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Therapists' Perspectives on the Effective Elements of Consultation Following Training

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Abstract

Consultation is an effective implementation strategy to improve uptake of evidence-based practices for youth. However, little is known about what makes consultation effective. The present study used qualitative methods to explore therapists' perspectives about consultation. We interviewed 50 therapists who had been trained 2 years prior in cognitive-behavioral therapy for child anxiety. Three themes emerged regarding effective elements of consultation: (1) connectedness with other therapists and the consultant, (2) authentic interactions around actual cases, and (3) the responsiveness of the consultant to the needs of individual therapists. Recommendations for the design of future consultation endeavors are offered.

Keywords

Consultation; qualitative methods; evidence-based practices; training; implementation science

Several psychosocial treatments for children and adults are empirically supported (Chambless & Hollon, 1998). Unfortunately, these treatments are not widely available in the communities where the largest percentage of individuals receive services (President's New Freedom Commission on Mental Health, 2003). Implementation science focuses on determining how to most effectively transmit knowledge about empirically supported treatments (i.e., dissemination) and how to use strategies that allow for increased adoption of such treatments (i.e., implementation; Lomas, 1993). The desired result of implementation science is to ensure that community clinicians are providing evidence-based practice (EBP), "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (American Psychological Association, 2005, p. 1). One barrier in this pursuit is a lack of training and ongoing support in such practices available to community clinicians (McHugh & Barlow, 2010).

One category of strategies that has been proposed to improve dissemination and implementation of EBPs includes education (Powell et al., 2011). Early research on training mental health providers in EBPs was dissemination-focused and examined the impact of printed education materials (e.g., treatment manuals) on therapist behavior (e.g., Beidas,

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Barmish, & Kendall, 2009), despite evidence from the medical literature suggesting that printed education materials have limited effect on clinician practices or patient outcomes (Giguère et al., 2012). Additionally, studies have investigated the impact of continuing education workshops (Herschell, McNeil, & McNeil, 2004). Three recent literature reviews on the use of education as an implementation strategy (i.e., printed education materials and/or one-day workshops) suggest that these modalities are ineffective at influencing therapist behavior and patient outcomes, although they do influence therapist knowledge and attitudinal change towards EBPs (Beidas & Kendall, 2010; Herschell, Kolko, Baumann, & Davis, 2010; Rakovshik & McManus, 2010). Importantly, all three reviews independently emphasized the importance of ongoing support as an additional implementation strategy following training. We use the term consultation to refer to ongoing support, usually following training, provided between an expert consultant and a consultee therapist with the goal of improving implementation and practice of an EBP (Caplan & Caplan, 1993).

A growing body of empirical evidence suggests the importance of consultation as an implementation strategy. For example, in the delivery of cognitive-behavioral therapy (CBT) for youth anxiety, a dose-response effect has been observed, such that each additional hour of consultation was associated with significantly improved protocol fidelity by trainees (Beidas, Edmunds, Marcus, & Kendall, 2012). Research on the delivery of multisystemic therapy (MST) has found signification relationships between perceived consultant competence and therapist adherence as well as a focus on MST procedures during consultation and lower youth externalizing and internalizing problems following treatment (Schoenwald, Sheidow, & Letourneau, 2004). Altogether, these findings indicate the important effects of consultation on both training and youth outcomes.

Although the importance of consultation has been recognized, little information is available to delineate the content and potential mechanisms through which consultation impacts therapist adherence and skill (Rakovshik & McManus, 2010). Information is needed to determine the necessary elements of consultation as an implementation strategy, such as optimal content, techniques, dose, and duration for diverse trainees (Weisz, Ugueto, Herren, Afienko, & Rutt, 2011). Not understanding the mechanisms through which consultation acts is akin to providing a treatment without knowing why it is effective, creating a black box of consultation. It is imperative for research to unpack this black box by delineating both how consultation is most effectively provided and the mechanisms of action.

One potential literature that can help inform consultation research includes empirical work on supervision of therapists. This literature provides information on both the content and process of consultation. One review identified techniques present in effective supervision studies (Milne, Aylott, Fitzpatrick, & Ellis, 2008). Overall, techniques fell into the categories of teaching (75% of the studies), corrective feedback (63% of the studies), and observing (42% of the studies). A survey of CBT therapists identified what they perceived to be the most effective methods for enhancing the learning process during supervision (Bennett-Levy, McManus, Westling, & Fennell, 2009). Results indicated that enactive methods, such as role-play and self-experiential work, were perceived as most effective for enhancing procedural skills, whereas reading, lectures, and modeling were believed to be most effective for improving declarative knowledge. Therapists viewed self-experiential work and reflective practice as most helpful for enhancing reflective ability and interpersonal skills. A qualitative analysis of supervisee interviews found that supervisees viewed supervision as a developmental process; the interactions among reflection, Socratic information exchange, scaffolding, and the supervisory alliance were thought to help move the supervisee through this process (Johnston & Milne, 2012). Other literature suggests that incorporating outcome monitoring and client assessment into supervision results improves outcomes for clients (Worthen & Lambert, 2007). Although there are some important

distinctions between consultation (i.e., non-legally binding relationship) and supervision (i.e., legally binding evaluative relationship), both share similar goals—to improve clinician functioning and the mental health care provided to the patient (Caplan & Caplan, 1993; Milne et al., 2008). Thus, similar techniques and mechanisms as the ones identified above may be present and effective within consultation.

Describing the content of consultation is the first step in being able to replicate the method in future studies and practice settings. A study examining the training of community clinicians in CBT for adult depression incorporated weekly group consultation telephone calls (Simons et al., 2010). Consultation was not intended to focus on case supervision and was instead viewed as a continuation of CBT training. The agenda for the consultation calls was based on sets of questions that therapists created prior to each call. Although study design did not allow for an examination of effective consultation components, this training and consultation package resulted in improved clinician skill and client outcomes. In another study investigating education (i.e., training and consultation) as a strategy for implementation of CBT for child anxiety (Beidas, Edmunds, et al., 2012), the content of virtually-delivered consultation predominantly included an emphasis on case review and the active ingredients of CBT for child anxiety (e.g., identifying somatic thoughts/arousal and exposure). This content was largely delivered through case discussions that the clinicians brought to consultation (Edmunds et al., in review). It was hypothesized that the time spent in active learning (Milne et al., 2008), or the time that the individual spent in behavioral rehearsal (i.e., role-plays), would be the mechanism through which consultation operated, based on recent assertions that active learning is the most effective way to impart clinical skills (Cross et al., 2011). Active learning, as measured, was not found to be predictive of therapist fidelity, self-efficacy, and satisfaction post-consultation, perhaps because the exposure to active learning was too limited in the study setting. However, clinician involvement (i.e., how much they actively participated in discussion and/or role-plays) significantly moderated the relationship between active learning and skill, such that the more involved the clinician was during consultation, the stronger was the positive effect of active learning on skill, suggesting the importance of involvement when active learning is used in consultation (Edmunds et al., in review).

Although the studies reviewed herein (Edmunds et al., in review; Simons et al., 2010) provide more information on the content of consultation, the search for the active ingredient of consultation remains elusive. The objective of this exploratory study was to describe what participating therapists perceived to be the potential active ingredients of consultation, similar to the methodology employed in a previous study (Johnston & Milne, 2012). We conducted semi-structured interviews with mental health therapists who participated in a training and consultation study (Beidas, Edmunds, et al., 2012) in order to explore potential active ingredients of consultation.

Method

Participants

Participants were 50 therapists who provided psychosocial treatments to youth in a variety of settings in a northeastern state who previously participated in a training and consultation implementation study (Beidas, Edmunds, et al., 2012). Ages ranged from 23 to 75 (M = 35.09, SD = 10.85) and 92% were female (N = 50). Clinicians self-identified as Caucasian (74.0%), African-American (8.0%), Asian (8.0%), and Other (4.0%)[1]. With regard to educational degree, 64.0% had a master's degree, 18.0% were enrolled in a graduate

[1]Ethnicity data was missing for 6% of participants.

program, 4.0% had a medical degree, 6.0% had a doctorate in philosophy, 4.0% had a doctorate in psychology, and 4.0% had a doctorate in education. Therapists reported previous clinical experience ranging from 0 to 372 months (M =69.59, SD = 86.85).

Procedure

Previous procedure—Semi-structured interviews were conducted with mental health therapists who treated youth in the community that were part of a training study 2-years prior (Beidas, Edmunds, et al., 2012). Details of this study are described elsewhere (Beidas, Edmunds, et al., 2012; Beidas, Mychailyszyn, et al., 2012). Briefly, community clinicians were randomly assigned to one of three training conditions (computer training, routine training, or augmented training). Clinicians were trained in CBT for child anxiety, a 16-20 session treatment that includes psychoeducation and exposure tasks (Kendall & Hedtke, 2006), and then participated in weekly consultation sessions for three months. Skill and adherence was assessed at pretraining, posttraining, and postconsultation. Self-efficacy and consultation satisfaction was assessed at postconsultation. Consultation was conducted via the WebEx virtual conferencing platform by the first author (RB) under the supervision of an expert in CBT for child anxiety (PK). A 12-week consultation curriculum was designed with participant input. A total of 108 consultations were completed, with an average length of 52.95 minutes (SD = 10.70; range = 23-66 minutes). On average, 7.83 participants attended each session (SD = 4.52; range = 1-20 participants). The average number of cases discussed per call was 2.69 (SD = 1.90; range = 0-7 cases). Participants attended an average of 7.15 consultation sessions (SD = 3.17; range = 0-10).

Interview Procedure—All procedures were approved by the Institutional Review Board. We contacted all participants in the original study (N = 115) to ascertain their interest in participating in a 2-year-follow-up. Fifty consented to participate. Therapist interviews were conducted individually via telephone with each of the participants at a time convenient to the participant with a study interviewer (JE, MMD) from 2010-2011. Interviews lasted approximately 45-60 minutes, were conducted using a semi-structured interview, and were digitally recorded. Participants were compensated $10.00.

Interview questions were open-ended and follow-up probes were included to tailor the interview to the participant's responses. The interview was designed, based on a similar interview guide (Stirman et al., 2012), to elicit information about participant experiences implementing CBT for child anxiety, perceptions of barrier and facilitators to implementation of CBT for child anxiety, and perceptions on practice-change following training. One question explicitly targeted the consultation that therapists had participated in two years prior: “What was most helpful about consultation? Would you have preferred a different type of consultation (e.g., more/less individual feedback, no recording, more/less role-playing)?”

Qualitative data analysis—The digital recordings were transcribed, reviewed, and checked. Transcripts were analyzed in an iterative process in consultation with a qualitative researcher (CC) and following similar procedures to previous studies (Hill et al., 2005; Hill, Thompson, & Williams, 1997; Stirman et al., 2012). Analysis was guided by grounded theory, which provides a systematic approach to collecting and analyzing qualitative data and has been shown to produce theoretical models of social behavior in healthcare settings (Guba & Lincoln, 1985). This approach uses an inductive process of iterative coding to identify recurrent themes, categories, and relationships in qualitative data.

A comprehensive coding scheme was developed and applied to the data to produce a descriptive analysis of therapist perceptions of consultation. Interviews were coded to

condense the data into organized units by several authors (RB, MG, MMD). Chunks of text that ranged from a sentence to a collection of sentences were coded based on both a priori categories (e.g., barriers and facilitators) and categories that were identified in line-by-line reading of 8 preliminary transcripts. The final data dictionary contained twelve codes. Using the data dictionary and the qualitative software QSR NVivo 10, text was grouped into these twelve nodes which included (see Table 1). Two raters (MG, MMD) were trained by the first author (RB) until they reached agreement on 91% of the codes. These two raters then coded a subset of the 50 transcripts on their own while meeting together on a regular basis and with the first author (RB) to ensure consensus. Any discrepancies that could not be resolved by the two coders were resolved through discussion mediated by the first author (RB). Rater consensus was calculated using Cohen's Kappa in a subset of 20% of transcripts with rater overlap: agreement was excellent (κ = .84-.99) (Landis & Koch, 1977).

In the present study, only the consultation node is reported upon. Two raters (RB, CC) independently read through the consultation node across cases. Each reviewer produced memos that incorporated a set of three newly-derived sub-codes, as well as examples and commentary regarding emergent themes. Subsequently, the two raters came to consensus on the themes that they abstracted through discussion and the provision of examples from the transcripts (Hill et al., 2005; Hill et al., 1997). In most cases, examples presented in the text were chosen to best reflect recurrent ideas described by participating therapists. In some cases, as specified within the text, the authors selected examples that were minority opinions but raised important considerations for future research.

Results

In therapists' reflections on the utility of consultation, the importance of *connectedness* in the training process dominated as an overarching theme. We define connectedness as the experience of building supportive professional relationships during training. Many therapists commented that connectedness was fostered both through the consultation group process and through one-on-one interactions with the consultant. The therapists indicated that these interpersonal connections reinforced their learning and application of CBT for child anxiety.

We also identified two related subthemes in therapists' reflections on consultation. We interpret these subthemes as facilitators of connectedness. The first facilitator of connectedness was *authenticity.* Therapists favored training approaches that they interpreted as authentic, including opportunities to bring their own challenging cases to the group setting, as well as opportunities to learn from peers' actual clinical experiences. A second subtheme was *responsiveness* during the training process. Therapists valued the ways in which the consultation process was designed to respond to the participants' stated needs for further learning. When the training process was viewed as responsive, therapists felt more connected to the consultant as a professional ally and were more engaged in learning and adopting CBT for child anxiety. Below, we further explain therapists' commentary around connectedness, authenticity, and responsiveness, offering concrete examples of how therapists perceived these forces to operate during the consultation process.

Connectedness

Consultation offered a forum for group discussion, which the therapists evaluated favorably as an opportunity to connect and learn with peers around CBT for child anxiety. In both the volume and the tenor of therapists' evaluations, the group process—and the opportunities for connectedness presented therein—was the most important ingredient in successful consultation. A preference for this relational style of learning was manifest in comments like this one:

> "the whole thing, it was really a very rich experience for me and I loved getting the follow up telephone calls, the conferences, you know people describe what they're doing and asking questions with you know 'this doesn't seem to be working you know do you have any suggestions?', I thought that was terrific...I liked people presenting various scenarios and saying you know, this is what I've tried and didn't seem to work or this is what I've tried and it worked... I mean it's the way to grow is hearing from your colleagues."

In the comment above, the therapist notes the centrality of connections with colleagues to her own growth and professional development.

Another therapist noted that the shared experience of learning, including discussions of both successful and unsuccessful strategies, aided her learning process:

> "I really just liked listening to, you know, other people's experiences and ... hearing like okay this worked, this didn't, this is hard, yeah okay I had trouble with this part too. Getting that kind of shared experience thing was extremely helpful."

The concept above was also frequently reported—that hearing another therapist's challenges allowed the trainee to recognize and reveal her or his own challenges in implementing CBT for child anxiety. In these exchanges, the emphasis was not on perfect fidelity to the protocol, but on sharing both successes and pitfalls with the implementation of CBT for child anxiety, which created a sense of alliance among peers in the training process. Relating to other therapists' clinical challenges and successes may have been particularly important to less experienced therapists. As one therapist noted, she found it valuable to "[hear] other people's experiences because at the time I was very new to actually treating and seeing clients."

The therapists likened the consultation to supervision, in which a more-senior colleague provides ongoing feedback and evaluation. Therapists' comments indicated that they valued receiving feedback from the consultant, who became a trusted professional ally, and in some cases wished for more of it. One therapist indicated that "more is better...more individual therapy feedback, is always something that I can ...not have enough." This feedback process, which incorporated pragmatic social support, enhanced the experience of connectedness. Receipt of feedback seemed especially important to therapists who did not have access to supervision in their practice settings.

The value that therapists placed on connectedness in the consultation process was also revealed in their critiques of the training. Here we briefly mention elements of the consultation process that were regarded by therapists as threats to connectedness—and therefore as less effective elements of the training. Elements of the training that were not specifically relational were perceived as more burdensome. For example, one therapist noted that the consultant offered background reading as part of consultation, and that "although they were helpful, I felt like at times it was a little much to keep up with"—particularly because she was busy with school at the time. Similarly, another therapist noted that she would be inclined to devote more time in her busy schedule to training activities that emphasized connectedness:

> "I think what probably would've worked a little bit more for me is if it were actual face to face, if we came in and it was more group-oriented because then I could've like I think I could've made more time for that. I think it's easier to make time for that."

Several critiques related to technology and its potential to undermine connectedness. Two participants specifically mentioned challenges associated with technology, which they attributed to their more advanced age:

> "Because I was on the computer training program, which let me tell you how much I did not like that... So for me, I like to have people there to discuss cases with, and to hear how they are implementing, and how they are using, what it's about...You know, as you can tell, I'm a retiring man. I'm not a computer person. So I mean, I use them when I have to..."

Several additional therapists commented that computer-based consultation was less desirable and conducive to connected learning. For example, one therapist noted the benefits and drawbacks involved in virtual consultation—trading less identification with (opportunity to "see") other therapists for convenience: he stated, "I mean you know its awkward cause it's a conference call I guess you don't get to see the people but nonetheless I mean with busy schedules that's kind of a lot of the way the meetings happen for me anyway so." However, this was not the case for all participants. For one participant, a sense of strong of connection was sustained despite the use of the computer—or in part because the computerized check-in with colleagues established a sense of accountability that she found motivating.

"I would have that call coming up, I sort of felt like I can't stop now, you know what I mean, I can't give up because I am going to be on a computer someday you know what I mean. So it kind of helped me like motivate me so I think that that was good. I think that was an important part of the training definitely because it just makes you accountable. I think that's why I think it's hard now because I am sort of just like my own supervisor so I've got to do a ton, I got to push myself. There's things that I think I will try to do more of now."

According to the comment above, the end of the consultation process represented an end to connected learning—raising the question of how individual therapists can work to sustain behavior change and implement new EBPs after the group process concludes.

Similarly, therapists views on the active learning component of consultation, the role-plays, were decidedly mixed, with some appreciating the opportunity to practice new skills and with others reporting anxiety about the process. As one therapist said, I didn't want to try it for fear of screwing up in front of all of these clinicians." In a sense, this performance anxiety can be viewed as a fear of losing face among peers, which could undermine their sense of connectedness and alliance with fellow trainees.

Authenticity

Several participants' comments reflected a high priority on authenticity in consultation. Consultation components were viewed as authentic if they were derived from actual clinical experiences. A recurrent message from therapists was that authenticity was maximized when they could bring their own cases to consultation. Therapists also appreciated peers' experiences—especially if those experiences closely reflected their own clinical challenges and concerns. Therapists valued as authentic, and therefore helpful, discussions of "stumbling blocks that we came upon as we were implementing the program... because as you would work through the program, different questions and different needs would arise." One therapist specifically noted that: "I liked when they were available to review cases when they were applicable to me."

In contrast, therapists were less rewarded by the consultation process when they could not connect with or relate authentically to the material being discussed. As one therapist said, "I never was able to utilize a real client and bring to the table an example from work and get the supervision consultation available to me during that time." This issue was particularly acute when the therapist worked in a treatment setting, or with a patient population, that differed dramatically from the population being discussed, as in the following example:

> "There were times when during consultation you spent a lot of time listening to someone else's issue that maybe had nothing to do with what you were doing because maybe their population was so drastically different from yours... [T]here would be times when you'd be listening to you know, someone ask questions about, you know using CBT or Coping Cat with, you know a mentally retarded 21 year old which is very divergent from what, you know those of us working in an elementary school are working with very young children. Or even someone in a hospital setting dealing with...an anxious youth who has a brain tumor."

The therapist above suggested that consultation groups would have been more effective had they been homogeneous with regard to practice setting or client age group. This recommendation further supports the idea that therapists valued opportunities to identify with, and build connections to, their peers who were most similar to them in the consultation setting. One potential framing of this concern is that the therapist felt disconnected from the discussions that felt irrelevant to her clinical experience, and therefore she could not authentically relate to her peers. This was perceived as undermining the success of the training process.

Concern regarding authenticity was echoed in critiques of the role-plays that were sometimes used in lieu of real cases. For example, one therapist said, "I think less role-playing and more talking about real situations that were happening in our school—I think that would've been helpful." Another therapist specifically resisted the idea of role-play when she had to adopt an inauthentic role—like the role of a child, or the role of a therapist interacting with a child:

> "Since I work mostly with adults, it's easier for me to participate as a role-player and imitate adults, I guess with having to work with kids sometime it felt a little funnier trying to role-play as a kid or participating with an adult knowing they're a kid."

Responsiveness and tailoring of the intervention

By design, the consultant sought the opinions of participants regarding the content of the consultation curriculum. Specifically, participants were asked to suggest topics for consultation and areas for which they wanted further didactic materials. Additionally, the consultant was available to therapists to answer individual implementation questions as they arose. In one case, a therapist sought the consultant's advice regarding how to adapt relaxation techniques for use with deaf clients. In the standard treatment, the client is asked to close her eyes and follow an audio script. As an alternative, the consultant suggested that the therapist could teach the relaxation script to the client first, so that the client could close her eyes and follow along without the audio. The consultant then found published material regarding adaptations of CBT for deaf populations and shared those materials with the therapist. In this case, the consultant and the therapist worked together, mostly in email exchanges, in order to adapt the protocol for use in a specific population. The therapist responded well to the feedback and concrete suggestions, expressing her gratitude to the consultant for her responsiveness.

In other cases, therapists noted that the consultant was respectful and responsive to ensuring that consultation was useful. For example, therapists noted that the consultant paid particular attention to effective use of consultation time, providing "backup information, articles or discussion to keep us moving, making that hour really productive." This effective stewardship of therapists' time signaled respect and responsiveness to their individual needs and challenging professional lives, which ultimately strengthened the connection or alliance between the consultant and the therapist.

Discussion

The present study is among the first to use qualitative methods to examine therapists' perspectives about the utility of consultation as an implementation strategy following training in CBT for child anxiety. We intend for this qualitative study to be read as a companion to the quantitative data reported in (Edmunds et al., in review) in that it helps provide meaning to the process of consultation and delineates core themes which may be useful in future studies of consultation, which qualitative inquiry is particularly well suited for (Palinkas et al., 2011). Overall, therapists' responses reflected common themes regarding their experience of consultation as an implementation strategy following training to support implementation of CBT for child anxiety in community settings. Many therapists reported that the most important part of the consultation, from their perspective, was the opportunity to experience connectedness, or the building of supportive professional relationships. Additionally, two subthemes were identified as facilitators of this connectedness: authenticity, or the ability to engage in authentic interactions during consultation, and the responsiveness of the consultant to therapist needs.

The most consistent finding across participants related to the theme of connectedness. Simply put, almost all participants reported that they found the most valuable part of consultation to be the opportunity to engage with others, including other therapists and the consultant, around issues related to the implementation of CBT for child anxiety. The group process engendered opportunities to form professional relationships, learn from struggles and successes experienced by others, and the opportunity to get information and feedback from an expert in CBT for child anxiety. This has important implications for the design of future consultation studies. Researchers have debated the utility of individual versus group consultation, with most recommending group consultation because of cost-effectiveness purposes (i.e., group is cheaper than individual; Prieto, 1996). These findings suggest that group consultation may be a highly desirable delivery method for some learners, particularly mental health therapists who tend to value social-connectedness, and is fortunately more cost-effective and feasible in community settings. Further, these findings are consistent with literature on learning collaboratives, centralized learning groups for individuals implementing EBPs, which are hypothesized to be partially effective through the opportunities to bring together individuals facing similar challenges and learn from one another through shared experiences (Ebert, Amaya-Jackson, Markiewicz, & Fairbank, 2012).

A subtheme emerging for many participants that facilitated connectedness was authenticity, or engagement with actual clinical experience rather than role-plays or hypothetical cases. This suggests that case review with actual cases is a critical component of consultation as it may assist therapists as they come up against challenges in the implementation of an EBP with a particular client (Nadeem, Gleacher, & Beidas, in review). This is consistent with previous research showing that clinical supervision in community settings typically centers around case conceptualization and therapy interventions (Accurso, Taylor, & Garland, 2011). This is also corroborated by ethnographic research showing that lag time between training and actual implementation of EBPs with youth negatively impacted implementation (Palinkas et al., 2008). We would recommend that consultation be undertaken with therapists who are learning a new practice to assist in their immediate application of that practice with their clients. This will likely increase the therapists' experience of authenticity and engagement in learning. A threat to authenticity arose as therapists reported feeling less rewarded by the consultation process when they could not connect with or relate authentically to the material being discussed. For example, if they worked in a hospital setting, it was less relevant for them to hear about cases being conducted in school settings. This was due to heterogeneity in consultation groups. When designing consultation, being

mindful of this issue by providing consultations within specific agencies or with therapists who serve similar populations may be necessary.

The second subtheme facilitating connectedness that emerged consistently across participants was an appreciation for the collaborative manner in which consultation was designed, the responsiveness of the consultant, and the manner in which consultation was tailored to each participant. Collaborating in planning for consultation with stakeholders has been identified as a critical part of the consultation process (Spoth, Clair, Greenberg, Redmond, & Shin, 2007; Wandersman, Chien, & Katz, 2012) and was present in another successful training and consultation package (Simons et al., 2010). Further, responsiveness to stakeholder needs (also termed 'proactive') within the consultation process has also been identified as an evidence-based consultation practice: "customize [consultation] so that it starts with and builds upon recipients' current capacities and moves towards an ideal level of capacity to use specific information and skills with quality" (Wandersman et al., 2012). Finally, the ability to tailor consultation to the individual needs of particular therapists offline (e.g., therapist with deaf patients) was seen as particularly helpful and desirable. We recommend that when designing consultation, stakeholders be actively engaged in the process and asked about what topics they would like to explore, and we also suggest that consultation design be an iterative process that dynamically changes in response to participant needs. Further, specific needs of individual therapists that cannot be addressed in the group setting can be provided offline.

Certain components of consultation were perceived as threats to connectedness, particularly the use of technology. A number of participants noted that face-to-face interaction would have been preferable and that the computer-based consultation was not ideal. Two of the individuals who expressed concerns regarding technology were older, suggesting a potential cohort effect. Future studies should examine how preferences vary by age. These results are somewhat consistent with quantitative data gathered from the same sample following training where participants were more satisfied with in-person training rather than computer training, although satisfaction scores were generally high across conditions (Beidas, Edmunds, et al., 2012). Previously, we have advocated for the use of technology in training and consultation in order to take efforts to scale and reach the most providers (Beidas, Koerner, Weingardt, & Kendall, 2011), particularly given findings that computer-based training is as effective as in-person training (Beidas, Edmunds, et al., 2012; Dimeff et al., 2009). These findings suggest thinking critically about how technology based training may be perceived by participants given their desire for social connectedness. This may be an individual difference that can be explained by age and/or learning style preference. Potential avenues to consider include offering both in-person and technology-based interactions in consultation (e.g., including some face-to-face consultations with a majority of computer-delivered consultation such as is done in learning collaboratives; Ebert et al., 2012) and/or assisting in setting up peer consultation networks that can be held in person to complement computer-delivered consultation (Benshoff, 1994).

A threat that emerged to both connectedness and authenticity were simulated interactions between therapists and fictional cases, or role-plays. Some therapists reported feeling that role-plays were not beneficial to the consultative process because of their preference for discussing actual cases and their anxiety about evaluation by peers and the consultant. Theoretically, anxiety about evaluation is not necessarily a negative predictor of learning given that there is an optimal level of anxiety that improves performance (Yerkes & Dodson, 1908). However, it may be that this anxiety about evaluation was more about impacting the strong, supportive relationships formed between professionals. Given that role-plays as part of consultation was not necessarily desirable, it is important to weigh this perspective with the rationale for the inclusion of role-play. Current training practices, with their emphasis on

passive learning processes, are ineffective at changing provider behavior and patient outcomes, resulting in a call for active learning (Beidas & Kendall, 2010; Farmer et al., 2008; Herschell et al., 2010; Rakovshik & McManus, 2010). Active learning is an effective way to impart skills because it enhances learning, particularly when engaging in new or complex skills (Milne et al., 2008). Role-play was used in consultation to tap into active learning processes, because of empirical research demonstrating that active learning can improve implementer fidelity (Cross et al., 2011). Thus, the balance between improving outcomes and participant desire for role-plays is an important area of future research. Another interesting avenue of research includes the exploration of other active learning mechanisms such as self-reflection given a growing literature which demonstrates the importance of these strategies in augmenting therapist skill (Bennett-Levy & Lee, 2012; Bennett-Levy et al., 2009).

A threat to responsiveness pertained to participants wanting more individual feedback. Consultation was delivered in a group format which made it difficult to provide individual feedback to all participants. Feedback has repeatedly demonstrated an effect in changing provider behavior (Ivers et al., 2012), and thus identifying how to provide individual feedback while balancing the need for group consultation is an important consideration. One potential option would be to use peer feedback, schedule separate times for individual feedback, or provide written feedback. However, it is important to consider that inadequate time is often cited as a barrier for implementation of EBPs (Williams, 2008) and is likely to be a barrier in the provision of consultation particularly in the case of individual feedback. In our study, the consultant often engaged in email correspondence with participants, such as the one described in this manuscript, to provide feedback and further resources specific to each therapist, so this may be the most feasible way of addressing time constraints associated with individual feedback.

How do these findings align with the quantitative findings about consultation? First, the quantitative report measured the content of the consultation and found that much of consultation included case review and review of CBT for child anxiety, as consistent with community supervision (Accurso et al., 2011). Qualitative data from this study suggests that therapists also identified group case discussion as being a valuable aspect of the consultation, thus corroborating the quantitative data. Second, in the quantitative report, the authors failed to confirm their hypothesis that the time spent in active learning would be the mechanism through which consultation operates. The findings from this qualitative inquiry suggest that this may be because role-plays were viewed as inauthentic and a potential threat to the social connectedness of participants, the most important aspect of consultation from their perspective.

A number of limitations to this study must be noted. The most major limitation is that this qualitative inquiry was conducted two years following participation in consultation. The retrospective report likely limited participants' memories of their experience. Given the long span of time between the consultation and retrospective report, it is probable that only the most memorable aspects of consultation (e.g., difficulties with the computer) were salient. Small details pertaining to specific consultation sessions or observed role-plays may have faded from memory. After two years, the relationship may be more memorable than the specific techniques used. Further, qualitative techniques tend to highlight factors germane to relationship rather than technical factors. While the relationship may indeed be foundational in consultation, further research to replicate these findings is necessary. Second, the sample only included 50 out of the initial 115 participants. Although saturation in responses was reached, there may be something different about participants who agreed to participate in the 2-year-follow-up. Third, the generalizability of this sample beyond therapists in a large Northeastern city is unknown. Fourth, because this is not a mixed-methods study, it remains

unclear statistically whether the identified themes predict training outcomes other than perceived usefulness. For example, given findings in the MST literature (Schoenwald et al., 2004) that the relationship between therapist and consultant was negatively associated with therapist adherence, we cannot assume that connectedness linked to therapist adherence to treatment principles even though it was highly valued. The method of inquiry also prevents us from clearly delineating optimal consultation content, length, and format. Despite these limitations, this study is an important step forward in delineating therapists' perspectives of consultation and providing more information on perhaps the least well understood aspect of training (Kilminster & Jolly, 2000).

This qualitative study provides important insights into the experience of therapists' when engaging in consultation as an implementation strategy. Several themes were identified as important components of consultation including connectedness with the group, authentic experience, and responsiveness of the consultant and tailoring of consultation. This is critical information given limited knowledge on what the active ingredients of evidence-based consultation are. Unfortunately, while the field has moved forward in advocating for EBPs, we have not made the same efforts with our training and consultation processes (Wandersman et al., 2012). We hope that this and other manuscripts in this special issue pave the way for future research around the development of evidence-based consultation.

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References

Accurso EC, Taylor RM, Garland AF. Evidence-based practices addressed in community-based children's mental health clinical supervision. Training and Education in Professional Psychology. 2011; 5(2):88–96. doi: 10.1037/a0023537.

American Psychological Association. American Psychological Association policy statement on evidence-based practice in psychology. 2005.

Beidas RS, Barmish AJ, Kendall PC. Training as usual: Can therapist behavior change after reading a manual and attending a brief workshop on cognitive behavioral therapy for youth anxiety? The Behavior Therapist. 2009; 32:97–101.

Beidas RS, Edmunds JE, Marcus SC, Kendall PC. Training and consultation to promote implementation of an empirically supported treatment: A randomized trial. Psychiatric Services. 2012; 63(660-665)

Beidas RS, Kendall PC. Training therapists in evidence-based practice: A critical review of studies from a systems-contextual perspective. Clinical Psychology:Science and Practice. 2010; 17(1):1–30. doi: 10.1111/j.1468-2850.2009.01187.x. [PubMed: 20877441]

Beidas RS, Koerner K, Weingardt KR, Kendall PC. Training research: Practical recommendations for maximum impact. Administration and Policy in Mental Health and Mental Health Services Research. 2011; 38(4):223–237. doi: 10.1007/s10488-011-0338-z. [PubMed: 21380792]

Beidas RS, Mychailyszyn MP, Edmunds JM, Khanna MS, Downey MM, Kendall PC. Training school mental health providers to deliver cognitive-behavioral therapy. School Mental Health. 2012:1–10.

Bennett-Levy J, Lee NK. Self-Practice and self-reflection in cognitive behaviour therapy Training: What Factors Influence Trainees' Engagement and Experience of Benefit? Behavioral and Cognitve Psychotherapy. 2012:1–17. doi: 10.1017/S1352465812000781.

Bennett-Levy J, McManus F, Westling BE, Fennell M. Acquiring and refining CBT skills and competencies: which training methods are perceived to be most effective? Behavioral and Cognitve Psychotherapy. 2009; 37(5):571–583. doi: 10.1017/S1352465809990270.

Benshoff J. Peer supervision in counselor training. The Clinical Supervisor. 1994; 11(2)

Caplan, G.; Caplan, RB. Mental health consultation and collaboration. Jossey-Bass Publishers; San Francisco, CA: 1993.

Chambless DL, Hollon SD. Defining empirically supported therapies. Journal of Consulting and Clinical Psychology. 1998; 66(1):7–18. [PubMed: 9489259]

Cross WF, Seaburn D, Gibbs D, Schmeelk-Cone K, White AM, Caine ED. Does practice make perfect? A randomized control trial of behavioral rehearsal on suicide prevention gatekeeper skills. Journal of Primary Prevention. 2011; 32(3-4):195–211. doi: 10.1007/s10935-011-0250-z. [PubMed: 21814869]

Dimeff LA, Koerner K, Woodcock EA, Beadnell B, Brown MZ, Skutch JM, Harned MS. Which training method works best? A randomized controlled trial comparing three methods of training clinicians in dialectical behavior therapy skills. Behaviour Research & Therapy. 2009; 47(11): 921–930. doi: 10.1016/j.brat.2009.07.011. [PubMed: 19695562]

Ebert, L.; Amaya-Jackson, L.; Markiewicz, J.; Fairbank, J. Development and application of the NCCTS Learning Collaborative model for the implementation of evidence-based child trauma treatment.. In: McHugh, RK.; Barlow, D., editors. Dissemination and implementaiton of evidence-based psychological interventions. Oxford University Press; New York, NY: 2012. p. 97-116.

Edmunds, JM.; Kendall, PC.; Ringle, V.; Read, K.; Brodman, D.; Pimentel, S.; Beidas, RS. An examination of active learning as an ingredient of consultation following training.. in review

Farmer AP, Légaré F, Turcot L, Grimshaw J, Harvey E, McGowan JL, Wolf F. Printed educational materials: effects on professional practice and healthcare outcomes. Cochrane Database of Systematic Reviews. 2008; 7 doi: 10.1002/14651858.CD004398.pub2.

Giguère A, Légaré F, Grimshaw J, Turcotte S, Fiander M, Grudniewicz A, Makosso-Kallyth S, Wolf FM, Farmer AP, Gagnon MP. Printed educational materials: effects on professional practice and healthcare outcomes. Cochrane Database of Systematic Reviews. 2012; 11 doi: 10.1002/14651858.CD004398.pub3.

Guba, Y.; Lincoln, E. Naturalistic Inquiry. Sage Publishers; Beverly Hills, CA: 1985.

Herschell AD, Kolko DJ, Baumann BL, Davis AC. The role of therapist training in the implementation of psychosocial treatments: a review and critique with recommendations. Clinical Psychology Review. 2010; 30(4):448–466. doi: 10.1016/j.cpr.2010.02.005. [PubMed: 20304542]

Herschell AD, McNeil CB, McNeil D. Clinical child psychology's progress in disseminating empirically supported treatments. Clinical Psychology: Science and Practice. 2004; 11:267–288.

Hill, C.; Knox, S.; Thompson, B.; Williams, E.; Hess, S.; Ladany, N. Consensual qualitative research: An update.. 2005. Retrieved from http://epublications.marquette.edu/edufac/18

Hill C, Thompson B, Williams E. A guide to conducting consensual qualitative research. The Counseling Psychologist. 1997; 25:517–572.

Ivers N, Jamtvedt G, Flottorp S, Young JM, Odgaard-Jensen J, French SD, O'Brien MA, Johansen M, Grimshaw J, Oxman AD. Audit and feedback: effects on professional practice and healthcare outcomes. The Cochrane Library. 2012; (7)

Johnston LH, Milne DL. How do supervisee's learn during supervision? A Grounded Theory study of the perceived developmental process. The Cognitive Behaviour Therapist. 2012; 5(01):1–23. doi: 10.1017/s1754470x12000013.

Kendall, PC.; Hedtke, K. Cognitive-Behavioral Therapy for Anxious Children: Therapist manual. Workbook Publishing; Ardmore, PA: 2006.

Kilminster SM, Jolly BC. Effective supervision in clinical practice settings: A literature review. Medical Education. 2000; 34(10):827–840. [PubMed: 11012933]

Kolb, DA. Experiential learning. Prentice Hall Press; New Jersey: 1984.

Landis J, Koch G. The measurement of observer agreement for categorical data. Biometrics. 1977; 45:233–268.

Lomas J. Diffusion, dissemination, and implementation: who should do what? Annals of the New York Academy of Sciences. 1993; 703:226–235. [PubMed: 8192299]

McHugh RK, Barlow DH. The dissemination and implementation of evidence-based psychological treatments. A review of current efforts. American Psychologist. 2010; 65(2):73–84. doi: 10.1037/a0018121. [PubMed: 20141263]

Milne D, Aylott H, Fitzpatrick H, Ellis M. How does clinical supervision work? Using a "best evidence synthesis" approach to construct a basic model of supervision. The Clinical Supervisor. 2008; 27(2) doi: doi:10.1080/07325220802487915.

Nadeem, E.; Gleacher, A.; Beidas, R. Consultation as an implementation strategy for evidence-based practices across multiple contexts: Unpacking the black box. in review

Palinkas LA, Aarons GA, Horwitz S, Chamberlain P, Hurlburt M, Landsverk J. Mixed method designs in implementation research. Administration and Policy in Mental Health and Mental Health Services Research. 2011; 38(1):44–53. doi: 10.1007/s10488-010-0314-z. [PubMed: 20967495]

Palinkas LA, Schoenwald SK, Hoagwood K, Landsverk J, Chorpita BF, Weisz JR. An ethnographic study of implementation of evidence-based treatments in child mental health: first steps. Psychiatric Services. 2008; 59(7):738–746. doi: 10.1176/appi.ps.59.7.738. [PubMed: 18586990]

Powell BJ, McMillen JC, Proctor EK, Carpenter CR, Griffey RT, Bunger AC, York JL. A compilation of strategies for implementing clinical innovations in health and mental health. Medical Care Research and Review. 2011 doi: 10.1177/1077558711430690.

President's New Freedom Commission on Mental Health. Report of the President's New Freedom Commission on Mental Health. Washington, DC.: 2003.

Prieto L. Group supervision: Still widely practiced but poorly understood. Counselor Education and Supervision. 1996; 35:295–307.

Rakovshik SG, McManus F. Establishing evidence-based training in cognitive behavioral therapy: A review of current empirical findings and theoretical guidance. Clinical Psychology Review. 2010; 30(5):496–516. doi: 10.1016/j.cpr.2010.03.004. [PubMed: 20488599]

Schoenwald SK, Sheidow AJ, Letourneau EJ. Toward effective quality assurance in evidence-based practice: links between expert consultation, therapist fidelity, and child outcomes. Journal of Clinical Child and Adolescent Psychology. 2004; 33(1):94–104. doi: 10.1207/S15374424JCCP3301_10. [PubMed: 15028545]

Simons AD, Padesky CA, Montemarano J, Lewis CC, Murakami J, Lamb K, Beck AT. Training and dissemination of cognitive behavior therapy for depression in adults: A preliminary examination of therapist competence and client outcomes. Journal of Consulting and Clinical Psychology. 2010; 78(5):751–756. doi: 10.1037/a0020569. [PubMed: 20873911]

Spoth R, Clair S, Greenberg M, Redmond C, Shin C. Toward dissemination of evidence-based family interventions: Maintenance of community-based partnership recruitment results and associated factors. Journal of Family Psychology. 2007; 21(2):137–146. doi: 10.1037/0893-3200.21.2.137. [PubMed: 17605536]

Stirman SW, Gutierrez-Colina A, Toder K, Esposito G, Barg F, Castro F, Crits-Christoph P. Clinicians' perspectives on cognitive therapy in community mental health settings: Implications for training and implementation. Administration and Policy in Mental Health and Mental Health Services Research. 2012 doi: 10.1007/s10488-012-0418-8.

Wandersman A, Chien VH, Katz J. 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. 2012 doi: 10.1007/s10464-012-9509-7.

Weisz JR, Ugueto AM, Herren J, Afienko SR, Rutt C. Kernels vs. ears, and other questions for a science of treatment dissemination. Clinical Psychology: Science and Practice. 2011; 18(1):41–46. doi: 10.1111/j.1468-2850.2010.01233.x. [PubMed: 21603252]

Williams C. Cognitive behaviour therapy within assertive outreach teams: barriers to implementation: a qualitative peer audit. Journal of Psychiatric and Mental Health Nursing. 2008; 15:850–856. [PubMed: 19012676]

Worthen VE, Lambert MJ. Outcome oriented supervision: Advantages of adding systematic client tracking to supportive consultations. Counseling and Psychotherapy Research. 2007; 7(1):48–53. doi: 10.1080/14733140601140873.

Yerkes R, Dodson J. The relation of strength of stimulus to rapidity of habit formation. Journal of Comparative Neurology and Psychology. 1908; 18:459–482.

Table 1

Qualitative Nodes

Node	Example
Attitudes: Attitudes refer to a thought, belief, or statement that a therapist has towards evidence-based practices, CBT, or the Coping Cat.	“Prior to training, I really felt that the relaxation component took priority over CBT aspects, and I feel differently about that now. I do feel that the CBT is crucial”
Practice change: A statement that refers to a change in practice following training (i.e., doing things differently than before). Note this includes specifically adding or augmenting their practice with CBT.	(Did the way you work with your clients change?) “Um somewhat, not a lot, but I did use more of the relaxation only prior to training”
Barriers: Anything that might have gotten in the way in the implementation of CBT for child anxiety.	“A lot of them don't finish exposures”
Facilitators: Anything that might have helped/facilitated implementation of CBT for child anxiety.	“The coping cat program was very helpful in identifying kind of a structure to your therapy sessions and a lot of good ideas and activities”
Adaptation: Changes, modifications, or adaptation that the therapist makes to make CBT fit their practice, setting, or client population better.	“..or kids with autism, I use a lot of visual support because they are very visual learned, so we may write a social story about how to handle different situations and they read it immediately, and we have little visual supports like a little book marker”
Organizational factors: Anything related to their organizational setting that impacts how they implement CBT for child anxiety (i.e., administrative support, champion leader, not enough resources).	“A barrier is...kids having to leave class, or being away from the teachers setting, sometimes you are going to run into teachers who are not going to be supportive”
Self-efficacy: Therapist's confidence in their own ability to deliver CBT for child anxiety.	“I feel very confident in using CBT to treat anxiety for adults and adolescents”
Eclecticism: Therapist usage of a variety of treatment modalities (e.g., CBT plus family therapy, psychodynamicism, play therapy).	“I guess there are some psychodynamic principles that get engrained in some longstanding complex cases, but I would almost entirely identify myself as CBT”
Client factors: Anything that pertains to the client and/or their family (i.e., comorbidity, motivation, resistance) that may have impacted implementation of evidence-based practice	“We would start the exposures and they would feel like they were so much better and they wouldn't want to go all the way up the ladder”
Evidence-based practice language: “Buzzwords” that suggest that the therapist is knowledgeable about evidence-based practices more generally (not just related to CBT for child anxiety)	“Ultimately, it came down to prolonged exposure as the part of the mechanism of change”
Treatment factors: Anything that is specific to the treatment modality being used (i.e., CBT for child anxiety and/or Coping Cat)	“In vivo exposures...learning thoughts and coming up with alternative thoughts”
Consultation: When they discuss the consultation provided through the study	“I actually liked the consultation calls”

Note. CBT = cognitive-behavioral therapy