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Learning from bottom-up dissemination: Importing an evidence-based trauma intervention for infants and young children to Israel

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ABSTRACT

This article describes a pilot study of a "bottom up" dissemination process of a new evidence based intervention for treating early childhood trauma. Clinicians applied to learn Child–Parent Psychotherapy (CPP), imported to Israel from the U.S. A focus group of six graduates of a CPP training program responded to questions concerning their experiences learning and using CPP. All 39 CPP graduates from two cohorts also completed a cross sectional survey related to their use of CPP. Within the focus group, the openness of the workplace and the intervention's characteristics were considered major factors impacting CPP use; the training program was perceived to promote CPP implementation, and lack of supervision and secondary traumatic stress were the major inhibiting factors. Using CPP-informed therapy, as opposed to CPP with fidelity, was perceived to be one of the main outcomes of the training. Survey results showed that 53% of graduates were using CPP in over three cases, and almost all intended to use CPP within the next year. Ninety-five percent were using CPP principles in their therapeutic work. The implications of importing a new evidence based intervention to a foreign country that utilizes a different dissemination system within a different professional culture are discussed.

1. Introduction

This paper will report the results of a pilot study of the implementation of an evidence-based intervention for traumatized young children and their families in Israel. It describes a "bottom-up" dissemination plan, whereby diffusion is accomplished through horizontal peer-to-peer networks (Nutley & Davies, 2000, p. 37). Interested practitioners are trained with the expectation that they will diffuse the intervention amongst their workplace peers. This contrasts with "top down" diffusion approaches, common in the U.S., that are driven by centralized or governmental initiatives that mandate or incentivize model selection and establish hierarchies. Today's implementation research on evidence-based practice (EBP) largely studies "top down" diffusion, emphasizing the characteristics of the organization – such as its readiness for adoption, resources, climate (Simpson, 2002) – as central factors in predicting EBP implementation success. Research on "bottom up" diffusion plans has not been noticeable in the implementation literature, although these types of initiatives are still often used.

While the use of EBP has become widespread in the fields of medicine, psychology and social work in the United States (Aarons, Hurlburt, & McCue Horwitz, 2010), it is in its nascent stage in Israel. The Israeli child welfare landscape has been heavily influenced by psychodynamic theories and as a result, the use of manualized interventions for this population does not yet play a dominant part in therapeutic discourse. Child welfare and child mental health organizations do not typically offer or require their staff to use EBP. Moreover, in Israel, a country prone to traumatic events, much has been written about the exposure of adults and children to the trauma of war and terrorism (Chazan & Cohen, 2010; Cohen, Chazan, Lerner, & Maimon, 2010; Keren & Tyano, 2009) and the existence of treatment models for these populations; however, no treatment model specifically oriented toward treating young children and their parents suffering from inter-familial trauma has been adopted.

Indeed, the Israeli professional community does not yet fully recognize the existence and prevalence of trauma in early childhood. As Lieberman (2007) and Osofsky (2007) claim, both parents and clinicians tend to believe that infants, toddlers and

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preschoolers are too young to remember, process, or think about the traumatic events they experience or witness, or that they can quickly recover from them; therefore, their distress, which they often cannot verbalize, is often not recognized as related to traumatic experiences. In addition, many people are unaware of the fact that trauma-focused treatment is possible with very young children.

Recognizing the paucity of interventions for traumatized young children,, the Haruv Institute, which specializes in training and research in the field of child maltreatment in Israel, offered training to senior practitioners in Child–Parent Psychotherapy (CPP) (Lieberman & Van Horn, 2005, 2008). It invited senior clinicians and leaders in the field of child welfare and mental health, to apply to learn this EBP, to begin using it, and to introduce it to their workplaces. This bottom-up diffusion plan was conceived because the probability that social service or mental health agencies would be willing or able to devote the resources to teaching a new treatment model seemed highly unlikely. The co-creators of the intervention from the U.S. taught the Israeli courses. They came three times a year for each course, giving three-day seminars each time, and provided ongoing group consultations via Skype twice monthly between each seminar.

The goal of this paper is examine the experiences of clinicians when considering, learning, and attempting to implement a U.S. based trauma-focused EBP that is new to their country. It will attempt to understand the perceived impact of a new intervention upon their professional thinking and practice, and their experiences when using it in a unique context: a professional framework that is not familiar with CPP, initiated by an external agent and not by their employer, in a country that does not yet fully recognize the impact of familial trauma on infants and young children. In addition, it will report the results of survey of CPP implementation, given to the first two CPP learning cohorts.

CPP: an evidence-based intervention. CPP is used when the relationship between the preschool child and his caregivers is disrupted or negatively affected by traumatic stressors such as domestic violence, bereavement, illness, or chronic stress (Lieberman & Van Horn, 2005). Its goal is to strengthen the relationship between the child and his caregiver, in order to restore the child's sense of safety, attachment, and self-regulation and improve his social, cognitive and behavioral functioning (NREPP: SAMHSA's National Registry of Evidence-Based Programs and Practices, 2014). Based upon three major conceptual frameworks – psychoanalysis/attachment theory, stress and trauma work, and developmental psychology – CPP is a treatment method, typically employed on a once-a-week basis, which uses joint child–parent sessions that are centered on the child's free play and spontaneous interactions between the child and his parent (Lieberman & Van Horn, 2008). Its core intervention components include: translating the child's behavior to his parents, addressing maladaptive behavior of the child or maladaptive parenting of the parents, providing developmental guidance to parents, encouraging parents and children to relate to the traumatic experiences through talk and through play, and helping to create a trauma narrative in order to give meaning to previously unprocessed, frightening events. The therapist actively encourages pleasurable interactions between parent and child, and helps the parent to provide a sense of safety to his previously unprotected child. Emotional support, crisis intervention and concrete assistance with problems of living, are all provided within this model. The family's cultural background is repeatedly referenced when exploring parenting styles and mores (Lieberman & Van Horn, 2008).

This intervention is registered in the U.S. National Registry of Evidence-Based Programs and Practices (NREPP: SAMHSA's National Registry of Evidence-Based Programs and Practices, 2014), and the following treatment outcomes have been evaluated and found to have been improved as a result of therapy: child PTSD symptoms, maternal PTSD symptoms, child behavior problems (Lieberman, Van Horn, & Ghosh Ippen, 2005), children's representational models (Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002), attachment security (Cicchetti, Rogosch, & Toth, 2006), and other maternal mental health symptoms besides PTSD (Lieberman, Ghosh Ippen, & Van Horn, 2006).

Learning, implementing and importing an EBP. Implementation science, which attempts to define the stages and processes whereby an effort is made to incorporate a program or practice at the community, agency or practitioner levels (Fixsen, Naoon, Blase, Friedman, & Wallace, 2005), has not placed much focus upon the learning process that the clinician undergoes when learning a new EBP. Indeed, Fixsen et al. (2005) claim that there is a dearth of evaluation research about the effectiveness of training programs for EBPs, even though the training program is recognized as instrumental in a practitioner's decision to use an EBP. Some research has examined practitioner attitudes toward EBP's following training, and their impact on the decision to adopt an intervention (Bartholomew, Joe, Rowan-Szal, & Simpson, 2007), while only a few others have explored their subjective experience of the training and implementation process (Aarons & Palinkas, 2007; Palinkas et al., 2008).

Aarons (2005) conceptualized four domains of attitudes to adoption of EBPs: the appeal of a particular EBP, requirements to adopt it, openness to innovation (the extent to which a clinician is generally open and willing to try or use EBPs), and its perceived similarity or divergence from current practice. This conceptualization helps to understand the effects of attitude of a practitioner learning a new treatment model, and helps to understand his/her motivations for using it. We will use his conceptualization for the interpretation of the subjective experience of the practitioner learning a new EBP.

Within the implementation literature, much emphasis has been placed upon the necessity of therapist treatment adherence, or fidelity (Schoenwald et al., 2011) when mastering a new EBP, and the dangers of "therapist drift" (Milne & Reiser, 2012). The literature that relates to the international dissemination of EBPs, while giving some thought to cultural adaptation, seems to conclude that only minimal cultural adaptations of EBPs are necessary and these adaptations do not endanger its fidelity (Schoenwald, Heibblum, Saldana, & Henggeler, 2008; Sussman & Palinkas, 2008). This paper will consider the perceived impact of new professional knowledge upon clinicians from Israel.

The research questions were (1) to what degree are clinicians in the (name of NGO) program implementing CPP (via quantitative data)? and (2) what is the clinician's experience of learning and implementing CPP (via qualitative data)?

2. Methods

At the time of this research, 39 clinicians had completed training in CPP. Nineteen studied between June 2010 and June 2011 (Cohort 1), while an additional 20 began training in June 2011 and completed the course in June 2012 (Cohort 2).

The research used a mixed methods design. The mixed methods approach builds upon both an analysis of associations between variables, and an analysis of processes and perceptions of participants, allowing for a deeper understanding of social phenomena (Creswell, 2012). Specifically, mixed methods research is considered appropriate and valuable for the study of EBP implementation, because, while quantitative methods can test and confirm hypotheses concerning what predicts implementation, as well as measure outcomes, qualitative methods may provide a depth of understanding regarding the perceived reasons for success or failure of implementation (Aarons, Fettes, Sommerfeld, & Palinkas, 2012; Palinkas et al., 2011). Qualitative methods may