

Common Elements Across Evidence-Based Trauma Treatment: Discovery and Implications

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Abstract: *The social work profession is facing a critical gap in its provision of effective services to an increasingly large number of clients who are affected by trauma. To explore for the presence of common components in evidence-based trauma treatments, a qualitative content analysis of 8 trauma treatment manuals was undertaken. Analysis resulted in the identification of 35 Intervention Objectives and 59 Practice Element codes. These were further organized into nine domains: trauma assessment, safety, engagement, attachment, core treatment interventions, attention to the social context, trauma processing, post trauma growth, and therapist self-care. Future work for the profession may involve synthesizing and integrating what has already been learned, and translating that knowledge into the classroom. Significantly, three domains which stress activities with the client in their social context were found to be common to trauma treatments, including safety promoting activities. Implications for social work education, practice, policy, and research are discussed.*

Keywords: *Trauma treatment, evidence-based practice, common elements*

The social work profession is facing a critical knowledge gap in its provision of effective services to an increasingly large number of clients who are affected by trauma. The prevalence of trauma exposure in many, if not most, clients served by social workers, coupled with the dual problems of both identifying appropriate treatments and accessing training for implementation of evidence-based trauma treatments, is presenting a major challenge for practitioners. A corresponding shortfall in social work education of both training in trauma and training in evidence-based practice may exacerbate the problem in the next generation of practitioners. In this article, dilemmas in the field in regard to dissemination of evidence-based trauma treatments and the parallel challenges in social work education are identified, findings regarding common elements in trauma treatments presented, and implications for social work education, practice, social policy and research discussed.

By definition, children who have experienced child abuse and neglect, sexual abuse, and/or witnessed domestic violence have been exposed to trauma. Many children, adults and their families have often also had exposure to community violence, war-related refugee experiences, combat violence for returning veterans, medical trauma, natural disasters, and traumatic loss. When these experiences are unaddressed, clients are at greater risk for a range of behavioral, emotional, educational and social problems in childhood and later in life. Many studies document the widespread prevalence of trauma

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exposure and its lasting impact across the life cycle in all the populations served by social workers (Dong et al., 2004; Felitti et al., 1998; Putnam, 2006). The Adverse Childhood Experiences Study (ACES), using a sample from a non-clinical population of adults presenting for routine annual physical exams found a significant relationship between negative childhood experiences (including physical, emotional, and sexual abuse, interpersonal violence, divorce, mental illness, alcoholism and family member incarceration) and a range of lifelong serious physical and mental-health problems. These adulthood problems included, but were not limited to, higher rates of adult depression, drug use, juvenile arrest, obesity, diabetes, and overall occupational health and job performance impairment as they were reported by those with histories of adverse childhood experience (Anda et al., 2006; Felitti et al., 1998)

Literature Review

The past several decades have yielded more evidence-based or empirically-supported treatment interventions and yet it has been challenging to integrate those treatment approaches into everyday practice for the typical front line clinician (Weisz & Gray, 2008). There are methodological issues along with differing opinions about whether treatments tested in a laboratory setting can be replicated in the field, as well as issues of fidelity to the model once the treatment approaches are introduced into natural settings. Weisz and Gray (2008) also report that there are some inconsistencies in the research findings resulting in evidence-based treatment approaches not consistently outperforming usual care. This results in a questioning of evidence-based treatments and leaves both clinical staff and social work educators to wonder about their effectiveness as a whole. In the area of trauma treatment, while evidence-based interventions for children and adolescents have been disseminated through the federally funded National Child Traumatic Stress Network (NCTSN), they are by no means universally available. Adult trauma treatment, lacking a funding “engine” like the NCTSN to drive dissemination, are not nearly as widely available as the child trauma treatments.

The debate has affected the degree to which training in evidence-based practice has been incorporated into social work education. According to a recent article (Bledsoe et al., 2007), fewer than 40 percent of MSW programs meet the “gold standard” of integrated clinical training as proposed by Weissman and colleagues (2006). “Gold standard training” consists of didactic training in an empirically-supported treatment (EST) paired with its implementation in a field setting with supervision by a clinician trained using the same EST. This 40% stands in contrast to 60% of PhD clinical psychology graduate schools and 90% of medical schools nationwide who provide training in at least one EST. To increase the prevalence of “gold standard training” in social work education, the importance of strengthening the link between classroom-based and field practicum learning settings has received enhanced emphasis (Boitel, Farkas, Fromm, & Hokenstad, 2009; Mullen, Bledsoe, & Bellamy, 2008; Proctor, 2007). In a parallel process, social work education has struggled with the need to incorporate trauma content into its curriculum (Bussey, 2008; Cunningham, 2004; Miller, 2003; McKenzie-Mohr, 2004; Strand, Abramovitz, Layne, Robinson, & Way, in press).

There is another interesting dialogue now occurring in the field. According to Chorpita and colleagues (2011), there is a present “knowledge management problem” (p. 494). They assert that the mental health professional community must begin to address how to manage the current knowledge base that is already in existence. In other words, it is no longer about creating more evidence-based treatment protocols, but about synthesizing and integrating what has already been learned. In a prior publication, Chorpita, Daleiden, and Weisz (2005) proposed a model to allow the treatment intervention literature to be “factored or distilled” in an effort to create a synopsis of evidence-based treatment elements that can then be matched to individual clients (p. 5). This distillation and matching model involves distilling the empirical data to develop profiles from the evidence-based models that allow for matching treatment interventions with clients’ problem behaviors and individual and environmental variables. Chorpita and colleagues (2011) have raised the question of whether greater proliferation of treatment approaches is helpful to the field or whether identifying ways to design, apply, and organize the information from treatments already in existence has more utility.

Barth and colleagues (2012) concur and argue that the social work profession is at a crossroads, suggesting that the time has come for the field to turn its attention to the development of common factors as well as common elements. Common factors are defined as those elements that are not specific to any particular treatment model but may contribute extensively to client outcomes (such as worker-client relationship). A common elements framework, incorporating a modular approach to treatment, is viewed as having potential advantage over individualized manualized treatment.

A similar question regarding how to organize information from treatments already in existence has been posed by the National Child Traumatic Stress Network (NCTSN), a federal initiative to both increase access and improve the quality of trauma treatment available to traumatized children and adolescents (Pynoos et al., 2008). As part of its mandate, the NCTSN has been active in the dissemination of evidence-based trauma treatments (EBTT). However, as early as 2007, the training arm of NCTSN identified the problem of duplication in training content across many of the treatments it was disseminating.

This led to a decision by the NCTSN leadership to create a foundational curriculum in child trauma that would draw on *common concepts, components and skills* across EBTTs. The Core Curriculum on Childhood Trauma (CCCT) Task Force was formed to develop this curriculum. Composed of national experts in trauma treatment, the CCCT Task Force first developed the *Core Concepts* phase of the curriculum. Twelve core concepts were identified using an expert consensus model and five developmentally and culturally contextualized cases created using a problem-based learning methodology. (See Layne et al., 2011 for a fuller description of the CCCT). The goal of the *Core Concepts* portion of the curriculum is to provide a foundation in trauma knowledge to assist with case conceptualization, formulation, and assessment. This curriculum has been adapted for social work education and disseminated nationally (Strand et al., in press) and the curriculum is in the process of being adapted by NCTSN for agency in-service training.

The second phase of curriculum development is designed to focus on *Core Components* of evidence-based trauma treatment, in which components are defined as both *intervention objectives and practice elements*. Rather than use an expert consensus approach to develop the Core Components portion of the curriculum, a decision was made to code trauma treatment manuals in order to identify the common intervention objectives and practice elements across these manuals.

Others have undertaken the challenge of defining and codifying client treatment operations/techniques/strategies. Bisson and colleagues (2010) used a Delphi technique, which recognizes the experience and knowledge of experts when empirical knowledge is lacking, to develop evidence-informed guidelines for post disaster intervention. Sburlati, Schniering, Lyneham, and Rapee (2011) also used a Delphi method, which they defined as a “procedure that draws together empirical evidence and iterative expert review to achieve consensus regarding effective and ineffective treatment approaches” (p. 91). Chorpita and colleagues (2005), as described in their distilling and matching initiative noted above, have defined practice elements as “discrete clinical techniques or strategies used as part of a larger intervention plan” (p. 11). Using an expert consensus method, those elements most often identified in the literature were combined into a coding manual (Practice Wise, 2005) and this coding manual was then used in analysis of evidence-based treatments focused primarily on child anxiety and depressive disorders.

The NCTSN developed a partnership with *Practice Wise* in 2010, with the intent to code 26 evidence-based trauma treatment manuals. However, when the Practice Wise (2005) coding manual was reviewed by the CCCT Task Force, it was felt that the codes would not capture trauma-specific practice elements in the EBTT manuals. Therefore, a special project was launched with the aim of identifying trauma-specific codes for use in coding the EBTT manuals.

Overview of the Coding Project

In 2010, a research team at the National Center for Social Work Trauma Education and Workforce Development, a center funded through the NCTSN initiative, utilized a grounded theory approach (Glaser & Strauss, 1967) to embark on a qualitative research project with a mission of creating a coding manual that could be utilized to code promising practices and empirically-supported treatments specifically related to trauma interventions. Evidence-based practice can be conceptualized as both a verb (an *approach* to practice) and a noun (a specific, usually manualized intervention with some level of empirical support). For purposes of this study, evidence-based practice is defined as a manualized, empirically-supported treatment that is considered to have a certain level of evidence supporting its efficacy (Barth et al., 2012; Pettus-Davis, Grady, Cuddeback, & Scheyett, 2011).

The coding manual would be developed by the National Center for Social Work Trauma Education and Workforce Development and then used to code the full sampling of treatment intervention manuals. This article reports on the process of developing the coding manual, and the implications for training, practice, policy, and research that arise

from the identification of common intervention objectives and practice elements codes in a sample of empirically-supported treatment manuals.

Method

Sample

The sample included eight trauma treatment manuals, which were drawn as a purposive subsample from the larger group of 26 manuals. The eight were varied in regard to treatment modality (e.g., child, dyad, family), age of the child for whom the intervention was designed (preschool, school-age, adolescent), intensity of intervention (i.e., trauma treatment or post-disaster intervention), and level of empirical support, ranging from those with RCTs to those with outcome studies only. The criteria used to assess the level of empirical support are based on the schema developed by Saunders and Berliner (2004), which defines treatments with the strongest empirical base (most efficacious) as those which have at least two randomized, controlled treatment trials (RCTs) that have found the treatment protocol to be more effective than that of an appropriate comparison group. The criteria also include that the treatment has a book, manual, or other writings that specify the components of the treatment and explain how to implement it. Five levels of empirical support are identified, with level 5 (an innovative or novel treatment) characterized by a theoretical basis, a small clinical literature but the treatment is not in wide use. All of the manuals in this sample fell between levels 1-4. (See table 1).

*Table 1. Trauma Treatment Manual by Level of Evidence**

Level of Evidence	Trauma Treatment Manual Number							
	1	2	3	4	5	6	7	8
1. Well-supported, Efficacious Treatment		X	X				X	
2. Supported and Probably Efficacious Treatment					X			
3. Supported and Acceptable Treatment	X			X				X
4. Promising and Acceptable Treatment						X		
5. Innovative or Novel Treatment								

* Saunders, B. E., Berliner, L., & Hanson, R. F. (Eds.). (2004). *Child physical and sexual abuse: Guidelines for treatment* (Revised Report: April 26, 2004). Charleston, SC: National Crime Victims Research and Treatment Center.

Design

The project was undertaken over a four month period and utilized a qualitative content analysis research methodology. A basic qualitative approach utilizes procedures to generate theory grounded in data. As noted by Babchuk (2011), “It involves an iterative process of simultaneous data collection and analysis, ... constructing codes and categories from data rather than from a preconceived hypothesis ... and the theoretical saturation of categories signaling a stopping point in data collection” (p. 386). While many “branches” of grounded theory have emerged since the seminal work of Glaser and Strauss (1967), this project adopted the overarching method, most consistent with Glaser’s (1978, 1992) open coding, in which the codes emerged from the data and were not selected prior to the data analysis. Consistent with this approach, codes are often labeled from words found in the data themselves. The codes are then clustered into categories and conceptual saturation is reached when no new categories are generated from the open codes.

Content analysis, a refinement of a qualitative approach for use with text documents, has been defined by some to include two approaches: an inductive method, in which codes or categories are derived from the data; and a deductive approach, which is based on previous knowledge and research (Elo & Kyngas, 2007). Others have suggested three categories—conventional (similar to the inductive method), directed, and summative. The latter both involve a deductive approach (Hsieh & Shannon, 2005). The qualitative content analysis methodology utilized here, while consistent with Glaser’s approach, has as its purpose not the construction of theory but the identification of categories or codes and is consistent with the inductive or conventional approaches. It uses open coding, the creation of categories, and abstraction. The purpose of creating categories using content analysis is to “describe the phenomenon, increase understanding and generate knowledge” (Elo & Kyngas, 2007, p. 111). Abstraction is used to group categories, or in this study, to group codes.

Unit of Analysis

The coding team prepared for the analysis by defining the unit of analysis as a trauma treatment manual available in print form. While this contributed to the development of a large data set, the use of computerized software (described in more detail below) allowed for relative ease in the management of the quantity of data. Since the purpose of the eventual analysis of a larger sample of manuals was to search for common intervention objectives and practice elements, an *a priori* decision was made to code for these using the following definitions:

Intervention Objectives: A specific therapeutic outcome the therapist intends to achieve through implementing a given set of practice elements in a given setting.

Practice Elements: Observable, concrete therapeutic procedures the therapist implements with the client or on behalf of the client (when acting in an advocacy role) with the intention of achieving one or more Intervention Objectives.

Multiple Coders

The use of multiple coders has generally been viewed as an aid to establishing methodological rigor in qualitative research (Berends & Johnston, 2005; Ryan, 1999). It has also been argued that having multiple coders is beneficial when the data set is large (Lu & Shulman, 2008). In this project the research team consisted of four coders, the three authors plus an additional doctoral student. This is consistent with a recommendation for team-based coding (Laditka et al., 2009). All four members were professional social workers, all four had worked as clinicians, and more specifically, all had provided trauma treatment, albeit with differing degrees of years of experience and intensity. There is some evidence that the history of working as a therapist, where the development and use of empathy is an important skill, supports the approach of open coding, where the researcher has to become immersed in the data and allow the authors' meaning to emerge.

Type of Content to be Coded

The team decided to code only for manifest, not latent content, since there is debate about whether "hidden" meaning can be accurately coded in text documents, as this usually involves considerable interpretation (Elo & Kyngas, 2007). Therefore, for example, to determine if a statement or description was to be coded as an Intervention Objective, the coder searched to see if the author of the treatment manual used words like "the goal is", "the desired outcome is", or "the purpose is" in describing the activity. Similarly, in deciding if a statement or description was to be considered a Practice element, the procedure, operation, strategy, or technique needed to be observable.

A separate issue relates to the presence of handouts in the manuals. Some of the manuals contained dozens of handouts totaling over 100 pages. While some developers argued that these should each be analyzed for content in order to capture the full scope of intervention objectives and practice elements in the treatment approach, this would have significantly increased the data set to be coded. After an exploratory analysis of handouts from two manuals, it was determined that coding handouts would contribute little to the development of new codes. A typology of handouts was developed instead for coding.

Computer Software

The research team used the Atlas.ti 7.1.4 software in the coding process. The advantages of using this kind of computer-assisted qualitative data analysis software include that it provides a straightforward data reduction method to handle large amounts of data. Each of the 8 manuscripts were on average 200 pages of text, and using Atlas.ti made it easy for every coder to have the same text and to be able to easily compare codes for sections of the text. The use of computer software also makes for flexibility in the coding process as new ideas or codes can be readily inserted. Furthermore, exploratory coding schemes can be developed as soon as the first data are entered, yet because there is an ongoing record of codes and memos, these can be refined or revised upon reflection and more in-depth consideration of initial codes. Fundamentally, it also makes the analytic process more transparent, as the process is explicit and easier to report.

The potential downside is that the capability to deal with large samples can lead to a focus on quantity, rather than meaning. Learning and using the software can in and of itself become a distraction, and the researcher needs to be careful not to let the structure of the software drive the research (Lu & Shulman, 2008).

Iterative Process

Three levels of review were included in this iterative process: 1) the team of primary coders independent and combined coding; 2) integration of feedback from the authors of the manuals; and 3) integration of input from an external review team of non-developer trauma experts.

1) The primary author and two others read each manual independently, coding as they went. To be immersed in the content and assure that the material was understood, sections of the manual were often read more than once as the codes were developed. The three coders then met to review each chapter of the manual, compare codes, identify areas of agreement and disagreement, and discuss options for consolidation. This method is consistent with the recommendation for frequent and face-to-face communication among team members (Laditka et al., 2009). The number of codes was not limited in the initial stages of the project, and after an analysis of three manuals, approximately 300 Practice element codes had been developed. The process of dialogue, dissection of the codes, and reconceptualization based on mutual agreement resulted in consolidating the number of codes by the time of the analysis of the seventh manual to approximately 30 intervention objectives and 60 practice elements. With the analysis of the 7th manual, saturation was reached and no new intervention objective or practice element codes were found. These codes were then used successfully in the coding of the eighth manual.

2) Outreach to EBTT authors. All of the authors were invited to comment and 5 of the 8 authors provided feedback to the research team. After codes were developed from a given manual, a report was generated for the authors. The authors were asked for both a reliability and validity check, that is, to see if the definition of the code adequately reflected the meaning they (the authors) would ascribe, based on a text sample from their manual provided for each code, and if the range of codes was sufficient to describe what they would estimate were the range of intervention objectives and practice elements contained in their approach.

3) A final step in the analysis was a review of the codes by the lead author and an external team of three additional trauma experts. The purpose of this review was to examine alternatives for further consolidation of the codes and to refine definitions of the codes. In writing definitions for the codes, the team retained the words of authors where relevant. This team met for two days and reviewed each of the codes. The final coding manual contained 35 intervention objectives and 59 practice element codes.

Categorization

There has been some attempt to define either the nature or levels of categorization as an aid to qualitative methods. Rabinovich and Kacen (2010) review the method developed by Tutty, Rothery, and Grinnell (1996) in which three key relationship types were identified: contained, temporal, and causal. Contained categories are those in which one category is contained in another, or several categories in one larger category. Temporal relationships, however, reveal relationship in time, that is, which categories precede others. Causal relationships identify the occasion when one category is the reason for another. In this study, “contained” categories were used. The large contained categories are termed “domains” for the purpose of this study. Temporal categories are used to a lesser extent; however a temporal arrangement of domains is suggested. By combining practice elements in the same domain as intervention objectives, a link is made in a causal sense (intervention objectives in a domain are achieved through the implementation of certain practice elements). However, as described in more detail below, neither intervention objectives nor practice elements are viewed as mutually exclusive to a domain in practice.

Results

As noted above, 35 intervention objectives and 59 practice elements were identified for the coding manual. Findings suggest that there are, indeed, common intervention objectives and practice elements across trauma treatments. Each code has a name and a 2-5 line description. An example of an Intervention Objective code is:

Address Adversities in the Social Environment: Includes activities aimed at addressing adversities which either pre-exist the trauma or are a secondary effect of the trauma experience with the goal of enhancing the ability of the social environment to support the child/family with needed resources and services. Interventions may include advocacy, case management and/or collaborative intervention service planning.

An example of a Practice element code is:

Narrative Story Building: Activities designed to provide a summary of important experiences which incorporate an integrated understanding of past experiences. May include the development of a “life story” book. Includes activities designed to help the individual share their story and receive acknowledgement.

Consistent with the abstraction process identified above, categories were created with the purpose of bringing together codes that could be argued belong together conceptually. The codes were thus clustered into domains based on an estimation of shared properties. Nine domains were identified, as follows:

- 1) Trauma Assessment: Specific to activities undertaken to assess the presence and impact of *trauma*;

- 2) Safety: Activities undertaken with or on behalf of the client to reduce the potential of *harm to the child*, self-harm, or harm to others, and to build stability within the social environment;
- 3) Engagement: Includes general assessment (non-trauma specific) as well as interventions to build a working alliance, increase motivation, identify obstacles and provide psychoeducation to the child and family;
- 4) Attachment/Strengthening Relationships: Activities undertaken to strengthen parent-child, caregiver-child and/or family relationships by enhancing attunement, communication and problem solving capacities;
- 5) Core Treatment Interventions: Interventions to reduce symptom distress and strengthen affective, cognitive and behavioral coping strategies within the context of the client's culture. Generally undertaken prior to trauma processing;
- 6) Attention to the Social Context: Activities undertaken with other service providers for collaborative treatment planning, advocacy or case management in an effort to address environmental adversities;
- 7) Trauma Processing: Activities specific to processing and integrating traumatic experience.
- 8) Consolidation/Post Trauma Growth: Future-oriented interventions subsequent to trauma processing focused on making meaning of the traumatic experience and promoting adaptive functioning.
- 9) Therapist Self Care: Interventions that the therapist engages in to anticipate and manage vicarious trauma or secondary traumatic stress;

There is an inherent chronology in the listing of the domains in that to some extent the creation of the domains can be considered in temporal order. Thus, assessment usually precedes treatment planning, safety planning precedes intervention, and intervention for trauma processing precedes post trauma growth or consolidation. However, the researchers caution against strict interpretation of these domains in temporal order, as assessment is on-going throughout treatment, regulation of affect may be achieved prior to trauma processing but need to be revisited during that phase of treatment, and issues in regard to safety can occur at any phase of treatment.

Table 2 lists these domains along with their respective intervention objectives and practice elements. It is acknowledged that these groupings are somewhat arbitrary and not mutually exclusive. The authors are of the opinion that a particular intervention objective could exist in more than one domain. For example, the intervention objective of "Enhance Affect/Emotional Regulation," which is defined as

“_____to assure that emotional difficulties are less intense and manageable, to regulate affective emotional arousal to trauma reminders and foster the capacity to respond realistically to threats, and enhance existing strengths; Includes the intention to identify feelings or emotional states, to interpret others' cues and expression, and to manage, organize, and coordinate emotional

responses; Also includes the intention to help the client/client system share emotional experience,”

could occur not only as part of the “Core Interventions” work done with clients (often undertaken before trauma processing), but also occur in the “Trauma Processing” phase of treatment. Similarly, the practice element entitled “Parent Skills Training/Development”, defined as “Introduction of skills to support effective parenting (praise, positive attention, selective attention, etc.)”, could be used not only to achieve the objective of “Improving Parental/Caregiver Functioning or Competence”, an objective in the “Attachment/Strengthening Relationships” domain, but also to meet the objective of “Building Routines and Rituals”, an objective in the “Safety” domain.

Table 2. Intervention Objectives and Practice Elements by Domain

<i>Domains</i>	<i>Intervention Objectives</i>	<i>Practice Elements</i>
Trauma Assessment	<ol style="list-style-type: none"> 1. Gather Information 2. Identify Grief & Loss 	<ol style="list-style-type: none"> 1. Assess Trauma/Symptoms/Reactions 2. Assess Presence of Trauma Reminders, Triggers, Stressors
Safety	<ol style="list-style-type: none"> 1. Promote Safety 2. Build Routines & Rituals 3. Stabilization 	<ol style="list-style-type: none"> 1. Safety Planning 2. Interventions to Build Routines & Rituals 3. Safety Promoting Interventions 4. Safety Actions
Engagement/General Assessment	<ol style="list-style-type: none"> 1. Develop Alliance/Engagement 2. Explain Phases of Treatment 3. Treatment/Intervention Planning 4. Promote Understanding of Dimensions Important to Treatment 5. Evaluate Treatment Model or Intervention 6. Identify Obstacles to Intervention/Treatment 7. Increase Motivation 	<ol style="list-style-type: none"> 1. Psychoeducation about Trauma and its Impact 2. Interventions to Carry Out Treatment Planning 3. Interventions to Promote Therapeutic Working Alliance/Engagement 4. Assess individual 5. Psychoeducation that is not Trauma Specific 6. Assess Family 7. Generalized Assessment Instruments 8. Assess Eligibility for Intervention/treatment 9. Assess Culture and Religion
Attachment/Strengthening Relationships	<ol style="list-style-type: none"> 1. Build Problem-Solving Skills 2. Improve Parental/Caregiver Functioning or Competence 3. Improve Family Communication 4. Improve Family Interactions/Relationships 5. Foster Attachment 6. Improve Family Structure 	<ol style="list-style-type: none"> 1. Validating Interventions 2. Therapeutic Interventions to Improve Parental Functioning 3. Interventions to Improve Family Interactions & Relationships 4. Attunement Promoting Interventions 5. Developmental Guidance 6. Parent Skills Training/Development 7. Interventions to Strengthen Family Structure 8. Interventions for Circular Causality

Continued

Table 2 (continued)

<i>Domains</i>	<i>Intervention Objectives</i>	<i>Practice Elements</i>
Core Interventions	<ol style="list-style-type: none"> 1. Enhance Affect/Emotional Regulation 2. Enhance Cognitive Restructuring/Regulation 3. Enhance Behavioral Regulation 4. Enhance Capacity for Physiological Regulation 5. Incorporate Cultural Sensitivity and Spirituality 6. Acknowledge the Child's Reality 	<ol style="list-style-type: none"> 1. Feelings Identification 2. Affect/Emotion Regulation 3. Communicating Emotions 4. Intervening to Improve Family Communication 5. Behavior Regulation Interventions 6. Cognitive Regulation/Restructuring Interventions 7. Problem Solving Interventions 8. Social Skills Development 9. Homework 10. Mindfulness 11. Relapse Prevention 12. Relaxation/Stress Reduction 13. Attend to Latent Content 14. Non-Verbal Interventions 15. Interventions to Incorporate Cultural Sensitivity and Spirituality
Attention to Social Context	<ol style="list-style-type: none"> 1. Promote Supportive Networks 2. Address Adversities in the Social Environment 	<ol style="list-style-type: none"> 1. Activities to Promote Supportive Networks 2. Case Management' 3. Assess Social Environment 4. Advocacy 5. Crisis Management 6. Collaborative Intervention Service Planning
Trauma Processing	<ol style="list-style-type: none"> 1. Promote Understanding of Connection Between Trauma and Current Experience 2. Process Trauma Memories/Integrate Trauma Experiences 	<ol style="list-style-type: none"> 1. Trauma-Specific Interventions/Tools 2. Narrative Story Building 3. Interventions to Process/Integrate Traumatic Memories/Experiences
Consolidation/Post-Trauma Growth	<ol style="list-style-type: none"> 1. Promote Post Trauma Growth 2. Build Integrated Sense of Self 3. Promote Adaptive Functioning 4. Make Meaning of Experience 5. Build Family Identity 6. Promote Therapeutic Termination 	<ol style="list-style-type: none"> 1. Termination Rituals/Interventions 2. Interventions to Promote Adaptive Functioning 3. Build Interpersonal Competencies 4. Interventions to Build Family Identity 5. Interventions to Build an Integrated Sense of Self 6. Build Cohesion 7. Meaning Making Activities 8. Strategies to Promote Post-Trauma Growth 9. Intervention for Grief/Loss
Therapist Self Care	<ol style="list-style-type: none"> 1. Attend to Self Care 	<ol style="list-style-type: none"> 1. Interventions to Promote Clinician Self Care

While a determination of the frequency of the codes across the 26 manuals awaits further analysis, the commonality found in these manuals during the coding process warrant discussion. First, there is preliminary evidence that, indeed, evidence-based trauma treatments do contain common intervention objectives and practice elements. This finding was true across all domains but was particularly striking in some.

For example, not surprisingly, almost all manuals articulated the objective of processing the trauma, defined in our codebook as:

“Processing/integrating traumatic memories/experiences – the goal is to develop a coherent, integrated understanding of trauma and of the abusive parent, to unpair thoughts, reminders or discussions of the traumatic event from overwhelming negative emotions, mastering or re-integrating traumatic memories, to re-integrate painful memories, and to build Individual and interpersonal resources to aid in this process.”

The following reflect examples from 3 of the texts reflecting the intervention objective to “Process Trauma”:

- a) “Work with children to actively explore, process, and integrate historical experiences into a coherent and comprehensive understanding of self in order to enhance their capacity to effectively engage in present life” (Blaustein & Kinneburgh, 2010, p. 209).
- b) “The main theme of the ... phase is the establishment of therapeutic communication about the traumatic experience so that the child and family are no longer consumed by the traumatic experience” (Saxe, Ellis, & Kaplow, 2008, p. 127).
- c) “ _____ is designed to help both parent and child understand and modulate their responses to traumatic reminders, to help them find ways to calm and soothe themselves when faced with upsetting feelings, to restore their trust in one another, and to address these misattunements between the parent and the child” (Lieberman & Van Horn, 2005, p. 12).

Another example of commonality is found in what we described as the “Core Treatment Interventions” domain. The practice element “Feelings Identification” was defined as:

“Interventions or strategies to build a vocabulary for emotional experience in self and other, discriminate among emotional states, and to acknowledge the presence of mixed or ambivalent feelings.”

The following are excerpts from three different manuals where this Practice Element entitled “Feelings Identification” was identified, illustrating the commonality of this practice element in many trauma treatment approaches.

- a) “There are several different ways to help children enhance their feeling identification and expression skills.... The therapist can initially ask the child to write down all the different feelings he/she can think of in 3 minutes (younger children may only be able to think of 5-10 feeling words, whereas adolescents will typically identify more feelings than they can write in 3 minutes). This exercise....” (Cohen, Mannarino, & Deblinger, 2006, p. 88).
- b) “Affect identification work often occurs in stages.... Interventions may include: Inviting the child to share daily emotional experiences (e.g. How are you feeling today?) ; Naming emotions in the context of specific experiences (e.g. How did it feel when it happened?). Inviting observation of the

experience of others (e.g. How do you think Jimmy was feeling when....)” (Blaustein & Kinniburgh, 2010, p. 119).

- c) “Use the "Knots" and "Personal Power" thermometers at the beginning and end of each session to guide a child to step back, self-monitor, and share with therapists how they are feeling. It is important to check in with a child periodically throughout a session and the thermometers can be used at any time. This will help the child begin to connect external variables with differences in his or her internal states. Use of the thermometers also provides a means for the therapist to validate a child's ability to 'stop' work that becomes too painful and to remind a child to utilize self-soothing skills.” (Kagan, 2007, p. 106).

These findings and many similar ones across the nine domains lead us to anticipate that continuing commonalities may emerge with a wider application of the codes to all 26 manuals. In the next phase of the coding project all 26 manuals will be coded by an independent coding team.

Discussion

Implications for Social Work Education

As noted above, the findings suggest that there are common intervention objectives and practice elements across trauma treatments. Just as we have found it to be helpful in building foundational knowledge about trauma through the dissemination of the Core Concepts course, it is anticipated that it will be useful for MSW students with only a beginning knowledge of trauma to be exposed to common intervention objectives and practice elements. Learning common practice elements, in particular, may help prepare students for training post MSW in specific trauma treatments. Knowing why and how to do a *trauma* assessment, understanding key components in collaborative treatment planning and case advocacy, and learning some of the common practice elements like affect, behavioral, and physiological regulation, will develop a foundation upon which training in a specific evidence-based treatment can more easily be built. The development of curriculum materials to foster this learning will put MSW students at an advantage in working with clients with histories of exposure to trauma.

Social work education reflects and attempts to imbue in the graduate the core value of the person-in-environment perspective. Results of this project suggest that practice with the child's family and social environment is essential to the delivery of evidence-based trauma interventions for children and adolescents. To prepare social work students for effective interventions will require elaboration of skills in working with traumatized children and their families in the social context. The second phase of curriculum development already underway by the NCTSN CCCT Task Force will assist social work educators with this task. However, new graduates will continue to be frustrated in their ability to deliver effective trauma services if the policy framework for reimbursement does not sufficiently support interventions in the social environment. Social work

education will need to continue to educate students regarding effective policy advocacy as well as effective practice.

Implications for Practice

Many of the implications discussed for social work education apply to current practitioners. However, the authors stress that the purpose of the coding project is to develop a familiarity among social work practitioners with trauma components common across interventions, and not the development of an intervention *per se*. It is critical to recognize that there is no empirical base for the effectiveness of *individual* components in trauma treatment; the research the field has compiled has studied these elements as they have been “packaged” by individual developers for specific target populations with specific modalities. It is the treatment as an entity that has an empirical base, not specific elements, “common” as they may be across trauma interventions. This is stressed in order to dissuade those who might think that because they have training in common elements they can practice trauma treatment. The evidence-based trauma treatments are still the class of interventions that have the *best* empirical support for working with traumatized children and adolescents. It is anticipated that familiarity with common elements will *prepare practitioners for training in a specific evidence-based treatment*.

Implications for Social Policy

Of particular interest was the emergence of three domains which are significantly consistent with the person-in-environment perspective of social work, and which have significant implications for policy. The domains are: 1) Safety, 2) Attachment/Strengthening Relationships and 3) Attention to the Social Context. The first—Safety—often involves interventions in the social environment (family, school, and neighborhood) and with other service providers. The Attachment/Strengthening Relationships domain includes a focus on improving attachment and relationships between the child and significant figures in the child’s environment: parents and siblings, extended family members, staff in residential settings, teachers, and peers. The third—Attention to the Social Context—is specific to interventions undertaken in the social environment, and includes, among others, activities to promote supportive networks, crisis management, and collaborative intervention service planning.

The relevance of these findings is that by and large these interventions involve activities outside of the 45- (or in these times even 30-) minute “hour” of direct client contact for which mental health clinicians can typically claim reimbursement. Intervention objectives (IOs) and/or practice elements (PEs) regarding the need to assure safety from future trauma or interpersonal abuse is a critical prerequisite for trauma treatment, and were found in 7 of the 8 manuals; those related to Attachment/Strengthening Relationships were found in all 8 manuals and IO and/or PEs regarding Attention to the Social Context were found in 7 of the 8 manuals, suggesting how important, and common, these components are for trauma treatment.

Federal and State funding sources, as they become more actively involved in promoting the adoption of empirically-supported treatments, will need to take these

factors into consideration. Innovative examples for such funding streams exist. It is clear that the federal government, through SAMHSA, has taken an active role in forming trauma-based initiatives, researching and discussing trauma-informed care, identifying barriers to implementing trauma informed care and creating dialogue about possible solutions.

Trends related to mental health reimbursement are an obvious barrier to accessible trauma informed care for consumers. The states' and insurance companies' control over the "who, what, how, when, and where" of reimbursement makes implementation of trauma-informed services very challenging. A state example helps illustrate the dilemma. In 2006, the New York State Office of Mental Health announced its Achieving the Promise initiative designed to authorize the single largest investment in children's mental health services in New York's history. As part of this initiative the Child and Family Clinic-Plus Program was initiated in New York State. Within this program, broad-based screening occurred as well as comprehensive assessment, expanded clinic capacities, in-home supports, and evidence-based practice supports. These features provided greater access and flexibility within the system to enhance positive outcomes. By 2009, however, a shift away from the expanded scope had already occurred in New York State with the initiation of a Clinic Restructuring Implementation Plan (NYS Office of Mental Health, 2009). Despite attempts by the New York State Office of Mental Health to soften the impact of this restructuring challenge, there is a dramatic shift occurring in the outpatient mental health service system in New York State. Given that over 100,000 children and families receive services annually from clinics throughout New York State (NYS Office of Mental Health, 2006), the impact is extensive. The shifts will disproportionately affect families with fewer financial resources and the child welfare population who utilize mental health services from clinic settings with few other options available to them.

As Kazdin and Nock (2003) point out, this issue is not limited to New York State. If 20% of the 70 million children and adolescents living in the United States suffer from developmental, emotional, or behavioral problems, then there are 14 million children who suffer from impairments in their functioning. Social policy advocates will need to be vigilant to assure that further legislative changes do not disadvantage traumatized children and their families who are entitled to effective treatments, which will need to include community-based as well-as office-based intervention.

Implications for Research

Assuming that the next phase of the coding project consolidates the identification of common intervention objectives and practice elements in trauma treatment, developing a second phase of the CCCT curriculum will necessitate evaluation. Does education at the graduate level in core concepts and components of trauma treatment prepare students for work with traumatized children and adolescents more effectively than education "as usual"? Does this education in fact accelerate the acquisition of an EBTT? Does in-service training for agency-based practitioners have similar results?

At the direct practice level, intervention studies to investigate the critical or "trauma-specific ingredients" of the social, or person-in-environment practice elements for

effective trauma treatment will be helpful and absolutely essential before the field of trauma treatment considers a move to a common elements intervention approach as advocated by Chorpita and colleagues (2011) and Barth and colleagues (2012). Comparative studies undertaken in environments that allow for provision of all elements of evidence-based trauma treatment in contrast to those environments that do not support the social context elements will also advance the fields' understanding of the relevance of the array of practice elements. There continues to be a need for research that compares different interventions to each other and for research undertaken by investigators other than the developers of individual trauma treatments.

Limitations of the Study

Limitations include the lack of a methodology to calculate statistical inter-rater reliability. There are now methods to do this; lack of time and resources meant that the research team relied on discussion, comparison and deconstruction in our deliberations to establish reliability. The coding manual may have been strengthened by more precise attention to this matter. The review at two additional levels was an attempt to assure the development of meaningful and representative codes. A second limitation is that not all 8 manuals used for this project were child and adolescent *treatment* manuals; one was an intervention designed for post-disaster work. This potentially skews the sample in unexplored ways. A third limitation is that implications are developed based on the coding of a sample of manuals, not all 26. The issues discussed must therefore be viewed as ideas for further consideration, not generalizations that are informed by the research. Fuller confidence in the inferences drawn awaits further analysis of the 26 manuals. While the authors anticipate that these findings may not be so different—partly based on the high level of evidence supporting the 8 trauma manuals used to develop the codes—the findings need to be viewed as preliminary.

Conclusion

As the search for common elements in evidence-based treatments has gathered steam, researchers and practitioners are increasingly turning to qualitative methods to synthesize what is known about empirically supported treatments for a given problem or class of disorders for particular client groups (Bisson et al., 2010; Hsieh & Shannon, 2005; Sburlati et al., 2011). This study adds to the growing literature, serving as an important place-holder for common components across evidence-based trauma treatments in the absence of more rigorous dismantling studies for many empirically-supported trauma interventions. It provides benchmarks for practitioners against which to evaluate a given trauma treatment as well as providing an important knowledge base for trauma education and training.

Evidence-based trauma treatments do appear to have common intervention objectives and practice elements. Incorporating these into social work education and agency in-service training has promise for increasing the preparedness of both MSW students and practitioners for trauma treatment. These evidence-based treatments typically have elements that require activity on the part of the clinician in the client's social environment

and beyond that of office-based direct client contact. This will remain true even with a move toward a “common elements” or modular intervention for trauma treatment.

The emphasis placed on the importance of providing empirically-supported interventions is based on a shared value among mental health providers including social workers, psychiatrists, psychologists, and others of the imperative to provide the best available mental health treatment for children and families. This value resonates with the social work principles of human rights and social justice which assert that children and families have a *right* to the best available health care. If as these results suggest, trauma treatment needs to include person-in-environment interventions, then reimbursement support clearly needs to be expanded to move us in this direction. Social work professionals have the ethical obligation to incorporate new knowledge into education and practice and to advocate for responsible and reliable choices in policies that affect the availability of effective services for traumatized children and their families.

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