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Assessing and Investigating Clinicians' Research Interests: Lessons on Expanding Practices and Data Collection in a Large Practice Research Network

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Conducted in naturalistic settings, practice-oriented research (POR) is aimed at building stronger connections between the science and practice of psychotherapy. Promoting the principles of POR, this article has 2 aims: (a) presenting the results of a survey assessing the interests of members of a large practice research network in topics that could guide future research conducted as part of clinical routine, and (b) describing difficulties in implementing a study in line with such interests. Despite the significant interest in and perceived clinical significance of two relationship constructs (alliance and countertransference), there were unique obstacles faced in their empirical investigation within an already operationally functional practice research network. Challenges in this process included resource-related difficulties (such as changes in staff and the time required to set up the study and administer the measures), logistics-related issues, and effectively incorporating the assessment procedure into an existing clinical system. The article also describes strategies to address these obstacles, with differing degrees of success, including the role of a "local champion" at each site, the importance of a personal/professional relationship between the researcher and participating centers, as well as the pragmatic assistance to sites during the preparation, coordination, and implementation process (e.g., providing templates and feedback on institutional review board applications, and technological assistance on how to incorporate the measures into existing center software). The article concludes with general recommendations and future directions for POR.

Clinical Impact Statement
Question: What are topics of research that providers and administrators find clinically helpful and valuable? How can we effectively integrate new research measures into existing clinical routine? *Findings:* Factors related to the process of therapy are perceived by members of a practice research network as highly relevant research topics. Among these factors are variables related to the therapeutic relationship, as well as constructs such as the generalization of therapeutic learning and insight. A combination of strategies including a "local champion" at the clinical site, strong researcher−clinician partnership, and pragmatic assistance can aid in the integration of research into practice. *Meaning:* Collaborative effort from researchers, clinicians, and administrators can lead to the identification of shared research interests, as well as the generation of strategies to effectively address obstacles in integrating science and practice. *Next Steps:* Future studies on factors perceived as clinically helpful by mental health stakeholders should continue to explore additional strategies to address the challenges faced when integrating research and practice within clinical routine.

Keywords: practice-oriented research, practice research network, alliance, countertransference, survey

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Practice-oriented research (POR) has been proposed as a bottom-up approach to address the gap that still divides science and clinical practice (Castonguay, Barkham, Lutz, & McAleavey, 2013). Anchored in clinical routine and based on the collaboration of researchers and clinicians, POR has been conducted in numerous naturalistic settings and differing types of partnerships across continents (Castonguay & Muran, 2015; Strauss et al., 2015). These collaborations have addressed a variety of clinically relevant questions, and the results of the studies conducted within POR have suggested ways, for example, to improve clients' outcomes within day-to-day practice, enhance the therapeutic process, and contribute to therapists' professional development and organizational gains (Castonguay, Youn, Xiao, Muran, & Barber, 2015). However, despite the benefits of conducting POR, this type of research has not eluded challenges. Previous articles have discussed the various obstacles faced by different researcher−clinician partnerships when establishing new collaborative initiatives and engaging in POR studies within this context, including balancing the immediate clinical value and relevance of research protocols with clinical reality, challenges related to feasibility, costs, and logistical concerns of implementing these research studies (Castonguay & Muran, 2015).

The current article adds to this discussion by focusing on the process, benefits, and challenges of implementing a new research protocol in a large practice research network (PRN). As a key component of POR, PRNs are aimed at reducing empirical imperialism, where full-time researchers predominantly decide what should be studied and how (Castonguay, 2011), by having clinicians serve as active participants in all aspects of research, including the selection, development, implementation, and dissemination of research protocols. Specifically, the article focuses on two aims: (a) describing and leveraging the results of a survey conducted with members of a large PRN to identify topics of interest for future research, and (b) delineating the obstacles that have emerged during the process of introducing a study meeting some of these interests within the same (already established and fully operational) PRN: the Center for Collegiate Mental Health (CCMH). This specific study involves the addition of two psychotherapy process measures assessing the alliance and countertransference in routine clinical work. The article also discusses strategies used to address the obstacles faced in launching this investigation, with differing degrees of success.

The CCMH and Its Established Practices

The CCMH (ccmh.psu.edu) represents the multidisciplinary and long-term collaboration of diverse mental health stakeholders, including providers, researchers, university administrators, information science and technology leaders, and industry partners. It was founded in 2005 in response to the growing pressures experienced by collegiate counseling centers to demonstrate effectiveness and address increased demand for services, with the goals of enhancing clinical resources available to counseling centers for practice, reporting, and self-advocacy, as well as improving the mental health services provided to college students through psychotherapy research (Hayes, Locke, & Castonguay, 2011; McAleavey, Lockard, Castonguay, Hayes, & Locke, 2015).

As a large-scale PRN, the CCMH strives to create mutually beneficial and interdependent relationships among its collaborators and members by establishing a sense of community, "including shared ownership of the kinds of data gathered and the research conducted" (Locke, Bieschke, et al., 2012, p. 238). Thus, following a multiyear collaborative process between researchers and clinicians, data collected as part of routine clinical practice became standardized to inform clinical practice in counseling centers both locally and nationally while minimizing further undue burden for already strained counseling staff. As part of its basic operational functioning for the past 7 years, the CCMH includes two measures within its standard protocol for all participating members: the Standardized Data Set and the Counseling Center of Assessment of Psychological Symptoms (CCAPS; Locke et al., 2011; Locke, McAleavey, et al., 2012; McAleavey et al., 2012).

Synthesized from the intake materials from more than 50 counseling centers, the Standardized Data Set measures client demographics and mental health history (Castonguay, Locke, & Hayes, 2011). The CCAPS was chosen over more than 35 different self-report assessment instruments that had been in use across counseling centers, for the following reasons: (a) it is specifically designed to measure the psychological distress of college students; (b) it is a multidimensional measure; (c) it has strong psychometric properties; (d) it was open for refinements to meet the needs of participating centers; and (e) it is provided at low cost to counseling center members (Castonguay et al., 2011). The CCAPS has two versions: a 62-item version with eight factor analytically derived subscales (Locke et al., 2011), and a 34-item version that was developed for the purpose of facilitating repeated assessment of treatment progress (Locke, McAleavey, et al., 2012). The CCAPS also includes a general measure of distress, the Distress Index, which is composed of 20 items across the various subscales (Nordberg et al., 2018). Both versions of the instrument have demonstrated good internal consistency (Cronbach's α ranging from .82 to .92 for the CCAPS-62 and .83 to .89 for the CCAPS-34), criterion validity (strong correlations with established measures of similar constructs), discriminant validity (low correlations with unrelated constructs), and test−retest reliability in nonclinical samples (ranging from .76 to .92 for the CCAPS-62 and .74 to .88 for the CCAPS-34; Locke et al., 2011; Locke, McAleavey, et al., 2012; McAleavey et al., 2012). In addition, the CCAPS-34 has been shown to be sensitive to change (Youn et al., in press).

Although the CCMH recommends the frequency of administration and use of the CCAPS (i.e., the longer 62-item version for initial and posttreatment assessment, and the shorter 34-item version for repeated assessments; McAleavey et al., 2012), the actual administration frequency varies depending on the need of the center and availability of resources. This solution balances collecting empirically rigorous standardized data with the clinical realities of each counseling center.

After the selection of the standardized measures, the CCMH partnered with Titanium Schedule, a commonly used electronic medical record (EMR) software in counseling centers, to integrate CCMH measures within its software (McAleavey et al., 2015). This ensured that the data collected would not only be reliable, as the technological integration does not allow for individual questions and answers to be edited, but that the administration of and access to the instruments would also be efficient.

Before data are shared with the CCMH, each counseling center obtains approval from its institutional review board (IRB) to send deidentified data to the CCMH's data repository, which houses

data from all participating centers (McAleavey et al., 2015). Once a month, each center sends these deidentified data through the EMR system in a secure manner, the process taking less than 5 min to complete. Member sites have been sending data to the CCMH data repository since 2008, having integrated this practice into their routine center procedures, and using the data collected locally for clinical, training, and policy purposes (Youn et al., 2015).

Moving Beyond Standardized Data to Unique Projects—Step 1: Assessing Research Interests of CCMH Members

Once the standardized data collection protocol was established, the research team conducted a survey of participating members to inform the selection of potential future research projects to be implemented within the PRN. This was guided by a specific assumption about the actualization of the scientific−practitioner model. Some scholars have suggested that if clinicians had opportunities to conduct research, they would be more inclined to attend to empirical results (Elliott & Morrow-Bradley, 1994). Others have emphasized that knowing what types of research clinicians are interested in is a necessary step to entice them in becoming active consumers of scientific knowledge (Goldfried & Wolfe, 1996). In contrast, we would argue that a combination of these two conditions is likely to be particularly fruitful in fostering the integration of research and practice. Reflecting the principles of POR, clinicians and counseling center directors, who are already collecting data as part of their clinical work, were asked to guide future research to be conducted within this infrastructure so that the research may have an additive and synergetic impact on mental health services.

Method

Participants

The survey was completed by a diversity of staff members in counseling centers. More than half of the participants were full-time clinical staff members (58.4%), followed by predoctoral/Masters clinical trainees (13.3%), staff primarily involved in administrative duties (11.8%), part-time clinical staff members (6.7%), postdoctoral clinical staff members (4.6%), other (4.2%), providers primarily of psychiatric services (0.6%), and primarily supervisors (0.3%). Within responders, 96 (16%) also identified as clinic directors. On average, the survey responders devoted 53% ($SD = 22.01$) of their time to clinical practice providing psychotherapy or counseling, saw an average of 14.87 ($SD = 7.16$) clients per week for individual therapy, ranging from 0 to 38 clients per week, typically seeing these clients for 9.02 ($SD = 5.38$) weeks for treatment (range = 0–52 weeks), and facilitated, on average, 0.85 ($SD = 0.95$) groups per week, with a range of 0–11 groups per week. The survey participants also supervised on average 1.74 ($SD = 2.51$) therapists per week, with a range of 0–26 supervisees.

Procedure

The CCMH is best viewed as a network of university counseling center members working independently with their own administrative and procedural policies, and diverse staff size compositions

(McAleavey et al., 2015). In order for our recruitment procedure to fit this organizational structure, we used a limited snowball sampling technique whereby one or two center staff, typically the center's director or the liaison with the CCMH, were contacted and asked to forward the survey link to their colleagues. The study also provided an incentive for the survey completion of a $5 Amazon gift certificate to the first 100 responders.

Recruitment included 208 people contacted, and of these, 73 (35.1%) sent out the survey to their colleagues. The other 135 contacts either did not respond to the original e-mail request or did not disseminate the survey for various reasons (e.g., staff were on vacation and administrative issues). The survey was sent out to a total of 871 counseling center staff.

Survey Questions

The survey questions were developed collaboratively by researchers and clinicians to assess participants' areas of interest in psychotherapy research and their willingness to incorporate research into their clinical routine (Appendix A). Purposely designed to require minimal time commitment for completion, the survey was composed of three main sections: The first asked participants' basic descriptive information. The second section focused on seven broad areas of psychotherapy research: effectiveness research, process research, client and therapist characteristics, assessment and treatment of minority students, treatment utilization, and high-risk behaviors. Participants were asked to rate the importance and value using a 5-point Likert scale, ranging from 1 = *not at all important/valuable* to 5 = *extremely important/valuable*. In addition, two themes (broad range of treatment process and outcome, and client factors) included subcategories of research projects, and participants were asked to rate their clinical usefulness using a 5-point Likert scale, ranging from 1 = *nearly none* to 5 = *extreme*. For participants who identified themselves as clinic directors, this section included an additional 10 questions regarding the specific procedures and activities related to conducting research projects at their center. For each question, clinic directors were asked to provide a rating of clinical value, feasibility of implementation, and willingness to participate using a 5-point Likert scale ranging from 1 = *low* to 5 = *high*. The third section was composed of an optional free response section, where participants were asked to provide their own research ideas and proposals in less than 100 characters, regardless of whether they had been discussed or not in the previous sections.

Qualitative Analyses

The qualitative coding of the free responses was guided by directed content analysis (Hsieh & Shannon, 2005). Three doctoral-candidate graduate students coded and categorized the free responses. Given the wide scope of research ideas proposed by the survey responders, Orlinsky, Ronnestad, and Willutzki's (2004) generic model of psychotherapy was selected to provide a theoretical framework that guided the development of the categories for the directed content analysis. This model provides a research-based metatheoretical understanding of psychotherapy, as well as a broad framework for the evaluation of universal change processes in treatment (Orlinsky, 2009). The model differentiates psychotherapy process variables, from individual and social con-

texts in which therapy occurs, and includes three broad temporal sequence of events: input, process, and outcome variables. The categories in each of the temporal levels highlight the interrelations between psychotherapeutic processes and the participants' contextual and environmental factors. Input categories, for example, focus on issues that exist prior to the start of a course of therapy, which include client and therapist characteristics (e.g., socioeconomic status) and treatment delivery systems (e.g., utilization of counseling services). Process categories include variables and processes that arise within a therapy session (e.g., therapeutic monitoring of alliance ruptures). Finally, outcome categories explore variables that occur after the conclusion of a session, including both immediately post conclusion of session and treatment (e.g., effect of counseling on academic factors, including grade point average and retention).

Using the generic model, the three coders independently categorized each of the free responses. A response item was coded into as many categories as necessary to capture all aspects of its inquiry, and could fall into any level of the model. In other words, a given response could have been coded into one or multiple categories. The three coders met on a weekly basis to discuss coding, and a consensus was reached for items that had differing categorizations before continuing to code. If solutions to these discrepancies led to changes in the coding procedures, all prior categorizations were recoded in accordance with the final coding procedures.

This iterative process also led to the development of two categories that were added to the ones provided in the generic model to capture all free responses in the survey. (a) Nontherapy: Responses were coded in this category if the free responses were related to mental health treatment issues but not specifically about psychotherapy. For example, ideas related to supervision, case management, psychiatric medications, and outreach programs were coded as nontherapy. (b) Uncodable suggestions: Responses in this category were coded as such when there was not enough information provided to accurately determine the applicable categories.

Results

Overall, there was a high response rate to the survey with 627 responders (out of 871, or 71.99%). Table 1 includes the results of the participants' ratings of how important/valuable they considered

each broad area of psychotherapy research to be. All of the seven broad areas were rated as definitely important/valuable or higher. Research on the process of counseling was reported as the most valuable, as 81% of responders rated this area as very or extremely important. Research on the effectiveness of counseling, high-risk behaviors and disorders, minority populations, and therapist characteristic were also rated as very or extremely valuable by 70% or more of the respondents.

Despite the diversity in participants' ratings in the clinical utility of specific research projects, these were all rated as moderately clinically useful or above. Table 2 includes the results for each of the specific projects related to a broad range of treatment process and outcome. The two highest rated projects within this theme included understanding how to generalize lessons learned from therapy to other parts of the clients' lives and exploring how to help clients obtain a new perspective of self and/or others (insight), with 85.0% and 80.6% of responders rating these as high or extremely high in clinical utility respectively. Projects related to the therapeutic relationship, corrective experiences, and difficulty establishing client engagement or dealing with resistance were also rated as high or extremely high in clinical utility by more than 70% of participants.

Table 2 also shows the clinical utility ratings for specific projects related to client factors. Results show that research projects addressing clients' acute difficulties were viewed as high or extremely high in clinical utility, such as suicidal clients (82.5% of participants), clients with trauma (81.4%), and risk prediction (80.9%). More than 75% of responders also rated projects focused on clients with depression, ethnic minority clients, and sexual orientation minority clients as high or extremely high in clinical value.

Table 3 includes the counseling center directors' ratings on the clinical value, feasibility, and willingness to engage in tasks required to conduct research projects at their centers. The results show that, overall, there was a high level of convergence between the research projects perceived as high in clinical value, the research-related tasks that directors viewed as feasible, and their willingness to engage in these activities. For example, the highest ratings in clinical value, feasibility, and willingness to engage in were reported for projects assessing clients' pre–post change in treatment. Another area rated highly by clinic directors was the provision of center-wide trainings on counseling techniques that could benefit their staff members, such as identifying and repairing alliance ruptures, as well as managing countertransference or therapists' personal reactions.

In terms of free responses, 188 (30%) participants provided at least one suggestion in the free response section, and on average providing 2.07 suggestions, for a total of 388 free responses. The results of the content analysis led to a total of 903 categorizations, with each free response being categorized with 2.32 different categories on average. Coding of 43.5%, 22.9%, and 33.6% responses fell into the input, process, and outcome levels of the generic model, respectively. Table 4 includes the results of the categorization of the free response answers.

The two most frequently suggested research topics focused on clients, addressing issues about the client as a participant (e.g., "First-generation students' struggles in comparison with non-first-generation") and the client's ongoing psychological functioning/life situation (e.g., "Getting a better handle on how counseling

Table 1

Survey Ratings of the Importance/Value of Different Types of Psychotherapy Research by Members of the Center for Collegiate Mental Health

Type of psychotherapy research	M	SD	% Rated 4 or 5
Effectiveness of counseling	4.04	0.98	73.6
Process of counseling	4.22	0.86	81.1
Client characteristics	3.79	0.96	63.8
Therapist characteristics	3.92	0.91	70.7
Members of minority populations	4.04	0.93	73.3
Utilization of services	3.64	1.01	57.9
High-risk behaviors and disorders	4.11	0.89	76.1

Note. Ratings range from 1 = *not at all important/valuable* to 5 = *extremely important/valuable.*

Table 2

Survey Ratings of Clinical Utility for Specific Research Projects Related to Treatment Effectiveness and Client Factors

Specific research project related to:	M	SD	% Rated 4 or 5
Broad range of treatment process and outcome			
Therapist effects	3.80	0.84	67.0
Institutional/counseling center differences	3.53	0.90	51.2
Treatment effectiveness	3.62	0.83	58.2
Effects of treatment length and frequency	3.90	0.84	69.8
Positive expectancies of outcome	3.71	0.76	62.9
Therapeutic relationship	4.01	0.86	73.7
Insight	4.05	0.72	80.6
Corrective experiences	3.93	0.78	73.8
Generalization of lessons from therapy	4.19	0.73	85.0
Other positive moments or events in therapy	3.48	0.87	50.6
Therapist skillful or effective use of specific techniques	3.54	0.91	54.9
Alliance ruptures	3.74	0.85	61.2
Countertransference	3.79	0.83	66.0
Difficulty establishing client engagement or resistance	3.90	0.84	79.8
Overt negative emotional or behavioral reactions from clients	3.60	0.85	53.8
Other negative events or moments in therapy	3.37	0.87	43.3
Client factors			
Suicidal clients	4.23	0.77	82.5
Clients with substance abuse	3.77	0.89	63.3
Clients with eating disorders	3.79	0.90	62.8
Clients with depression	4.06	0.78	78.2
Ethnic minority clients	4.09	0.81	77.8
Sexual orientation minority clients	4.07	0.81	78.1
Clients with trauma	4.17	0.75	81.4
Clients with academic problems	3.51	0.92	48.4
Standardized assessment of clients' personality features	3.18	0.95	35.2
Standardized assessment of resiliency	3.71	0.93	61.2
Standardized assessment of therapy readiness	3.49	0.97	51.0
Standardized assessment of therapy expectations	3.43	0.94	48.0
Risk prediction	4.20	0.83	80.9
Measurement development for assessing and tracking personalized treatment goals	3.58	0.98	55.4

Note. Ratings range from 1 = *nearly none* to 5 = *extreme*.

center treatment can help with academic success") with totals of 197 (21.8%) and 152 (16.8%) of the responses, respectively. Another 13 responses (1.4%) were coded as patient's self-relatedness (e.g., "Research on self-stigma and the impact it has on counseling"). Issues related to the process of treatment were the topic of a substantial number of suggestions, including 123 (13.6%) responses coded for therapeutic contract (e.g., "Individual vs. group therapy"), 42 responses (4.7%) coded for therapeutic operations (e.g., "How to better use immediacy in session"), and 19 responses (2.1%) about the therapeutic bond. Together with other less frequently endorsed categories, roughly 60% of the free responses indicated interest in research focused on clients, as well as on the conduct of therapy.

Another cluster of responses focused on the therapist, including the therapist as a participant (46 responses, 5.1%; e.g., "Characteristics of successful therapists regardless of theoretical orientation"), and therapist self-relatedness (seven responses, 0.8%; e.g., "Therapist self-revealing to client in therapy"). There were also 14 suggestions (1.6%) related to professional development (e.g., "Research on supervision qualities that best prepare trainees to provide good clinical treatment"), and nine suggestions (1.0%) for therapist's ongoing psychological functioning (e.g., "Teamwork in counseling centers and therapist job satisfaction"). These types of responses were aimed toward a better understanding of therapist's learning, improvement, and "burn-out," as well as other similar issues not necessarily tied to a specific client.

Additionally, there was interest in research studies aimed at administrative/policy-related issues. These were coded as psychotherapeutic treatment delivery system questions at both input (84 responses, 9.4%) and output (six responses, 0.7%) levels. For example, several suggestions aimed at discovering ways to overcome existing barriers of utilization of services prior to treatment, or determining "best practice" policies after gathering information following treatment.

Interestingly, 83 responses (9.2%) proposed research questions categorized as nontherapy in addition to other applicable categories. These suggestions inquired about a number of issues relating to psychotherapy without specifically delving into a direct therapy session or course of psychotherapy treatment per se. For example, responses ranged from the development of therapy feedback systems to outreach programs and pharmacological treatment.

Among the 188 respondents of the free response section, 34 (18.1%) were counseling center directors, who contributed 65 (16.75%) responses with an average of 1.9 per director. On average, the director items were coded to fall into 2.17 categories: 31.9% of responses were coded as input categories, 24.1% as process, and 44% as outcome. When examining specific categories, the three most frequently requested research topics for only directors involved client characteristics (17.7%), client ongoing psychological functioning/life situation (23.4%), and therapeutic contract (12.8%). The results showed similarities in clinicians and directors' interests.

Table 3

Survey Results of Clinic Directors' Assessment of Clinical Value, Feasibility, and Willingness to Engage in Tasks Related to Conducting Research Projects

Tasks involved in conducting research projects	Clinical value		Feasibility		Willingness	
	M (*SD*)	% Rated 4 or 5	*M* (*SD*)	% Rated 4 or 5	*M* (*SD*)	% Rated 4 or 5
Complete outcome measure pre- and posttreatment	4.58 (0.78)	89.1	4.33 (0.92)	81.8	4.47 (0.91)	86.0
Complete outcome measure every session	3.19 (1.31)	40.9	2.59 (1.35)	24.7	2.46 (1.32)	21.5
Ask clients to complete psychotherapy process/impact measures after each session						
on paper	3.62 (1.16)	59.1	2.97 (1.23)	32.3	2.81 (1.30)	28.0
on a computer (e.g., through EMR system)	3.92 (0.98)	68.8	3.14 (1.31)	43.0	3.26 (1.28)	43.4
Ask counselors to complete psychotherapy process/impact measures after each session						
on paper	3.28 (1.28)	47.9	2.61 (1.24)	26.9	2.49 (1.30)	24.7
on a computer (e.g., through EMR system)	3.69 (1.13)	63.5	3.37 (1.24)	53.8	3.19 (1.25)	45.2
Have counselors receive/provide additional supervision to others (e.g., trainees)	3.44 (1.20)	50.6	2.87 (1.23)	31.1	2.92 (1.29)	31.9
Have center-wide trainings on counseling techniques related to management of countertransference or personal reactions of the therapist	4.13 (0.96)	79.4	3.88 (1.06)	64.2	3.88 (1.10)	69.3
Have center-wide trainings on counseling techniques related to identification and repair of alliance ruptures	4.13 (0.85)	78.1	3.97 (0.90)	67.1	3.92 (0.93)	66.6
Have center-wide trainings on counseling techniques related to another topic	3.99 (1.18)	70.9	3.79 (1.20)	60.5	3.85 (1.18)	65.1

Note. EMR = electronic medical record. Ratings range from 1 = *low* to 5 = *high*.

Moving Beyond Standardized Data to Unique Projects—Step 2: Leveraging Survey Results to Develop a Specific Research Project

Overall, the results of the survey showed that clinicians and counseling center directors viewed research on the process of therapy as most valuable. Specifically related to the therapeutic process, providers reported a high level of interest in participating in studies focused on generalization therapeutic learning, insight, corrective experiences, the therapeutic relationship and related issues of alliance ruptures, countertransference, and difficulty establishing client engagement (resistance), as well as positive ex-

Table 4

Results of the Free Responses Categorization Based on the Generic Model of Psychotherapy

Levels	Generic model of psychotherapy categories	Number of responses (%)
Inputs	Participant as patient	197 (21.8)
	Participant as therapist	46 (5.1)
	Society	42 (4.7)
	Psychotherapeutic treatment delivery systems	84 (9.3)
	Other contracting parties in patient's social network (e.g., employers, family insurer)	5 (0.6)
	Other contracting parties in therapist's professional network (e.g., referral sources, supervisors)	19 (2.1)
Process	Therapeutic contract (treatment model, roles, goals, tasks, techniques, format, rationale)	123 (13.6)
	Therapeutic operations (patient presentation, therapist understanding, interventions, patient responsiveness)	42 (4.7)
	Therapeutic bond (includes patient and therapist interpersonal behavior)	19 (2.1)
	Participant self-relatedness—Patient	13 (1.4)
	Participant self-relatedness—Therapist	7 (0.8)
	In-session impacts—Patient	3 (0.3)
	In-session impacts—Therapist	NA
Outcome	Postsession outcome	9 (1)
	Professional development	14 (1.6)
	Therapist ongoing psychological functioning/life situation	9 (1)
	Patient ongoing psychological functioning/life situation	152 (16.8)
	Daily events in patient's social network	NA
	Psychotherapeutic treatment delivery systems	6 (0.7)
	Long-term outcome & follow-up status	26 (2.9)
	Society (cultural belief and value patterns, social institutions)	2 (0.2)
Other	Nontherapy (supervision, psychiatric medications, case management, outreach programs)	83 (9.2)
	Uncodable suggestions	2 (0.2)

Note. Based on Orlinsky, Ronnestad, and Willutzki's (2004) generic model of psychotherapy. NA = There were no responses coded in this category. Other = categories created by study coders, not part of generic model of psychotherapy.

pectations of outcome. Training in identification and repair of alliance ruptures and management of countertransference were also rated highly valuable by clinic directors.

Most of these study topics highly overlap with the expertise of researchers who are part of the CCMH core research team (Castonguay, Constantino, Boswell, & Kraus, 2010; Hayes, Gelso, Goldberg, & Kivlighan, in press). This point of convergence and complementarity, which is frequently at the heart of POR, was leveraged to design a research project to test the feasibility of implementing two psychotherapy process measures focused on the therapeutic relationship, both from the clients' (i.e., the therapeutic alliance) and the therapists' (i.e., countertransference, or emotional, cognitive, and behavioral reactions to the client) perspective. These clinical variables were also chosen as they would be clinically applicable, regardless of a provider's theoretical orientation, or a client's presenting concerns. The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) was selected to assess the therapeutic alliance. It is a well-established transtheoretical scale that assesses three dimensions of the therapeutic relationship: agreement on goals, agreement on tasks, and the therapeutic bond. For the study, a short, six-item, client self-report version (Falkenström, Hatcher, Skjulsvik, Larsson, & Holmqvist, 2015) was chosen and administered after each session. This short version of the WAI has two subscales, Bond and Tasks/Goals, and a total score to assess the therapeutic alliance. To assess countertransference, an adapted, self-report version of the Countertransference Behaviors Measure (CBM; Mohr, Gelso, & Hill, 2005) was used. The CBM is a 10-item observer-rated measure that assesses therapists' overt manifestations of countertransference with three subscales: Dominant Countertransference Behavior, Distant Countertransference Behavior, and Hostile Countertransference Behavior. The CBM in this study was completed by therapists after each session. These two measures were chosen due to being short, easily implementable, practical, and potentially clinically useful.

Procedures for Implementing the Process Measures

To initiate the recruitment of centers for the study, an e-mail describing the study aims and procedures was sent to the CCMH member listserv, asking members to contact the research team if they were interested in participating in the study. Interested centers were provided additional detailed information about the study, including the study measures in paper and EMR-consistent format, and recruitment scripts to be used with their clients. Centers who maintained their interest in participating after receiving this information were offered assistance from the research team with their institution's IRB application for the study. Once IRB approval was obtained, each site was able to start collecting data, which would be transferred to the research team during the regular center upload to the CCMH data repository in a deidentified manner.

Due to challenges described below, recruitment for the study took place at four different times for data collection. Figure 1 shows the number of centers recruited during the first three instances of recruitment, which followed the aforementioned recruitment steps, including the number of centers that dropped out at the different stages of implementing the study procedures. Most centers withdrew interest or were lost to follow-up after they were sent additional information regarding the study, and discussions related

to implementation procedures began. The IRB application procedure was the next big obstacle during which centers withdrew interest or were lost to follow-up. These three waves of recruitment yielded sporadic data collection from three of the 11 total sites that were eligible to collect data.

Using this limited data collection from the previous three initiatives as a learning experience, the research team adopted a completely different recruitment approach during the fourth recruitment instance, in terms of whom to target and how to pursue potential sites. Recognizing the importance and necessity of regular communication to expedite the installation of a new study protocol at any given site, the researchers attempted recruitment from the CCMH members who already had established communication lines with the research team. This recruitment initiative was carried out through the CCMH advisory board, a rotating board of members comprising elected individuals from centers, representing the diversity of the PRN, and which was already meeting regularly to further the various goals of the CCMH. This resulted in the interest of many members, and eventual commitment of individual "champions" from two centers, a large mid-Atlantic U.S. state university, and a large Western U.S. private university. Working closely with these individuals, the research team provided support for each center's IRB applications. To date, these two centers have collected data from ~20 therapists and 110 clients.

On the basis of the experiences during these four waves of recruitment, we will discuss the challenges encountered during the implementation of the study and the strategies used to address them. During the first three recruitment instances, these obstacles and efforts were identified through the experiences and inferences of the research team members, and e-mail communication with participating centers. The fourth initiative included qualitative interviews with the individual "champions" at the two centers, as well as written descriptions of their experiences (see Appendix B for the interview guide).

Challenges in Implementing a New Study Within an Existing PRN Infrastructure

IRB-Related Challenges

The overall implementation of the study proved cumbersome, both logistically and resource-wise. Among the early obstacles encountered were those related to seeking IRB approval. Although this process was aided by the research team through phone calls and provision of example study protocols and other materials, the unique emphases of each institution's IRB imposed varying amounts of information requested as part of the application material, and inestimable time necessary for the review process. For example, one of the sites described the added challenges of having to provide extensive explanations and clarifications regarding the specific data collection, storage, and sharing processes innate to a POR project. These included how the study data would be stored and shared in a deidentified manner if it was collected through the counseling center's EMR system, clarifying the roles of the individuals participating in the POR project, and who would have access to the data, as well as asking additional information regarding the data analytic plans. Furthermore, the specific site's IRB
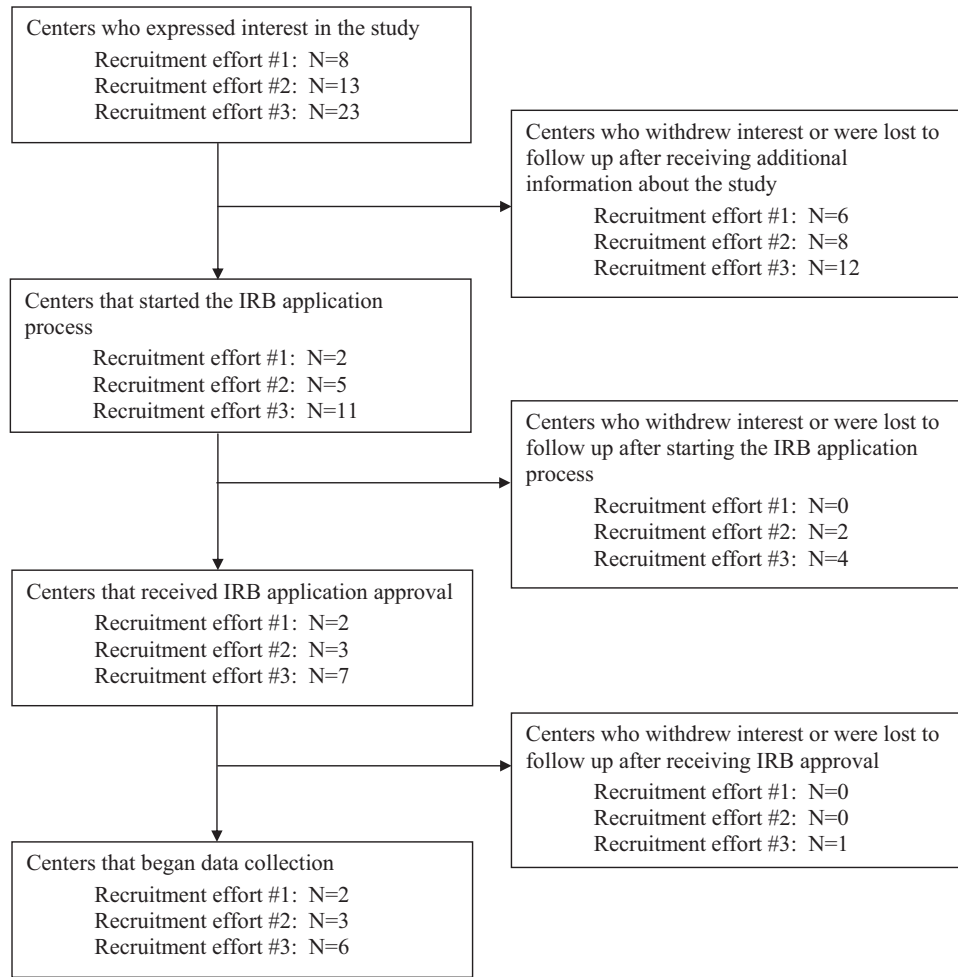
Figure 1. Study recruitment process for Efforts 1–3.

required that all therapists participating in the study had to complete extensive IRB training prior to enrolling their clients. Overall, providing clarifications to these questions, and addressing the specific modifications requested by the IRB, significantly delayed the start of the project.

This process was necessary despite each center having an IRB approval to contribute deidentified data to the CCMH data repository, as it involved the implementation of new measures and protocols not originally included in the approval to contribute standardized data. Ultimately, it fell to the "champion" at the center to coordinate applying for and acquiring IRB approval for the pilot study. This also created an unpredictable obstacle in the form of the "champion's" availability to advance the review process, amid other official duties.

Study Setup Challenges

One of the main obstacles encountered was the time required to initially set up the study. After IRB approval, each participating site had to obtain the measures from the research team, embed the measures within their EMR system, and verify functionality. These steps required significant time outside of routine clinical and administrative responsibilities, and were nearly exclusively conducted by the site champions. When these staff members were unfamiliar with the procedures necessary to import study materials, additional time was needed to request and receive support from the research team.

In the fourth wave, site champions were also responsible for staff training, which was an added difficulty to study initiation. Some sites had frequent staff changes during the academic year which made it difficult, both time- and resource-wise, to train the new staff in the study procedures, particularly when coordinating and locating time for a group training. One site even saw a unique challenge in the loss of administrative resources: The retirement of an involved research faculty member also led to a minimization of research lab and graduate student support.

Interestingly, some centers expressed difficulties getting "buy in" from administration to support the implementation of the study in their centers, whereas other centers had no such difficulties. However, all centers appeared to have difficulty recruiting therapists. Some therapists did not find assessments beyond the existing standardized treatment progress monitoring necessary or helpful to clinical practice, whereas others did not find the specific measures

included in the study helpful, which potentially led to hesitation and/or lack of enthusiasm in participating in the study. Even at centers where there was strong initial interest in the study and many potentially identified therapists, the actual number of providers that enrolled in the study represented a small percentage of the initial interest. For the final round of recruitment from the CCMH advisory board, similar issues arose despite strong initial interest from a majority of members. It is important to note that although these members comprise an important board of leadership in the PRN, they are also ultimately one individual amid a team of mental health care providers at their respective centers.

Study Implementation Challenges

There were study implementation-related challenges as well. Flexibility in the study protocol implementation was interestingly both a positive reason for therapists joining the study (discussed further in the strategies section) and a challenge in the study implementation. For example, some therapists decided not to recruit all of their clients to reduce burden, but this decision added the logistic of having to remember which clients had been enrolled in the study to administer the study measures consistently. Additionally, each site recruited therapists on a volunteer basis, and not all therapists participated. Thus, tracking the therapist−client dyads that were enrolled in the study became an additional task for study administrators and therapists. Some centers also reported that their clients frequently received incentives, sometimes as small as candy available near where survey data are collected, to participate in studies. For these types of centers, the lack of incentive in this study may have led to potential recruitment difficulties.

The study procedures for data collection were also different than typical clinical practice. Most centers had their therapists and clients complete measures prior to sessions so that they could have the results of the assessments available during the session. However, the current study asked both therapists and clients to complete the measures postsession, which meant that most centers were not able to use the existing reminder system and instead had to create a new way to remind therapists and clients to complete the measures after the session.

Given the existing EMR system to collect data, there were technological challenges that arose as well. Some centers experienced errors while clients were attempting to use the EMR system to submit their responses to the measures. Given that these measures were newly created, the errors were new to administrators at centers, requiring additional time for troubleshooting.

How Do We Solve All These Problems?

Strategies to Deal With IRB Issues

The research team was highly involved in the IRB process and provided assistance to each site in addressing their specific needs during this procedure. For example, the research team provided general templates for the IRB application materials, including consent forms, recruitment materials, such as flyers and handouts that therapists could use to explain the study to their clients, and responses for the IRB application form questions. The research team then worked with the sites' contact person to adjust the

answers from the general templates to address each site's specific IRB's formatting and questions, as well as any additional information that was requested by each site's IRBs. For example, some IRBs requested detailed information on the data analytic plan for the project. The research team also worked with each center to tailor recruitment materials for clients and therapists that could be seamlessly integrated and used within each center's existing procedures.

Strategies for Study Setup Challenges

Strategies that have worked, at least partially, to recruit therapists included sending numerous reminders, center-wide announcements, selecting measures with clinical utility and therapist interest, and individual invitations from both the local champion and the research team.

It appeared essential for each site to have a "local champion" who is invested in the study and willing to actively engage in all aspects related to the study at their site. This local champion is an individual who can embody the characteristics of a scientist-practitioner and is highly invested in the integration of research and practice: S/he serves as the local site's principal investigator of the study, knowledgeable in all study-related procedures, in constant communication with the research team, and is also continuously assessing the clinical utility and implementation feasibility of the research project within the local site's infrastructure and resource availability. Given the complexities of implementing a new study into an existing PRN infrastructure, our experience has shown that it is imperative to involve a point person who is both an expert on the study procedures and the clinical system where the study is implemented, so the procedures can be cohesively integrated within the existing clinical practices. The first three recruitment attempts yielded interested individuals at each of the sites, but none of them were able to spearhead the implementation of the study at their center due to a variety of reasons, such as their other responsibilities and lack of time. The change in strategy for our fourth recruitment effort included establishing a local champion in the recruited centers, which allowed us to successfully complete all aspects of the project, from study setup, recruitment of therapists and clients, and data collection.

The local champions served as the go-to person between the research team and the center. For example, the local champions regularly checked in with participating clinicians to gain feedback and help problem solve any emerging issues. There was also frequent communication between the champions and the research team to share the progress of each site's project implementation, and to provide clinician feedback to the research team so as to ensure that the project continued to be scientifically rigorous and clinically relevant. The local champions helped maintain the clinicians' excitement about the study by periodically reviewing the utility of the measures within their clinical practice and eliciting feedback from clinicians related to the study protocol. This in turn may have increased the likelihood of providers presenting the study to their clients, and also positively impacted *how* they discussed the study details with them. In other words, therapists who continued to see the clinical value of the study might have been able to share that with their clients, which might have increased the probability of study enrollment.

In addition, given the significance of the local champion, it is important for the champion to have a strong vision of the research and clinical purposes of the project. Having local champions who understand the added value of the project to existing clinical practice is crucial because they will be able to help share this benefit within the context of their center practices to the therapists and administration. Therefore, just as the working alliance is a foundational factor in therapy (Castonguay et al., 2010), a strong working relationship between the research team and the local champions was essential for the success of the project.

This became particularly evident with the successful fourth wave of recruitment. As mentioned above, the local champions in that wave were also part of the CCMH advisory board, and thus were already professionally involved with the research team. Accordingly, it was easier to facilitate important meetings in a collaborative manner. Indeed, this preexisting relationship allowed for open communication from both ends regarding the needs, difficulties, and feedback necessary to institute the study at every level.

Finally, the study itself can and should be a selling point for potential participants. For many interested centers, the measures utilized in the study provided strong incentive for interest. Despite the fact that the alliance and countertransference have been well researched and are considered to be theoretically and clinically important, most centers did not have a routine way to empirically gather these data. Thus, this study provided a way to regularly collect potentially important clinical information in a way that maximized clinical utility with research standards.

Strategies for Implementation Challenges

The research team played a large role in providing pragmatic assistance to participating centers during the preparation, coordination, and implementation process to help customize the study materials to each center's policies and procedures, while also retaining the core study components intact. For example, in addition to the assistance related to the IRB application mentioned above, participating centers highlighted the crucial step of having the research team provide technological assistance to each center. The research team created all study measures in the format consistent with the EMR system used in each center, and then worked with the local champion and other staff as needed at each site to incorporate the measures into the software and make them easily accessible within routine clinical care. If there were any technological difficulties that emerged, the research team worked with the EMR vendor to problem solve the issues and then sent detailed instructions to the sites on how to resolve the challenges faced.

Importantly, the research team also provided help in modifying the routine procedures that had become habitual for clinicians. In other words, providers are used to following their normal end-of-session routine, such as scheduling the next appointment with their clients and walking the clients out of the door. Therefore, altering these behavioral habits, and cueing clinicians and/or clients to remember to complete the study measures at the end of the session, was a challenge in ensuring consistent data collection. To address this concern, a few different strategies were explored to cue and remind therapists, including bringing the iPads that are used to complete the study measures into the therapy room instead of returning them to the front desk per usual, or putting up sticky notes on the therapist's computer or wall. Centers also used existing features within the EMR system to help cue therapists and clients, such as putting the measures into therapists' to-do tasks lists, and flagging clients who were in the study, as this generated an alert for therapists when they were scheduled to meet with those clients. However, these solutions were not perfect and were sometimes technologically limited, such as the inability to mark participating clients as "special" without also creating new categories which made administrative reporting tasks more difficult.

The local champions helped problem solve data collection-related difficulties. For example, they would check to see if measures were completed and clarified any questions and concerns that arose from therapists related to data collection. Typically, this was done informally whenever possible, including checking in when passing participating therapists in the hallway. If additional assistance was needed, the local champion contacted the research team with the problems noted by the providers, and the research team worked with the local champion and/or the EMR software vendor to solve these challenges as needed. Some centers had additional help in managing the day-to-day study-related activities, such as by using an undergraduate research assistant, who would help monitor data collection, check and problem solve missing data and data entry errors, remind therapists and clients to complete the study measures, as well as follow up with therapists as needed.

The study's flexibility in implementation was also a strategy that increased feasibility. For example, centers decided whether all therapists would participate in the study or include only those who were interested. Therapists also had the option of enrolling all of their new clients, or have a few enrolled at a given time (e.g., four active clients at a given time). This flexibility in recruitment was purposely designed into the protocol of the study to be attuned to the daily demands of participating therapists and center policies.

Training in the study-specific procedures is essential. Therapists are familiar with how to complete assessments and review measures that are part of clinical routine. However, for study-specific measures, it is important not to assume that therapists will be able to administer and retrieve the results just because the measures were added to the EMR system. Training therapists in study-specific procedures includes aspects such as how to complete the measures and find the results when needed, how to interpret the results of the measures in a clinically helpful manner, how to answer questions that clients may have about the study procedures, measures, and results, as well as helping therapists think about how they would go about introducing these study-related steps into their daily routine. For example, as mentioned above, local champions and/or research team members helped therapists use strategies that worked for them in terms of helping them remember to complete the study measures at the end of sessions. These efforts take time, but it is important time to invest. Ensuring clarity from participating therapists makes it easier to adhere to the study protocol.

Additionally, it is important to also train support staff in the study procedures and aims when appropriate. If a center uses front desk and other support staff in administering their assessment measures, such as undergraduate research assistants, then it could be invaluable for the research team and/or local champion to train these staff in the aims and procedures related to the study, as clients and therapists often resort to them for clarifications. Thus, providing study training to the support staff ensures that therapists

and clients are receiving correct information from them, which not only increases data collection accuracy but also decreases any potential frustrations that may arise related to the study.

Participating centers used various training strategies. Some centers conducted a one-time group training with all interested staff members, in which the goals, nature, and study procedures were presented, including specific procedures for obtaining client consent, the clinical utility of the study measures, and how to use the study data for feedback and clinical purpose. Another site adopted an individual training method, where the local champion scheduled 20-min training sessions with each participating therapist, and reviewed the study-related materials and procedures with them. To ensure the retention of information acquired at the training, one site created handouts and diagrams describing the study procedures and decision-tree depending on whether clinicians and clients consented to participate. These materials served to help clinicians reference the procedure when questions arose. Additionally, when possible and helpful, the research team aided with the trainings. For example, at one site, the research team conducted a presentation of the study to the center staff and provided on-site training to participating clinicians on several occasions. This had the added effect of furthering the sense of collaboration between the research team and providers.

Conclusion

The current article focused on integrating research and practice with two aims: (a) leveraging the results of a survey that assessed the interests of members of a PRN in university and counseling centers toward future research, and (b) describing the challenges faced and strategies used when implementing a new project fitting some of these interests. Among the topics that were perceived as highly useful or valuable by providers and clinic directors were factors related to the therapeutic relationship. These findings are consistent with the research interests of clinicians in independent practice who also rated the therapeutic relationship as an important and clinically useful research theme (Tasca et al., 2015). Furthermore, they also showed high convergence and complementarity with the CCMH research team's areas of expertise. By investigating two relationship constructs (alliance and countertransference), the project described in this article represents the first investigation developed solely by and for the CCMH members that moved beyond the standardized assessment protocol used in this PRN infrastructure. As such, this article not only illustrates an example of the type of study that can be of interest to clinicians, administrators, and researchers, but also provides lessons about how to design and implement such a study in an already established PRN.

Despite the everyday demands at counseling centers, the results show that it was possible to recruit therapists and clients, as well as collect data for the study. However, this endeavor required the active collaboration between the research team and participating sites to overcome significant obstacles. The biggest challenge was achieving consistent and reliable data collection. This difficulty was mostly due to creating a procedure to administer the study measures in a manner that aligned with routine clinical practice. Having the context of an established PRN allows for significant benefits, with members accustomed to collecting standardized measures as part of standard routine clinical care for both research and clinical purposes. However, the process of introducing a new

research protocol within this context highlighted how difficult it is to change what has become familiar and/or habitual procedure among staff and center policies. As a research member stated, "When a large ship has left the port and successfully navigated through storms and challenging waters, it is difficult to change course, even when the new direction is viewed as promising." For example, the study asked participants to complete the study measures postsession, as opposed to the routine presession collection of standardized outcome data as part of the PRN procedures. Furthermore, the study's flexibility in who participated in the study (i.e., all therapists in the counseling center or just a few, or all clients within a therapist's caseload or just a few) was aimed at increasing enrollment and reducing provider burden, but appeared to add to the logistic difficulty of needing staff to remember who was participating in the study so as to collect the study measures, leading to inconsistent data collection. Other challenges to data collection included recruitment of therapists and clients into the study, as well as administrative difficulties, such as IRB applications, and embedding the study measures into the existing EMR system.

True to the principles of POR (Castonguay et al., 2013), the strategies that successfully addressed these obstacles and led to the implementation of the study and subsequent collection of data were rooted in the strong partnership between research team and the counseling center, specifically with the identification of a local champion. As evidenced by the success of the fourth recruitment wave, this champion was an individual at each site who assumed the leadership of the study locally, and spearheaded the implementation of the project through regular contact with the research team to problem solve any difficulties that emerged and maintained the excitement, scientific rigor, and clinical relevance of the study. Furthermore, representative of the principles of POR, the local champions are also involved in the dissemination of the results the study by being coauthors in articles and research presentations. Given the importance and significant time commitment for the local champion, future studies should explore strategies to be used when such an individual is not available. Are there ways that the research team could use to fill this gap, such as by providing incentives? It might be helpful for situations like these to revisit methods applied when first establishing PRN partnerships (McAleavey et al., 2015). Experience also showed that investing time and resources to provide adequate training of study procedures is crucial to address the challenges related to data collection.

Overall, the challenges discussed in this article highlight some of the difficulties that maintain the science–practice gap: when clinicians gradually become separated from research, and when researchers increasingly conduct research in insulated settings that do not represent the real-world clinical practice. As evidenced by the process engaged to implement the current study, overcoming these difficulties requires significant levels of effort from everyone involved. However, through sustained interest and collaborative energy from all participating members, it is possible to generate strategies that are effective in addressing these obstacles in a clinically applicable and scientifically rigorous manner.

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(Appendices follow)

Appendix A

Survey Questions

Basic Information

1) Please select which of these best represents your role in the Counseling Center:
   Full-time clinical staff member
   Part-time clinical staff member
   Postdoctoral clinical staff member
   Primarily psychiatric services
   Primarily administration
   Primarily providing supervision
   Other (please specify):

2) What percent of your time is devoted to clinical practice (that is, providing psychotherapy or counseling directly)?

3) How many clients do you personally see each week for individual counseling at your counseling center? That is, for regularly scheduled counseling or psychotherapy appointments as part of a routine treatment course.

4) How many counseling groups do you facilitate each week at your counseling center? That is, for regularly scheduled group counseling or psychotherapy appointments as part of a routine treatment course.

5) How many therapists do you supervise on a regular basis? Supervisees may be at any level of training or your peers.

6) How long (in weeks) is the typical total length of treatment that you see clients for regular counseling or psychotherapy?

Types of Research

There are many types of research that could be conducted in CCMH. Please rate the types of research below in terms of how important and valuable, overall, they are to you.

Types of research	Not at all important/valuable	A little important/valuable	Definitely important/valuable	Very important/valuable	Extremely important/valuable
Research on the effectiveness of counseling					
Research on the process of counseling (i.e., what facilitates or hinders therapeutic change)					
Research on client characteristics that may influence the process and/or outcome of counseling					
Research on therapist characteristics that may influence the process and/or outcome of counseling					
Research on assessment and/or treatment of members of minority populations in counseling					
Research on utilization of counseling center services					
Research on high-risk behaviors and disorders (e.g., substance abuse, violence, suicidality)					

Willingenss to participate	Not at all	Unlikely	Somewhat likely	Very likely	Almost definitely
If a research project seemed clinically valuable to you, how willing would you be to participate in it?					

(*Appendices continue*)

Specific Research Goals

This section, like the ones following it, focuses on specific issues related to some of the general types of research addressed in the previous section.

In this section, please rate how **clinically useful** this type of research project (or the outcome of this type of research project) would be to you, as a counselor. The ratings go from 1 (*nearly no clinical value*) to 5 (*extremely high clinical value*).

If you have ideas for research projects that you would like to see addressed, there will be a space at the end of the survey to describe them.

Specific research topics	Nearly none	Little	Moderate	High	Extreme
Broad range of therapeutic process and outcome					
Research on the therapist effect, such as identifying the strengths of particular types of therapists for specific types of clients					
Differences between institutions and/or counseling centers that may affect the effectiveness of treatment					
Differences between the types of treatments (e.g., skills groups, drug and alcohol services) offered at counseling centers					
The effect of treatment length and frequency					
Creating positive expectancies regarding treatment outcome for clients					
Establishment and development of the therapeutic relationship					
Helping clients obtain a new perspective of self and/or others (insight)					
Providing clients with opportunities to have corrective experiences (unexpectedly beneficial outcomes to anxiety-provoking situations)					
Providing clients with ways to generalize lessons from therapy to other parts of their lives					
Other positive moments or events in counseling or therapy					
Therapist skillful or effective use of specific techniques (e.g., two-chair experiences)					
Alliance ruptures					
Therapist negative emotional experiences in therapy (e.g., frustration with client)					
Difficulty establishing client engagement in therapy or resistance to therapy					
Overt negative emotional or behavioral reactions from clients					
Other negative events or moments in therapy					
Client factors					
Research on suicidal clients					
Research on clients with substance abuse					
Research on clients with eating disorders					
Research on clients with depression					
Research on ethnic minority clients					
Research on sexual orientation minority clients					
Research on clients who have been victims of abuse, assault, sexual assault, or other trauma					
Research on clients with academic problems					
Standardized assessment of personality features of clients					
Standardized assessment of resiliency and other strengths to be used in counseling					
Standardized assessment of therapy readiness					
Standardized assessment of therapy expectations					
Risk prediction (e.g., for suicide attempt, dropout, or other events)					
Development of a measure to assess and track personalized treatment goals for individual clients					

Are you a Clinic Director? (*yes/no*).

(*Appendices continue*)

Specific Tasks—Clinic Directors Only

This section lists some specific tasks that may be involved in conducting some research projects. For each item, please rate the four categories. In cases for which you are uncertain, please select the response that best fits your opinion.

1. Clinical value. Please rate how clinically useful this activity (or the outcome of this activity) would be to you, as a counselor.

2. Feasibility. For you, in your counseling center, IF you were to do this, how feasible would it be?

3. Willingness. Regardless of whether it is feasible for you right now, would you be willing to do this?

The ratings go from **1 (*low*) to 5 (*high*)**. Ratings for each category may be similar to or different from each other. If you have ideas for research projects that you would like to see addressed, there will be a space at the end of the survey to describe it.

	Clinical value	Feasibility	Willingness
Asking clients to complete the CCAPS (either −62 or −34) at the beginning and end of treatment			
Asking clients to complete the CCAPS (either −62 or −34) before every session during treatment			
Asking CLIENTS to complete postsession questionnaires regarding psychotherapy process and/or impact (e.g., a measure of working alliance or session helpfulness) after sessions ON PAPER			
Asking CLIENTS to complete postsession questionnaires regarding psychotherapy process and/or impact (e.g., a measure of working alliance or session helpfulness) after sessions ON A COMPUTER			
Asking COUNSELORS in my center to complete postsession questionnaires regarding psychotherapy process and/or impact (e.g., a measure of working alliance or session helpfulness) after sessions ON PAPER			
Asking COUNSELORS in my center to complete postsession questionnaires regarding psychotherapy process and/or impact (e.g., a measure of working alliance or session helpfulness) after sessions ON A COMPUTER (e.g., through Titanium)			
Having counselors receive or provide additional supervision of other counselors (either trainees or professionals)			
Having center-wide brief training(s) on counseling techniques related to the management of countertransference or personal reactions of the therapist			
Having center-wide brief training(s) on counseling techniques related to the identification and repair of alliance ruptures			
Having center-wide brief training(s) on counseling techniques related to another topic (there will be space to describe this later in the survey)			

Note. CCAPS = Counseling Center of Assessment of Psychological Symptoms.

Additional Research Projects and Unmet Needs: Free Response

If you have suggestions for any additional research projects that you think would help CCMH to meet the needs of practicing counselors and their clients, please describe these ideas below. If there were any questions in the survey that seemed particularly important to you, feel free to include those here as well.

You may describe a relatively well-described study, or simply indicate the topic that you feel deserves more attention—any level of detail is acceptable.

(*Appendices continue*)

Appendix B

Qualitative Interview Guide Used to Interview Local Champions

Questions Related to Study Introduction/Initial Setup

1) What were the most significant challenges faced during study set up? (possible prompts: IRB application, client and/or therapist interest, and engagement in study)

2) How was the study introduced to the staff at your center?

3) Did you conduct any study-specific training at your center?

   a. If yes: How much time did you spend on the training?

   b. How and to whom was the training delivered? (e.g., All staff, only those interested)

   c. What did the training encompass?

Questions Related to Study Implementation

1) Study procedures: Did your center conduct any study procedures adherence checking?

   a. If yes: How often did the therapists check the completed WAI?

   b. Were there any difficulties checking the results of the WAI?

2) Data collection:

   a. Were there any significant barriers to data collection?

      i. If yes: Were these barriers related to the clients, therapists, or administration?

      ii. What kind of barriers to data collection did you experience?

   b. Did your center conduct any data checking during data collection?

      i. If yes: How often did you check the data collected?

      ii. What kind of difficulties were encountered?

3) Are there any recommendations or changes to the study protocol that you would make?