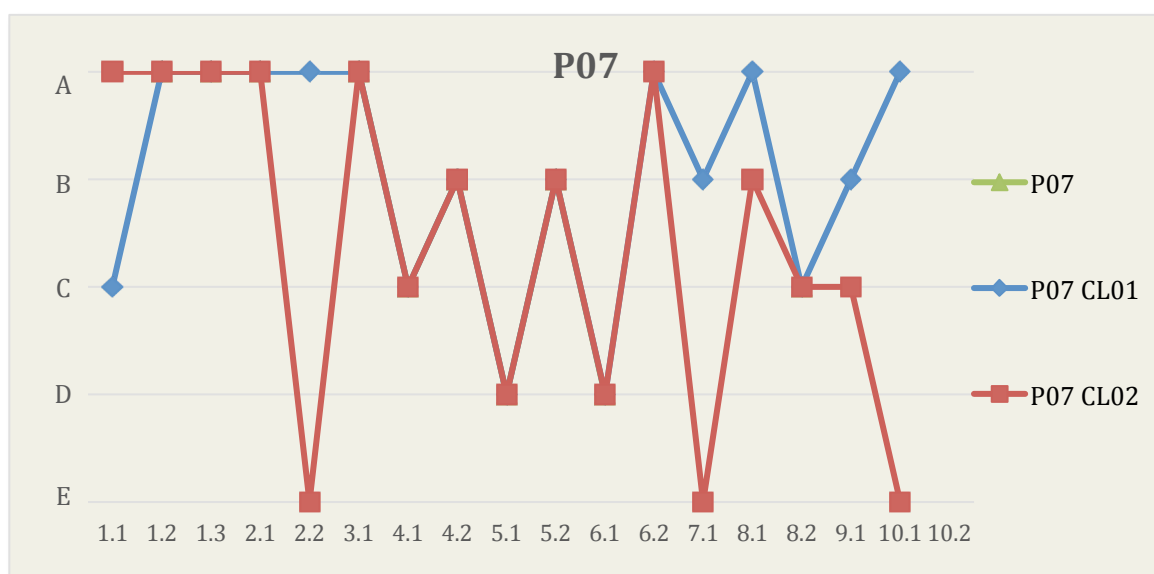


Figure F.2. Participant 7 IC Map Profile: All Clients

Notable emergent codes related to the way this participant conducts therapy included a focus on behavioral techniques and involvement of family members in treatment process.

Attitudes About Innovation

Relative Advantage

The participant used a lot of speculative language (e.g., “I think...”), but largely had a positive salience about the advantage of using GTO in CP. He described the steps

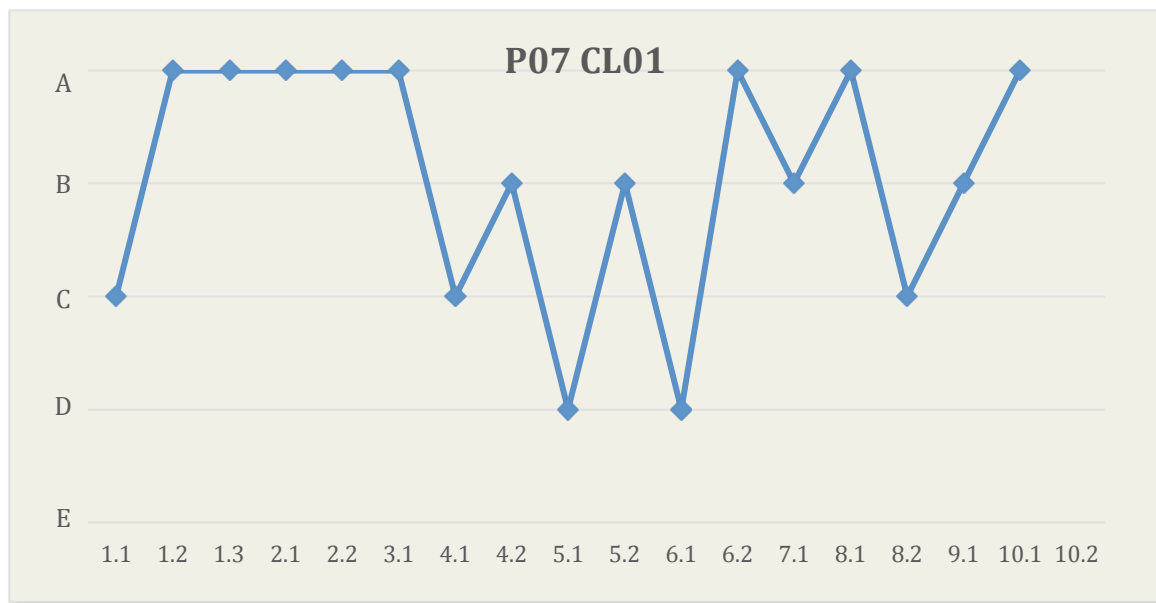


Figure F.3. Participant 7 IC Map Profile: Client 1

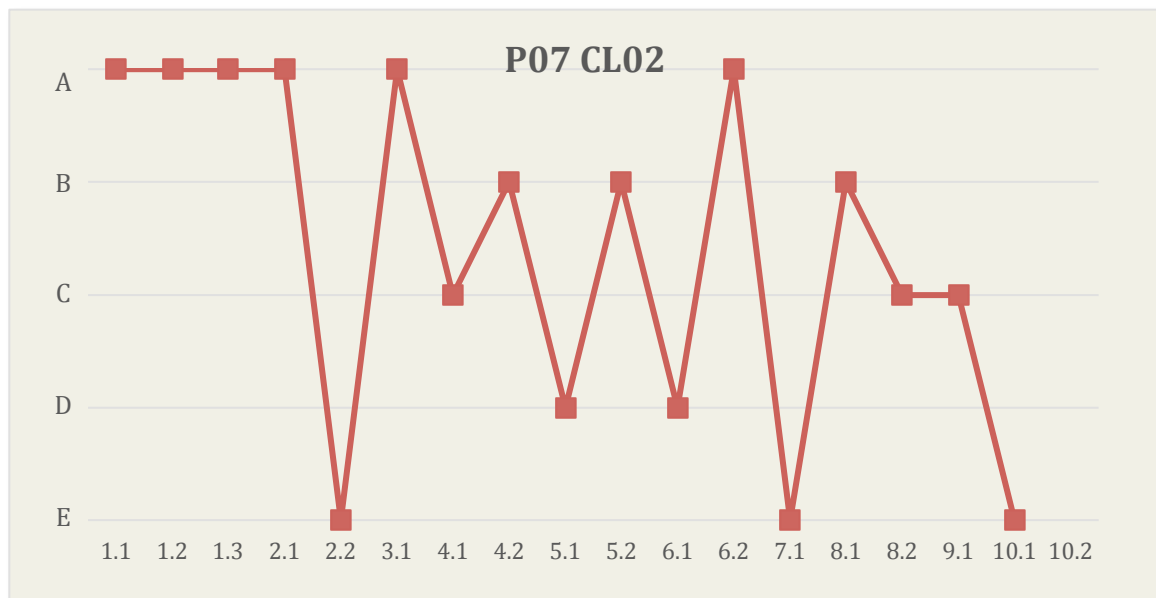


Figure F.4. Participant 7 IC Map Profile: Client 2

“keep[ing] things very organized... putting things within a framework.” He states that having “outcomes in mind” as “helpful.”

He describes a belief that without GTO in CP, practitioners would likely map all treatments onto diagnoses rather than considering contextual factors.

Participant 7 states:

I guess you guys rolled it out about the same time that I started— I: Yeah. P: --[Chuckles] um, so I kind of heard about it, I guess since my first year in research methods. Um, but beforehand when I was just do-when I was doing [behavioral] therapy, I think that it was very easy to just kind of get in, you know, kind of a day to day, you know, “This is what we do, and these are the things that we work on” um— I: Mhm. P: --working at that. And so I think it’s been helpful for me, um, to kind of always kind of have those outcomes in mind and to be thinking about end goals and, “What do we want to see happen?”—

Compatibility

The participant describes the steps as “intuitive” and consistent with “things that we were learning in class anyway.” He goes on to say it is relevant to hypothesis testing as well as a problem solving model learned in class, and that GTO in CP helps the therapist do things that might happen “organically... in a more consistent way.” Participant states, “I just think there’s a value—um—in following the steps and good practice, I guess.”

He describes the innovation as consistent with what he finds important:

I mean I think it’s important to really get a good picture of the client before you do anything, you need to know, you know, strengths and what they want to work on, and all sorts of those things history, so that case conceptualization is really important to kind of make sure you have a good picture of what’s going on— I: Yeah. P: --um...I think it’s important to be outcome oriented and to make sure that you kind of have that goal in mind and a picture of what you want, um, and what the client wants their life to be like when you’re kind of wrapping up, and— I: Yeah. P: --ending treatment so...

He states he does not believe the innovation gets in the way of doing good therapy. He describes it as helpful to self-assess the questions, “Am I being effective? What can I do differently?”

He describes liking “flow charts” and “structure” and that therefore he “enjoy[s] the organization.” Again, he references how his level of training might impact this impression, saying, “For me the unknown is a little scary.”

Complexity

The participant, according to field notes, mentioned, “reviewing the steps” prior to arriving to the interview. This indicates an inability to remember the steps. It might also relate to the participant’s reaction to the interviewer’s role at the [CLINIC]. He also states during the interview, “I’ll be very honest, I don’t remember the names to all of the steps... I just remember the beginning ones and the end ones.” He describes feeling less clear about the steps he cannot remember. He later suggests perhaps consolidating some of the steps.

The participant is able to conceptualize the framework as “almost a problem solving model... where you’re trying to figure out what’s happening and how you can best move forward to reach whatever outcomes... you were looking for.”

The participant describes a need for more support in terms of technical assistance, saying the trainings were helpful, but that “it didn’t really come up as much as I thought it would during courses.” He also says he struggles with knowing when to utilize the steps, “You know at what point do I do that?” He struggles to come up with a solution, describing needing time in practicum to learn new techniques, and describing the training as “a whirlwind in a day,” implying that it’s difficult to decide when a good time would be to emphasize GTO in CP more. He does say later, “I could see potentially being woven into practicum being really helpful, and I know in our syllabus and I tried to kind of review it, um, periodically, but then my cases didn’t quite line up exactly [with the timeline].” He describes knowing he has “not been perfect at... implementing all of the ten steps...”

The participant implicitly describes difficulty with some of the steps when the case was brief and there was less time to use all of the steps. For example, responding, “I probably would have a better answer for you in a couple more weeks.”

The participant describes having difficulty “coming up with goals initially... especially when I feel like some of the information is fuzzy...”

He describes the framework as “taking more time... so I guess that would be a cost.”

In terms of specific steps, the participant mentioned still refining conceptualization skills and described determining an outcome evaluation plan as difficult. He also describes following the steps and doing therapy in external settings as more challenging, specifically mentioning working at a homeless shelter.

Trialability

When asked if participant has had a chance to “try out” the innovation, the participant states, “Um, I guess so. I don’t know that I was—to be very honest—I don’t know that I was really thinking of it in terms of-of the steps themselves.” He describes thinking of the steps more “fluidly” rather than using the framework step-by-step.

Observability

The participant describes not necessarily valuing the labeling of the model. “I guess what would be the most important, I guess you know, are we hitting all of these important parts and making sure that they are accomplished.”

He does state that he notices he has been collecting more data since being trained in GTO in CP. He mentions this could be impacted by the nature of previous training experiences as he previously was assigned cases post-assessment to do a particular type of intervention.

Requirements

Participant does not mention requirements and describes that the innovation as not brought up as much as he anticipated.

Appeal

The participant describes the structure of the innovation appealing. “That makes me feel safe.”

Participant Context

All clients were seen after the second orientation and the participant had only attended the second orientation. Factors that impacted the participant’s attitudes or implementation of GTO in CP include: case load characteristics, exposure to the training, previous experiences, the implementation setting, status as a trainee, training, treatment orientation, practicum enrollment, level of experience, and program enrollment. The participant describes working with disabled populations indicates more clinical observations than interviews for the information-gathering phase in treatment. He describes using [CLINIC] resources as well as following [CLINIC] “requirements” in terms of goal-setting. He describes fast-paced settings being a bit more “fluid” in terms of these requirements. He does describe tapping into his background in behavioral therapy when considering treatment options. In external settings, such as a homeless shelter, the participant describes being systematic as a bit more challenging because there are external and “logistical” factors that impact the client’s ability to participate in therapy. He references how different cases implicate different levels of complexity in terms of development an outcome measurement strategy. He describes using “manualized treatment” in other settings.

The participant described GTO in CP consistent with what has been taught in classes: “We’re always talking about collecting data, and you know... case conceptualization...” He acknowledged that he is unsure of what therapy looks like pre-GTO in CP because of his level of training and when the innovation was introduced.

He describes his previous setting involving “implementing” a specific therapy rather than determining any of the earlier decisions.

He states about the implementation setting: “I do think there’s more of an emphasis potentially on data collection at the [CLINIC] and kind of what that outcome and making sure to monitor progress periodically and kind of collect, assess, in that way. I: Yeah. P: Um, and than maybe through my other practicum placement—“ He also provides an interesting perspective during follow-up, describing a residential setting where following all of the steps was easier than at the [CLINIC]. He attributes this to the client being a captive audience in that setting.

He mentions his previous training priming him to take data collection seriously in therapy.

He references a “problem solving model” used in his program as consistent with the ideology of GTO in CP.

Summary of Findings

The participant is largely adherent to the model. He describes a process in which he follows the concept of GTO in CP “fluidly” and admits he cannot remember the steps, despite very much valuing the model and structure. He emphasizes over and over again a need to get innovation support through technical assistance or supervision. He also describes it difficult to follow the model with clients in different settings depending on the context. Interestingly, during follow-up he describes an example with a residential patient where it was easier to follow through with a lot of the steps.