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.

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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

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

also help describe and explain the directions and forms that implementation develops, not all of which can be predicted in advance. The research design consisted of two parts: (1) a preliminary study using a focus group and (2) a cross-sectional survey.

Focus group. A focus group was first conducted to provide insight about the clinicians' experiences in learning and using CPP, as well as their perceptions of what helped and hindered such use. Focus groups are considered a cost effective way of obtaining large amounts of qualitative information, and are useful to explore topics about which little is known (Parker & Tritter, 2006). It therefore seemed to be an appropriate data collection method for a pilot study on CPP implementation. Six graduates (5 women and one man) of Cohort 1 were recruited to participate in the focus group, on a volunteer basis. Cohort 1 graduates were chosen because more time had lapsed since their training, thereby affording them more time to experiment with CPP in their clinical work, as well as more perspective in understanding their successes and barriers to implementation. They represented a variety of professions – psychology, social work, and psychiatry. All worked in different psychosocial agencies within the public sector, while three also worked in private practice.

The study was approved by the Hebrew University of Jerusalem Ethics Committee and all participants signed an informed consent form agreeing to participate in the research. One of this article's authors, who is director of CPP training for the Haruv Institute and knows the participants, served as leader and interviewer of the focus group. Another researcher, who did not know the participants, attended the session as an observer of group mood and dynamics (Parker & Tritter, 2006).

This focus group used a structured approach (Morgan, 1997); participants were asked four questions. They were: (1) What brought you to this program? (2) What are the factors helping you use CPP? (3) What factors are hindering your use of CPP? and (4) How has the program affected you professionally? All participants answered a question before progressing to the next question. Few probing questions were needed, since participants spontaneously elaborated upon their responses. The taped group discussion was transcribed, and the results were analyzed according to a mapping analysis which delineates categories and sub-categories and finds the links in meaning between them (Shkedi, 2003). The categorizing process was reviewed by an independent researcher in order to maintain quality assurance.

Cross sectional survey. All 39 clinicians – the entire graduating classes of Cohorts 1 and 2 – were requested to answer a questionnaire, and all of them completed it. It included demographic information – profession, age, and years of experience – as well as information regarding CPP use: how many CPP cases they have treated, how many cases they have treated using principles of CPP, or CPP-informed treatment, and their intent to use CPP in the next year. CPP-informed treatment was described as treatment that did not adhere to all or most of the therapeutic tasks that are considered use of the intervention with fidelity, but that did use theoretical underpinnings of CPP, or therapeutic interventions that are described in the model (see examples in Table 1). Respondents were also asked how much supervision they received in CPP (none at all, irregularly, once every two weeks, every week).

3. Results

3.1. Focus group: clinician's experiences of learning and using CPP

(1) What brought you to CPP training? Four categories were delineated regarding clinicians' motivation to learn CPP: workplace needs, learning something new, the teachers, and the desire to be a leader in its dissemination.

Table 1
Types of CPP-informed treatment, (n) and % of the total sample.

Types of CPP-informed treatment	*n* (yes)	% (yes)
At intake I asked about past and current traumas	34	87.2
I did dyadic therapy with a child over 6	25	64.1
I spoke to a parent about the trauma his child experienced	36	92.3
I spoke to a parent about the effects of trauma on his/her parenting	35	89.7
I focused on trauma in the treatment of a child	27	69.2
In my collateral work, I told about the traumatic background	32	82.1
Other[a]	5	12.8

[a] "Other" uses of CPP-informed treatment included building a trauma narrative in family therapy, using CPP principles in group work, writing diagnostic reports using a trauma focus, using a reflective focus that "explains" parents to children and children to parents, and doing trauma-based psychotherapy with children in residential treatment.

The workplace: Participants told about working with difficult client populations within their agencies, without having the appropriate tools to help them.

> *We received many referrals of very young children who underwent trauma, and were looking for a way to work with them. (Participant #1)*

> *We meet a lot of families with difficult divorces, and have no therapeutic response for that. This, at least for young children, is an option. (Participant #6)*

Learning something new. The opportunity to learn an as-yet unknown intervention in Israel provided a motivation for some participants to learn CPP.

> *It spoke to me that this is something new, knowledge we don't have in Israel. (#6)*

> *I felt that I wanted to learn and be part of something new. (#2)*

The teachers. The original creators of CPP, who are internationally well-known, provided a powerful incentive for clinicians to come learn their treatment method.

> *. . .the opportunity to learn from women who are leading experts in their field – usually I don't have that kind of opportunity. (#3)*

> *. . .her name attracted me. Because I read her books, and heard her lecture, and was very impressed by how she writes and thinks and talks. She came to Israel a few times and I met her personally. . .and we thought, "Wouldn't it be great if we could learn in her course some time." And her personality also plays a dominant part. (#1)*

Becoming a disseminator. Finally, some spoke of their role as pioneer and potential disseminators a new EBP.

> *I'm here to pass it on. (#6)*

> *What really spoke to me, was that there will be an opportunity for me to disseminate this knowledge onward, which I really want to do – at least in my field. (#3)*

(2) What factors are helping or hindering your use of CPP? Two categories were strongly represented: the workplace, and the treatment method itself.

The workplace: Not surprisingly, the agency was perceived by participants having a major impact on their ability to use CPP.

Those who felt support from the agencies spoke mainly of the freedom they received in using a new EBP.

I first and foremost want to relate to my agency, which gives me free reign to try and experiment with any kind of treatment I want. That is, no one is impeding me. (#3)

No one is familiar with it yet, so they give me free reign and no one interferes. (#6)

Alternately, one respondent felt her agency inhibited the actual use of a new treatment model, while another, who spoke of having freedom in her agency, also related to its ambivalence about a new EBP.

I don't know if it's me or the agency, but I feel that there isn't openness, in my agency, for new interventions. There's very orthodox psychodynamic treatment. (#4)

It's an agency that welcomes new interventions with open arms, but there's always some wariness. We also have a tradition of dynamic therapy, so on the one hand they accept it and on the other hand they also say, Wait a second, that's enough. (#6)

Respondents related to the lack of a trauma-focus in early childhood among both parents and professionals, and the difficulty of receiving referrals either from within or outside their agencies.

Even when they know about it (CPP) it's amazing how people don't see that small children and their families have undergone trauma and that they could benefit from it. (#6)

I think people are less cognizant of the fact that one can do therapy with children that age. (#3)

The treatment method: Participants were preoccupied with their ability to incorporate CPP into their professional repertoire. They spoke of three factors that either aided or impeded their ability to use it: the depth of the intervention, its similarity/dissimilarity to how they had worked in the past, and its evidence base.

Some participants spoke of the theoretical depth of CPP as a promoting factor in its use.

There's a real depth here. On the one hand, it's based on the knowledge bases we all know and respect...Selma Fraiberg, Mary Ainsworth...all the knowledge bases that those who work with this age group know are the foundations. (#1)

...it's an intervention that enables you to work on the intersubjectivity of the relationship and simultaneously speak both voices, and I think that's terrific. (#6)

Those who were familiar with dyadic treatment felt that their previous treatment knowledge enabled them to more easily incorporate CPP into their work.

I learned dyadic treatment in the past, tried it and it spoke to me. I felt there was an opportunity here to further my knowledge in this method. (#3)

I think that what helped me was the structure of the treatment, that it's parent-child, so I didn't have to change the setting, rather just the therapeutic stance. (#2)

On the other hand, some participants described the conceptual and setting changes they had to undergo in order to turn into CPP clinicians. In particular, the shift from working individually with either parents or children, to working with a dyad, was described as challenging.

It was important for me to get tools to deal with this problem (familial trauma), especially because our routine work is separate therapy for child and for parent and I wanted to make the integration. (#4)

One of the main difficulties is that I, and my colleagues, have many years of training and professional habits, of individual or family therapy. The ability to focus not on the child and not on the parent, rather upon their interaction, is totally different. When you have many years of experience, habit tends (to constrain) you. It's a difficulty you have to work with all the time, in the therapy, with yourself, in supervision. (#1)

Only one participant related to CPP's evidence-base as a reason to adopt it.

Personally, it's important to me that the intervention was empirically tested and found to be effective...so when you use it, you get the feeling that you have a strong professional backing. (#1)

The learning process. In addition to the workplace and the treatment method, respondents related to the training program as a promoting factor in CPP use. They spoke of two elements of the training: the teachers and the program itself.

The course instructors were perceived to be highly skilled and charismatic.

The desire to use it...are tied to the characteristics of the teachers, and not just to the structure of the intervention. This intervention comes with a therapeutic stance, personality, something that is easy to admire... (#2)

In addition, the training program was experienced to be of high quality.

...there was a balance between theory and the clinical part, with a heavy emphasis on the clinical part. One of the most meaningful things in the clinical part was that the work didn't focus just on theory – which often happens – rather dealt with the most effective intervention. So you learn not only the concept, rather the way to implement it, which is missing in many clinical training programs. (#2)

...to see how extensively it exists (early childhood trauma) – first in the course and then in cases in the field – and the quality of the program. That's what excited me – the quality of the program. (#6)

A personal toll. Starting to use CPP exacted a toll upon clinicians, in three ways: they found themselves with too much work, they felt lonely using it, and felt it caused secondary trauma.

Since these professionals were bringing a new intervention to the workplace, they sometimes found themselves inundated with new cases.

There's a process that happens where you ask yourself how many new cases you are capable of receiving, the need to weigh them against the rest of your caseload, etc. (#2)

I have many responsibilities and do many other things, so there's a limit to how many cases I can take, even though I'd want to take more. There's starting to be a bottleneck situation. (#6)

Since these clinicians were the first in Israel to learn CPP, they expressed a sense of professional loneliness when attempting to use the intervention. The lack of ongoing supervision also presented an obstacle to its use.

You find yourself with an intervention that you've just learned, and you're alone with all of your questions – that's hard. (#1)

I also don't have anyone in my agency to talk with about it (a colleague is now learning in the course), so it's building up slowly. If I consult with an outside professional, I start to hear about different directions, and that blurs things a bit. (#6)

The focus on trauma in CPP was felt to exact an emotional toil upon some participants.

I feel myself in a much more traumatic state than I've ever been, from all of the trauma I'm absorbing. I don't know if that's because I've started doing this work, if there's something in CPP that ties you more closely to trauma, or maybe it's the young age of the children that have undergone trauma – I don't know, but I feel I'm paying the price emotionally. (#3)

Last year, during the seminars and during the consultations, I felt myself feeling post-traumatic. I felt that it was too much exposure to traumatic content and that I can't hear it anymore. (#6)

(3) How did the training program affect you professionally? Participants spoke of four major impacts of CPP training: their understanding of early childhood, their ability to work empathically with families, their intention to further disseminate CPP, and their use of CPP-informed treatment.

The CPP training significantly enhanced participants' knowledge and motivation to work with very young children.

This course really strengthened my awareness of how this world, the emotional world of early childhood, is rich and important and meaningful and needs to be respectfully related to. When I say that, it sounds obvious – what, we didn't know that before? But we needed the boost. (#1)

It gave me knowledge and a clear professional stance regarding the effects of trauma on early childhood and on parenting. It taught great skills for a therapeutic stance and appropriate ways of intervening. (#2)

The empathic and understanding stance toward very difficult families was mentioned as an important by-product of CPP training.

The most impressive part is the respect and acceptance of parents. We were freaked out by each case, each time – they aroused so much anger. It's so easy to be angry at them (parents). It took me to a whole new direction; that ability strengthened in me, and it really enlists the parents. (#4)

. . .the ability of the teachers to find directions that lift us out of the horror – that there is a port of entry. Port of entry is a very professional word, but there's something so humane in finding in each family, no matter how difficult it is, the place where they can be helped. It taught me to think differently – to find where change can be accomplished and be content with that, instead of just looking at the difficulties. (#6)

Their ability to grow professionally by disseminating CPP was seen as another by-product.

I'm thinking of teaching a seminar in CPP next year, and maybe furthering it that way. (#6)

The program encouraged me to convince other professionals of these directions. (#1)

The program enabled me to bring the principles to my staff. (#4)

Finally, the principles of CPP were perceived as helpful in doing therapy that was not actually CPP.

I use all kinds of elements from the course, not just in CPP. For instance, building a trauma narrative, and the subject of reflective supervision. It's given me many tools. (#4)

I use CPP in its entirety, and also use elements of it, such as translating the parent to the child and vice versa – even if they're not together in the room and the child is older – it's the way I express myself with parents. (#3)

3.2. Quantitative study results – how much, and how, are clinicians using CPP?

In the cross-sectional survey, descriptive data was collected and analyzed. In addition, t-test was used to measure differences between groups, while Pearson and partial correlations were utilized to test associations between variables.

Twenty-one (53.8%) respondents, for the total sample, treated three or more cases using CPP. Only one did not treat any CPP cases, and the other 17 treated one or two cases. The mean number of CPP cases treated was 2.91, $SD = 1.44$. Clinicians who treated at least 3 cases of CPP were considered to be implementing the treatment. This number was chosen because, although it was suggested that clinicians treat two cases during the CPP training program, most only treated one case, because of difficulty finding referrals. Three cases therefore indicated an active effort to master and implement the intervention.

Respondents reported treating a significantly larger number of CPP-informed cases than actual CPP cases ($M = 6.67$, $SD = 4.27$ and $M = 2.91$, $SD = 1.44$, respectively, $t(36) = 6.28$, $p < .001$). Thirty-seven (95%) had treated CPP-informed cases. Twelve respondents (30%) reported using CPP-informed principles in over 10 treatment cases, while only 2 (5%) reported not using CPP-informed treatment at all. Table 1 describes the types of CPP-informed treatment employed.

The intention to use CPP in the future was almost unanimous (97.5%). The large majority (71.1%) thought that they would treat only one or two cases in the upcoming year, while 29% thought that they would be treating three or more cases.

Respondents were receiving little supervision in CPP. In the total sample, nineteen clinicians (48.7%) reported getting no supervision in CPP; 10 (25.6%) received supervision irregularly, 5 (12.8%) received supervision once a month, while only 5 (12.8%) reported receiving supervision once every two weeks. The less supervision clinicians received, the fewer CPP cases they treated ($r = -.33$, $p = .043$). When the groups were examined separately, this association held only for Cohort 1 ($r = -.623$, $p = .003$) and not for Cohort 2 ($r = -.039$, $p = .88$); however, a partial correlation controlling for the potential effect of the groups showed a significant association ($r = -.34$, $p = .04$). Thus, the amount of supervision is positively associated with using CPP.

4. Discussion

This study examined the initial results of one NGO's plan to disseminate a new EBP, using a bottom-up dissemination approach. It presents Israeli clinicians' use of a new treatment model imported from the USA, as well as their experiences in learning and implementing a. The focus group respondents' responses show a high motivation to implement CPP, either because it provides a therapeutic response where none existed

before, or because they wanted to learn and disseminate something new. That is, the intervention was considered in Aaron's terminology, to have great appeal (Aarons, 2005). Respondents experienced themselves as being pioneers in learning this intervention. Furthermore, the quality of training and the charisma and expertise of internationally well-known teachers was described as enhancing their desire to learn and to use CPP. Indeed, learning CPP was experienced as a meaningful experience that affected them professionally. These findings were supported by the survey, which found that over half were treating three or more cases and that almost everyone intended to use CPP in the next year.

These respondents showed high openness and willingness to learn and to try CPP because they personally wanted to learn it; it was not offered or mandated by their workplaces, and, therefore, they were not required to adopt it (Aarons, 2005). While their individual motivation to learn CPP is undoubtedly a promoting factor of its implementation, the fact that their agencies did not initiate CPP training also means that they were left to their own devices when using it in their agencies. The lack of adequate supervision in the intervention – because of a dearth of CPP experts in Israel – was mentioned in the focus group and supported by the findings in the questionnaire, which showed that few were getting any kind of regular supervision in CPP. In addition, a sense of loneliness when attempting to use it alone and the secondary traumatic stress (Phelps, Lloyd, Creamer, & Forbes, 2009) that some respondents report experiencing, may strain clinicians' ability to use CPP. Implementation literature relates to the vital importance of ongoing support, after training, in maintaining EBP use (Proctor, 2004). Furthermore, trauma literature has identified conditions such as working extensively with severely traumatized clients, lack of support or supervision, isolation, and inexperience as risk factors for secondary traumatic stress for those in the caring professions (Phelps et al., 2009). All of these conditions appeared in the focus group discussion, so it seems that practicing CPP can potentially take a toll upon Israeli clinicians.

Aarons relates to the innovation/intervention's similarity or divergence from previous practice as having an impact on its eventual implementation (Aarons, 2005). Within the focus group, some felt CPP to be a natural extension of the dyadic therapy they had provided in the past, where others, without this type of clinical experience, struggled to learn the dyadic treatment format. It seems that CPP implementation may be easier to use for those professionals who have worked intensively with young children and are used to seeing them with their parents.

Focus group participants described using CPP principles in their general therapeutic work. Indeed, a key finding in the questionnaire was that almost all CPP graduates were using CPP-informed treatment. CPP-informed treatment may been defined as treatment that uses theory or practice skills learned in the CPP training course, but that does not fill all the criteria for the actual intervention. In actuality, CPP-informed treatment would not be considered actual implementation because it does not show fidelity to the CPP manual (Dusenbury, Brannigan, Falco, & Hansen, 2003), However, its extensive use among graduates has been striking. The professional discourse about early childhood trauma and its treatment is still so new in Israel that CPP elements such as routinely checking trauma background at intake, talking about the effects of trauma on children, parents, and the child–parent relationship itself, and talking to collateral sources about trauma, have been easily and eagerly incorporated into clinicians' therapeutic work. As one focus group participant explained, even when she did not do therapy that conformed to the actual EBP, "the thinking is CPP."

No literature in the implementation field, including literature on international dissemination of EBP, has been found that explores this phenomenon – using principles of an EBP when it is new to the professional landscape. Indeed, fidelity is considered such a major requisite for the implementation of EBP that using principles of an EBP is sometimes considered a failure of implementation. However, Israel is a country where professionals are not necessarily informed about EBP or committed to using an EBP with fidelity – only one focus group member mentioned CPP's empirical base as a significant factor in his decision to learn it.

Should this widespread tendency of incorporating CPP into general treatment be considered detrimental to its implementation? By using principles of CPP and disseminating them through collateral work, clinicians are providing valuable treatment elements to their clientele and new knowledge to other professionals in Israel. Indeed, the discourse on early childhood familial trauma has been so underdeveloped in the country that one might assert that the use and dissemination of CPP-informed principles may be an important, first step on the way to actual CPP implementation and dissemination (P. Van Horn, private communication, December 30, 2012). Furthermore, as early childhood trauma enters the professional discourse, it stands to reason that more referrals will be made of very young children who have undergone traumatic events – thereby providing CPP graduates with more opportunities to implement the intervention with fidelity.

5. Study limitations

This pilot research study presents data on a small population of clinicians, both in the focus group and in the quantitative study. The focus group findings are further limited because only graduates of Cohort 1 participated; therefore, the findings highlight only their experience at a specific stage of their implementation process. Furthermore, the group studied in the quantitative study – a fairly homogenous population of experienced clinicians, many of whom are directors of agencies, instructors, and supervisors – makes generalization of implementation attempts difficult to determine. Finally, the survey relies on clinician report regarding CPP implementation, which might be biased or not reflect use of CPP with fidelity. Further studies, accompanied by the fidelity measures recently developed by CPP researchers, may enable a more rigorous study of actual CPP use.

5.1. Practice and policy implications

Clinician's desire and determination to disseminate CPP may well be instrumental in "spreading the word" in Israel, via a "bottom up" diffusion system (Nutley & Davies, 2000). These senior clinicians may be seen as "champions" (Greenhalgh, Robert, Bate, MacFarlane, & Kyriakidou, 2005) of a new EBP, those who take responsibility for its implementation. However, since organizations are not initiating use of CPP, individual clinicians may be left alone, relatively unsupervised, and experiencing secondary trauma when using this new intervention. They must be provided with ongoing supervision and support if they are to be expected to disseminate CPP.

It is unlikely that the workplace, which did not instigate CPP training, would be immediately motivated or able to provide the support these clinicians need. Therefore, the institute which imported the EBP must provide a long-term, ongoing commitment to teaching, supervision and support in order to achieve the goal of disseminating CPP in Israel. In addition, groups of professionals from the same agencies – at least two – may be encouraged to apply together for training in order to have a greater impact on CPP implementation within their workplaces.

Moreover, it seems that the delicate balance between maintaining EBP fidelity on the one hand, and developing a new

professional language for all professionals not necessarily intending to use CPP on the other, will constitute an implementation challenge. CPP graduates are telling us that their use of CPP-informed treatment is helpful and valuable to them in their work, and this voice should be heard and heeded. The training institute importing CPP may continue to teach CPP with an insistence upon its use with fidelity, while also providing additional training programs which teach CPP principles to professionals who are not intending to use the actual intervention.

6. Conclusion

This paper presents the results of an attempt to disseminate CPP, a trauma-focused psychotherapy, in a foreign country. It illuminates the factors influencing a bottom-up implementation program: clinician motivation, the quality of training, perceptions of the EBP, as well as the impact of the workplace and ongoing support and supervision. The latter are especially meaningful and necessary for clinicians coping with familial trauma of very young children and their families. This article also demonstrates the complexity of EBP implementation and the importance of a relatively neglected topic – EBP-informed treatment. Results suggest that the introduction of a new professional discourse and conceptual framework on early childhood trauma within the relevant professional community may be a natural precedent to the more wide-scale dissemination of an EBP that is exported to a foreign country.

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References

Aarons, G. A. (2005). Measuring provider attitudes toward evidence-based practice: Consideration of organizational context and individual differences. Child and Adolescent Psychiatric Clinics of North America, 14, 255–271.

Aarons, G. A., Fettes, D., Sommerfeld, D., & Palinkas, L. (2012). Mixed methods for implementation research: Application to evidence-based practice implementation and turnover in community based organizations providing child welfare services. Child Maltreatment, 17, 67–79.

Aarons, G. A., Hurlburt, M., & McCue Horwitz, S. (2010). Advancing a conceptual model of evidence-based practice implementation in public service sectors. Administration and Policy in Mental Health & Mental Health Services Research, 38, 4–23.

Aarons, G. A., & Palinkas, L. A. (2007). Implementation of evidence-based practice in child welfare: Service provider perspectives. Administration and Policy in Mental Health & Mental Health Services Research, 34, 411–419.

Bartholomew, N. G., Joe, G. W., Rowan-Szal, G. A., & Simpson, D. D. (2007). Counsellor assessments of training and adoption barriers. Journal of Substance Abuse Treatment, 33, 193–199.

Chazan, S., & Cohen, E. (2010). Adaptive and defensive strategies in post-traumatic play of young children exposed to violent attacks. Journal of Child Psychotherapy, 36, 133–151.

Cicchetti, D., Rogosch, F., & Toth, S. L. (2006). Fostering secure attachment in infants in maltreating families through preventive interventions. Development and Psychopathology, 18, 623–649.

Cohen, E., Chazan, S., Lerner, M., & Maimon, E. (2010). Posttraumatic play in young children exposed to terrorism: An empirical study. Infant Mental Health Journal, 31, 159–181.

Creswell, J. W. (2012). Mixed methods [PowerPoint slides]. Presentation for ICQI, University of Illinois-Champaign.

Dusenbury, L., Brannigan, R., Falco, M., & Hansen, W. B. (2003). A review of research on fidelity of implementation: Implications for drug abuse prevention in school settings. Health Education Research, 18, 237–256.

Fixsen, D. L., Naoon, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). Implementation research: A synthesis of the literature. Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, the National Implementation Research Network (FMHI Publication #231).

Greenhalgh, T., Robert, G., Bate, P., MacFarlane, F., & Kyriakidou, O. (2005). Diffusion of innovations in health service organizations: A systematic literature review. Malden, MA: Blackwell.

Keren, M., & Tyano, S. (2009). A developmental approach: Looking at the specificity of reactions to trauma in infants. In D. Brom, R. Pat-Horenczyk, & J. D. Ford (Eds.), Treating traumatized children: Risk, resilience and recovery (pp. 85–101). New York: Routledge/Taylor & Francis Group.

Lieberman, A. F. (2007). Ghosts and angels: Intergenerational patterns in the transmission and treatment of the traumatic sequelae of domestic violence. Infant Mental Health Journal, 28, 422–439.

Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2006). Child–Parent Psychotherapy: 6-month follow-up of a randomized control trial. Journal of the American Academy of Child and Adolescent Psychiatry, 45, 913–918.

Lieberman, A. F., & Van Horn, P. (2005). Don't hit my mommy! A manual for Child–Parent Psychotherapy with young witnesses of family violence. Washington, DC: Zero to Three Press.

Lieberman, A. F., & Van Horn, P. (2008). Psychotherapy with infants and young children: Repairing the effects of stress on early attachment. New York: The Guilford Press.

Lieberman, A. F., Van Horn, P., & Ghosh Ippen, C. (2005). Toward evidence-based treatment: Child–Parent Psychotherapy with preschoolers exposed to marital violence. Journal of the American Academy of Child and Adolescent Psychiatry, 44, 1241–1248.

Milne, D., & Reiser, R. P. (2012). A rationale for evidence-based clinical supervision. Journal of Contemporary Psychotherapy, 42, 139–149.

Morgan, D. L. (1997). Focus groups as qualitative research (2nd ed.). Thousand Oaks: Sage Publications.

NREPP: SAMHSA's National Registry of Evidence-based Programs and Practices (2012). Child–Parent Psychotherapy (CPP) Retrieved from http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=194.

Nutley, S., & Davies, H. T. O. (2000). Making a reality of evidence-based practice: Some lessons from the diffusion of innovations. Public Money and Management, 20(4), 35–42.

Osofsky, J. D. (2007). Introduction: Different ways of understanding young children and trauma. In J. D. Osofsky (Ed.), Young children and trauma: Intervention and treatment (pp. 3–9). New York: The Guilford Press.

Palinkas, L. A., Aarons, G. A., Horwitz, S., Chamberlain, P., Hurlbert, M., & Landsverk, J. (2011). Mixed methods design in implementation research. Administration Policy in Mental Health, 38, 44–53.

Palinkas, L. A., Schoenwald, S. K., Hoagwood, K., Landsverk, J., Chorpita, B. F., & Weisz, J. R. (2008). An ethnographic study of implementation of evidence-based treatments in child mental health: First steps. Psychiatric Services, 59, 738–746.

Parker, A., & Tritter, J. (2006). Focus group method and methodology: Current practice and recent debate. International Journal of Research & Method in Education, 29(1), 23–37. http://dx.doi.org/10.1080/01406720500537304

Phelps, A., Lloyd, D., Creamer, M., & Forbes, D. (2009). Caring for carers in the aftermath of trauma. Journal of Aggression, Maltreatment & Trauma, 18, 313–330.

Proctor, E. I. (2004). Leverage points for the implementation of evidence-based practice. Brief Treatment and Crisis Intervention, 4, 227–240.

Schoenwald, S. K., Garland, A. F., Chapman, J. E., Frazier, S. L., Sheidow, A. J., & Southam-Gerow, M. A. (2011). Toward the effective and efficient measurement of implementation fidelity. Administration and Policy in Mental Health & Mental Health Services Research, 38, 32–43. http://dx.doi.org/10.1007/s10488-010-0321-0

Schoenwald, S. K., Heiblum, N., Saldana, L., & Henggeler, S. W. (2008). The international implementation of Multisystemic Therapy. Evaluation and the Health Professions, 31, 211–225.

Shkedi, A. (2003). Words of meaning, qualitative research – Theory and practice. Tel Aviv: Ramot (Hebrew).

Simpson, D. D. (2002). A conceptual framework for transferring research to practice. Journal of Substance Abuse Treatment, 22, 171–182.

Sussman, S., & Palinkas, L. A. (2008). Reflections on international translation of evidence-based health behavior programs. Evaluation and the Health Professions, 31, 323–330.

Toth, S. L., Maughan, A., Manly, J. T., Spagnola, M., & Cicchetti, D. (2002). The relative efficacy of two interventions in altering maltreated preschool children's representational models: Implication for attachment theory. Development and Psychopathology, 14, 877–908.

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