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Trauma Treatment for Youth in Foster Care: A Mixed-Methods Study of Clinician Perspectives and Treatment Model Use

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Trauma Treatment for Youth in Foster Care: A Mixed-Methods Study of Clinician Perspectives and Treatment Model Use

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Abstract

Youth in foster care experience trauma exposure and subsequent trauma-related disorders at much higher rates than their peers, with prevalence rates comparable with veterans of war. Although youth in foster care appear to receive services at higher rates than their peers, little is known about what outpatient care consists of, particularly for trauma-related disorders. Furthermore, although several evidence-based treatments exist for the treatment of child and adolescent trauma, little is known about how appropriate and effective existing treatment approaches are for youth in foster care. The current study used a mixed methods approach to examine a) the range of evidence-based approaches used by clinicians treating youth in foster care who have trauma symptoms, b) barriers and facilitators to treating this population, c) clinician attitudes toward evidence-based treatments (EBTs), and d) adaptations made to existing trauma treatments. Barriers and facilitators were assessed based on concepts outlined in the Exploration. Preparation, Implementation, and Sustainment (EPIS) framework (Aarons et al., 2011). These topics were assessed by a brief quantitative survey and a semi-structured qualitative interview. Participants (N = 148) were mental health clinicians with master's (n = 126) and doctoral degrees (n = 22), primarily in social work (n = 106). A majority (91%) of providers reported using at least one evidence-based treatment (EBT) when working with youth in foster. Providers also reported using a number of treatment models with limited empirical support for the treatment of child trauma, such as client-centered play therapy (n = 68), art therapy (n = 68), and individual mind-body skills (n = 86). Quantitatively, providers reported encountering barriers (n = 127) more than facilitators (n = 50) when working with youth in foster care. Working with youth in foster care was widely described as more challenging than treating their typical caseload (n = 111) or other clients with trauma symptoms (n = 109). Participants reported

most barriers to treating youth in foster care were related to outer contextual factors (i.e., external variables defined in the EPIS framework), such as working with caseworkers (*n* = 91), working with court systems (*n* = 77), and working with biological caregivers (*n* = 91). Conversely, providers described inner contextual variables (i.e., internal variables defined in the EPIS framework) as facilitators, such as agency policies and support (*n* = 68) and clinician practices (*n* = 89). Total scores on a measure of evidence-based practice attitudes (EBPAS) were higher than community samples (*M* = 2.86, *SD* = 0.53). Qualitatively, providers reported making modifications to existing trauma treatments, such as eliminating narration and increasing an emphasis on feeling identification, which may lead to drops in efficacy. Providers described existing treatment models as appropriate and effective with youth in foster care but indicated that external challenges prevent model use. Implications for policymakers, stakeholders, and implementation developers include capitalizing on widely disseminated interventions, considering the fit between provider theoretical orientation and model theory, and adapting existing interventions to match the needs of youth in foster care.

Keywords: *foster care, trauma, evidence-based treatment, implementation, EPIS framework*

Dedication

To my Nana, Carolyn Ann Barber. The woman who, even when Alzheimer's had taken her memory of who I was, asked me what I planned to do with my life. Each and every time I answered, "child and family psychology," she encouraged me and exclaimed, "Oh honey, you will be so good at that!" as if it were the first time she'd heard it. May love persist beyond the bounds of time, space, and memory.

Thank you to Dr. Alex Dopp, who believed in me before I did. Thank you for supporting me throughout my graduate training as a mentor, teacher, and friend.

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Introduction

Foster care and kinship care are broadly defined as temporary living placements for children and adolescents whose biological parents or caregivers are unable to care for them adequately due to factors such as maltreatment or neglect. While foster care can include caregivers with various relationships to the child, kinship care is a specific temporary living placement where youth are placed with a relative or close friend (Child Welfare Information Gateway, 2016). More than 440,000 children and adolescents reside in foster care in the United States during a given year (U.S. Department of Health and Human Services, 2018).

The Prevalence of Trauma for Youth in Foster Care

Youth in foster care are disproportionately affected by trauma and stressor-related disorders (Salazar et al., 2013). Between 70-90% of youth in care experience traumatic events (Greeson et al., 2011; Stein et al., 2001). Posttraumatic stress symptoms are prevalent among youth in foster care, affecting approximately 15-20% of the population, which is similar to the prevalence rate of veterans of war (Hoge et al., 2014; Iversen et al., 2009). This is particularly concerning, given that youth who develop trauma symptoms are more likely to exhibit symptoms of acute- and posttraumatic stress disorders, reductions in emotional and behavioral regulation, delayed academic achievement, and disrupted development of hypothalamic-pituitary-adrenal (HPA) axis, a physiological system responsible for stress responses (Fisher et al., 2006; Jacobsen et al., 2013).

The Foster System as a Gateway to Mental Health Care

Given the mental health difficulties faced by youth in foster care, it is perhaps unsurprising that access to mental health care is a priority for the child welfare system. In fact, foster care has been characterized as a gateway to mental health care (Farmer et al., 2001; Leslie

et al., 2005; Stiffman et al., 2004), leading to higher mental health service utilization (Bellamy et al., 2010; Leslie et al., 2005) and increased Medicaid claims for mental health services (Landsverk et al., 2006; Takayama et al., 1994). This widespread access to services is evident across all age groups in foster care. Children under the age of 5 years in foster care have been reported to be seven times more likely to receive mental health services than youth not in care with mental health symptoms and tend to receive care at substantially higher rates after being placed in foster care. Similarly, school-aged foster care youth receive mental health services at triple the rate of youth not in foster care (Center for Mental Health Services and Center for Substance Abuse Treatment, 2013).

Although placement in foster care can often lead to access to mental health services, the needs of many in this population are still not met, as many encounter significant delays in receiving services once placed into care. Burns and colleagues (2004) found that most children in foster care do not receive mental health services within the first 12 months of child welfare involvement, although most receive treatment within 18 months of placement (Leslie et al., 2005). Furthermore, systemic disparities are evident within the child welfare system, as foster youth from racial and ethnic minority backgrounds are less likely to receive outpatient mental health services than White foster youth (Burns et al., 2004; Garland et al., 2000). Youth also receive care at differing rates based on the reason for removal from the home, with neglected children being less likely to receive outpatient mental health services than children who are victims of physical or sexual abuse (Burns et al., 2004; Leslie et al., 2000).

Little is known about the type, quality, and efficacy of care received by foster care youth (Akin & Gomi, 2017). For example, evaluations of outpatient treatment for youth in foster care have found variability in the intensity and impact of outpatient mental health services across

youth with similar diagnoses and functional impairment (McKay et al., 2004). Furthermore, other evidence indicates that youth in foster care may receive minimal benefits from outpatient mental health services as usual (Bellamy et al., 2010). McCrae and colleagues (2010) found that 60% of foster care youth in their sample experienced minimal to no reductions in mental and behavioral health symptoms with treatment, but youth who did not receive mental health services tended to have a reduction in symptomology.

Outpatient Interventions for Youth with Trauma-Related Symptoms

Given high rates of trauma exposure and subsequent psychopathology among youth in foster care, effective mental health care for this population is critical. *Evidence-based treatments* (EBTs) are interventions supported by empirical evidence for their use in clinical practice for specific clinical problems (Chambless & Ollendick, 2001). Fortunately, many evidence-based treatments for trauma symptoms in youth exist and have been tested in youth in traditional living arrangements. A recent systematic review by Dorsey and colleagues (2017) identified several treatments for youth exposed to traumatic events, although the review does not focus specifically on youth in foster care. Below, I review empirical evaluations of treatments specific to for youth in foster care based on the following criteria defined by Southam-Gerow and Prinstein (2014): Level 1= well-established, Level 2= probably efficacious, Level 3= possibly efficacious, Level 4= experimental treatments, and Level 5= treatments of questionable efficacy.

Trauma-Focused Cognitive-Behavior Therapy

Trauma-focused Cognitive Behavior Therapy (TF-CBT), a trauma treatment that uses cognitive and behavioral principles to address trauma symptoms, is considered well-established based on principles outlined by Southam-Gerow and Prinstein (2014) . Treatment involves both youth and parents and includes session topics of psychoeducation, coping skill development,

trauma exposure, and cognitive processing (Cohen & Mannarino, 2008). TF-CBT is the most widely researched trauma treatment for children and adolescents, has been shown to produce significant reductions in symptoms of traumatic stress in various community samples, and has outperformed both waitlist and control conditions (Cohen et al., 2011; Danielson et al., 2012; De Roos et al., 2011; Jensen et al., 2014). Despite numerous evaluations of TF-CBT with child and adolescent populations, I identified only one study that involved clinical outcomes of foster care youth. In this study, racially diverse foster care youth demonstrated significant improvements in psychological functioning when treated with TF-CBT regardless of ethnicity (Weiner et al., 2009).

Child-Parent Psychotherapy

Child-Parent Psychotherapy (CPP) is a psychodynamic, attachment-based treatment for children under 5 who exhibit trauma-related symptoms (Lieberman et al., 2004). CPP has demonstrated reductions in traumatic stress and improvements in parent-child attachment across five randomized controlled trials (e.g., Lieberman et al., 2006), all involving children ages 0 to 6 years and their mothers. CPP has been classified as an EBT by numerous agencies (e.g., California Evidence-Based Clearinghouse for Child Welfare, 2015; National Child Traumatic Stress Network, 2012). CPP is classified as a possibly efficacious treatment (Silverman et al., 2008), although recent empirical evidence supports it as a probably efficacious treatment (California Evidence-Based Clearinghouse for Child Welfare, 2015). CPP also can be used with caregivers who have engaged in non-sexual maltreatment (i.e., physical, emotional, and verbal abuse and neglect) or with caregivers and children who have experienced other non-maltreatment traumas (e.g., death of a loved one, change in placement, serious medical procedures; Lieberman et al., 2005).

In a systematic review of outcome studies, findings indicated that CPP significantly reduced trauma symptoms for youth who experienced maltreatment (Leenarts et al., 2013; Weiner et al., 2009). CPP also has been associated with a reduction in future reports of child maltreatment, improved placement permanency in foster care, and decreased traumatic stress symptoms (Barto et al., 2018). An evaluation of CPP in the New York State child welfare system found that families who received CPP had lower maltreatment rates than the national average, and youth were more likely to obtain a permanent placement with a biological caregiver following foster care placement than national averages. In addition, youth who received CPP with a biological or foster caregiver were more likely to subsequently receive appropriate services to address developmental delays (Chinitz et al., 2017).

Parent-Child Interaction Therapy

Parent-Child Interaction Therapy (PCIT) is a parent training program initially developed to address disruptive behavior disorders in children (McNeil & Hembree-Kigin, 2010). There is substantial evidence for PCIT reducing externalizing behaviors in various populations, including youth in foster care (Chaffin et al., 2011; Landsverk et al., 2006; Mersky et al., 2016). However, support for reductions in trauma symptoms is more limited (Urquiza & Timmer, 2014). PCIT is considered a well-established treatment.

Efforts have been made to implement PCIT within the child welfare system through modified approaches (Topitzes et al., 2015), although efforts remain ongoing and existing evaluations of a modified protocol are not presently available. Adaptations of PCIT, such as Child Adult Relationship Enhancement (CARE), have shown positive results for foster parents, especially when adapted to be brief and concentrated (e.g., two-day, lengthy trainings; Messer et al., 2018).

Eye Movement Desensitization and Reprocessing

Eye Movement Desensitization and Reprocessing (EMDR) is a manualized trauma treatment involving imaginal exposure to traumatic events, cognitive reprocessing, relaxation, and, typically, bilateral eye movements (Shapiro, 2007). EMDR has been shown to be effective in treating trauma symptoms, and modifications have been made for youth populations, including the use of finger tapping rather than eye movements (Ahmad & Sundelin-Wahlston, 2007). EMDR is classified as a possibly efficacious treatment (California Evidence-Based Clearinghouse for Child Welfare, 2004).

An evaluation of EMDR that included youth in foster care revealed a benefit of EMDR in reducing trauma symptoms over a waitlist control condition for all participants (Ahmad et al., 2007). Modifications of EMDR for use with children and adolescents, such as simplifying distress ratings and changes to cognitive reprocessing strategies, also yielded significant results in reducing trauma symptoms (Ahmad & Sundelin-Wahlston, 2007). It is important to note that youth in foster care comprised very small proportions (i.e., 12-20%), of the samples in the referenced evaluations and no evaluations have examined the effects of EMDR on foster care youth specifically.

The Importance of Treating Youth While in Foster Care

Despite the availability of evidence-based treatments for children with trauma-related symptoms, evidence specific to treating youth in foster care is sparse. This is especially problematic as foster care youth with significant emotional and behavioral disturbances are likely to experience frequent disruptions in placement (James et al., 2004; Smithgall, 2005). Foster care youth with severe mental health issues are also nearly ten times less likely to achieve reunification with their biological caregivers than youth without mental health issues (Smithgall,

2005). Similar results have been noted for the adoption of foster care youth, where youth with mental health issues are more likely to be adopted than youth without mental health issues. However, there appears to be less impact on adoption rates than reunification rates (McDonald et al., 2007). Another study also found that youth with mental health issues are half as likely to move from foster care to permanent placement than youth without mental health issues (Akin, 2011). Therefore, it is important to identify and use EBTs to reduce mental health symptoms while in foster care to avoid delays and reductions in permanency, adoption, and reunification.

Considerations for Treating Trauma-Related Symptoms for Youth in Foster Care

There are unique challenges in completing trauma treatment for foster care families. For example, many evidence-based trauma treatments require significant caregiver involvement and were developed for use with parent-child dyads. Frequent changes in caregivers, adjustments to a family member taking on the role of parent in kinship care, and concerns about disruptions in placement can interfere with the application and feasibility of trauma interventions (Taussig & Raviv, 2013). Kinship caregivers may face the unique challenge of managing their relationship as the youth's caregiver and the relative of youth's previous biological caregiver, especially if the biological caregiver perpetrated the primary traumatic event (Fechter-Leggett & O'Brien, 2010). Logistical issues like placement instability also pose unique challenges for youth outpatient mental health services. Most youth in foster care have experienced more than one placement, with some having more than six placements, which can significantly impact the continuity of mental health care (James et al., 2004). Furthermore, foster caregivers are often over-burdened with caring for multiple children in the child welfare system, and thus it can be difficult for them to find time to engage in treatment or transport multiple children to multiple treatment appointments (Dorsey et al., 2014).

Beyond the numerous logistical barriers foster care families face, states vary widely in the availability of EBTs for mental health problems, which is especially problematic when considering the complex needs of youth in foster care (Bruns & Hoagwood, 2008; Landsverk et al., 2006). Even when evidence-based trauma treatment training is widely available, it is uncertain how often providers pursue training in EBTs or use them specifically with youth in foster care (Dorsey et al., 2017; Silverman et al., 2008). Little is also known about providers' attitudes toward evidence-based treatments and their willingness to pursue training in EBTs if available, which is important for informing dissemination and implementation efforts (Aarons, 2004). Therefore, it is important that the therapeutic approaches and strategies used by therapists treating youth in foster care be evaluated to assess: a) the prevalence of EBT utilization, b) the challenges of working therapeutically with this population, and c) the perceptions therapists may have about needs for tailoring interventions broadly.

Despite the many challenges of working with youth in foster care, potential facilitators (i.e., factors that are supportive) may improve the therapeutic process. For example, caseworkers have been defined as "brokers" that facilitate youth access to mental health treatment (Stiffman et al., 2004), and increased training can improve referrals by caseworkers for appropriate EBTs (Dorsey et al., 2012). Additionally, therapy sessions with youth in foster care may produce more consistent reimbursement than other child populations (Pottick et al., 2005). Most foster care youth qualify for Medicaid services and may not encounter lengthy delays in insurance enrollment or lapses in coverage once in the child welfare system. Medicaid coverage may also reduce barriers encountered by other clients, such as high copays. Finally, therapists may receive more information about foster care youths' trauma history because there are detailed accounts of

trauma experiences in court documents or child advocacy center interviews. This may serve as a facilitator to diagnosis and treatment for clinicians.

Foster care youth are a unique population requiring unique considerations. It is likely that providers adapt interventions to fit the particulars of the population. Previous literature suggests providers in community and child welfare settings tend to adapt existing treatment models in their clinical practice, which may be especially true when working with foster care populations (Aarons & Palinkas, 2007; Marques et al., 2019). Furthermore, clinicians may generally modify trauma treatments involving exposure components (e.g., trauma narratives) due to personal discomfort or concerns of causing emotional distress to patients (Allen & Johnson, 2012). There is an adapted EBT manual for TF-CBT, but there appear to be no evaluations of this manual. So, although providers may make modifications to their use of interventions for foster care youth, there are no empirically studied manuals that support clinicians in the decision-making process of adaptations or provide guidance on adaptation selection that does not reduce efficacy.

EPIS Framework

The Exploration, Preparation, Implementation, Sustainment (EPIS) framework is an ideal implementation framework to consider the needs of youth in foster care who experience traumatic stress. The EPIS framework is a comprehensive implementation framework that details four stages of implementation (i.e., exploration, preparation, implementation, and sustainment), identifies variables within the inner context (i.e., factors within a community or organization that influence implementation) and outer context (i.e., external factors that may influence implementation), and the interplay of both contexts through bridging and innovation factors (Aarons et al., 2011). It is one of the most widely cited implementation frameworks and has been used to guide many implementation projects related to health and mental health in allied service

sectors (Brookman-Frazee, 2020; Moullin et al., 2019). Indeed, the EPIS implementation framework was developed with a specific emphasis on widescale service systems, such as child welfare (Aarons et al., 2011; Moullin et al., 2019).

In the exploration phase of the framework, interested parties (e.g., researchers, stakeholders) work to identify the health needs of a target population (e.g., clients in foster care), evaluate potential EBTs that may address those health needs, and make plans for future EBT adoption. The exploration phase also includes an emphasis on the potential need for adaptation across contexts (e.g., changes to the outer context of the foster care system, adaptation to mental health organizations serving youth in foster care) to adequately address the population's needs and facilitate successful implementation of EBTs (Aarons et al., 2011). In sum, the EPIS framework is an ideal model to assess the treatment implementation needs of youth in foster care as it emphasizes inner contextual factors (e.g., organizational influences such as leadership, values, and climate), outer contextual factors (e.g., foster care legislation and funding), and the interplay between inner and outer contexts, which is imperative with a multi-system-involved population.

The Current Study

The present study used a mixed methods design that focused on the "exploration phase" of implementation within the EPIS framework. Specifically, the present study used this framework to guide evaluation of implementation needs for the treatment of youth in foster care by considering the needs of the population and the influences of inner contexts, outer contexts, and the interplay between the two. The present study examined a) the kinds of therapeutic approaches foster care youth are receiving, b) the extent to which those approaches are evidence-based, c) barriers and facilitators providers encounter when treating youth in foster care, d)

provider attitudes toward EBTs, and d) strategies providers use to adapt existing treatments to fit perceived barriers or potential facilitators. Figure 1 presents the conceptual EPIS framework with examples of themes used in the present study (adapted from Aarons et al., 2011; Brookman-Frazee et al., 2020; Moullin et al., 2019). Given the paucity of research on the treatment of youth in foster care, a priori hypotheses were not made regarding the treatment models used by providers, barriers and facilitators encountered when treating youth in care, and adaptations providers make when working with youth in foster care. Based on previous literature related to evidence-based practice attitudes, We hypothesized that providers who held more positive attitudes about evidence-based practices would be more likely to use treatments that have been supported by empirical literature.

Research Aims

1. Determine the therapeutic approaches and strategies reported to be used by providers who treat trauma-impacted youth.
2. Determine the statistical relationship between rates of use of intervention models.
3. Determine the barriers to and facilitators of treatment across inner contexts, outer contexts, and bridging factors are identified by providers who treat trauma-impacted youth.
4. Determine the extent to which providers who treat trauma-impacted youth in foster care are accepting of and open to using evidence-based treatments.
5. Determine the statistical relationship between provider attitudes toward evidence-based treatments and their rates of use of intervention models.
6. Determine the strategies providers who treat trauma-impacted youth use, if any, to adapt existing treatments to fit perceived barriers or potential facilitators.

Method

Participants

To obtain the largest, most representative clinician sample possible, recruitment included both purposive and snowball sampling methods (Teddlie & Yu, 2007). I first recruited a convenience sample of clinicians that treat youth in foster care (N = 150) in the following ways: (a) national practice and professional organizations, (b) social media, (c) training initiatives and centers, (d) state licensing boards, and (e) snowball sampling. Purposively, clinicians (i.e., clinical and counseling psychologists, clinical social workers, marriage and family therapists) were identified through various national practice and professional organizations (see Table 1 for the complete list of organizations and recruitment strategies). The surveys were also disseminated through social networking platforms, including Twitter and Facebook (see Table 1 for a full list of social media groups included in recruitment).

Additionally, participants were recruited via invitation through centers and training initiatives that focused on the dissemination of evidence-based treatments for youth who experienced trauma. Training initiatives and centers were identified from a project in similar methodology and aim (i.e., assessing clinician perspectives when treating adolescents with trauma and substance use issues; Adams et al., 2017). Centers and initiatives that were contacted are listed in Table 1. Finally, participants were recruited from state licensing boards from the ten most populous states in the United States (i.e., California, Texas, Florida, New York, Pennsylvania, Illinois, Georgia, North Carolina, and Michigan).

Upon completing the survey portion of the study, participants were asked to nominate up to five colleagues who may be interested in participating. All nominated individuals were invited to participate in the survey.

Measures

Demographics

Relevant demographic information (e.g., age, sex, race, ethnicity, geographic region, type of licensure) was assessed via a demographic questionnaire. Please see Appendix A for the full demographic questionnaire measure.

Therapeutic Strategies

Potential trauma-focused intervention models and strategies for youth were identified from a series of "Evidence Base Reviews" and "Evidence Base Updates" published in the *Journal of Clinical Child and Adolescent Psychology* (see Southam-Gerow & Prinstein, 2014 for an overview of this publication series). I used both of these recent reviews of psychosocial treatments for children and adolescents who have been exposed to traumatic events (Dorsey et al., 2017; Silverman et al., 2008). Only strategies or models that represented individual or parent-child outpatient mental health treatment for trauma symptoms were included (i.e., not group or school-based therapies). All strategies or models that met criteria were included, regardless of the designated level of empirical support (Dorsey et al., 2017; Silverman et al., 2008), to provide a comprehensive selection for participants. A brief definition of each intervention was included in the quantitative survey (Appendix B).

Barriers and Facilitators

Barriers and facilitators encountered by participants were assessed using a self-report measure. Measure content was constructed by reviewing previous literature detailing barriers and facilitators encountered by therapists who treat youth in foster care (Akin & Gomi; Dorsey et al., 2017; Ganser et al., 2017; Kerker & Dore, 2006; Kerns et al., 2014; Taussig & Raviv, 2013) and by a review of EPIS framework constructs (Aarons et al., 2011). First, the presence of barriers or

facilitators was assessed by asking participants two "yes" or "no" questions (i.e., "*Have you encountered things that makes your job easier when treating trauma symptoms with a client in foster care"; "Have you encountered things that make your job harder when treating trauma symptoms with a client in foster care?"*). Then, providers were asked how much harder or easier treating trauma symptoms in youth in foster care was when compared to their typical caseload and other clients with trauma symptoms. Items were rated on a 5-point Likert scale, from 1 (much harder) to 5 (much easier).Then, barriers and facilitators were presented in a multiple selection list across EPIS constructs relevant for the treatment of foster care youth (i.e., client factors, foster caregiver factors, biological caregiver factors, assessment of symptoms, working with caseworkers, working with court systems, clinician factors, training, treatment models, agency factors, funding factors, external support factors, or other). Participants could write in barriers and facilitators that may not have been presented in the self-report measure in the "other" category. See Appendix C for the full self-report measure.

Evidence-Based Practice Attitudes Scale (EBPAS)

The Evidence-Based Practice Attitudes Scale (EBPAS; Aarons, 2004), a 15-item self-report measure, was used to assess clinicians' attitudes toward adopting and utilizing evidence-based practices (EBPs). The EBPAS assesses attitudes across four dimensions (and subsequent subscales): Requirements, Appeal, Openness, and Divergence. Participants respond by answering on a 5-point Likert scale from 0 (not at all) to 4 (to a very great extent) regarding their attitudes toward EBP use (Aarons, 2004). The Requirements scale assesses clinician likelihood of EBP use if required by supervisors, their agency, or their state. The Appeal scale measures whether a provider would use a new treatment if it made intuitive sense or if colleagues were also using the EBP. The Openness scale measures a clinician's willingness to use new practices,

and the Divergence scale assesses typical clinician practices and how much their typical practice diverges from research-based interventions. The EBPAS has demonstrated good psychometric properties, with an overall reliability score of α = .77 and subscale scores ranging from α = .90 to .59 (Aarons, 2005). Confirmatory factor analysis results from 1,089 mental health providers from a nationwide sample revealed a second-order factor model with overall subscale reliability of α = .74, with subscales ranging from α = .91-.67 (Aarons et al., 2010).

Qualitative Interview

I used guidance from Kallio and colleagues (2016) to construct the qualitative interview. A semi-structured interview format was chosen to allow diverse perceptions from participants and discussion of complex issues such as ideals, values, and intentions (Astedt-Kurki & Heikkinen 1994; Cridland et al., 2015). Questions were open-ended to allow for accurate, rich information gathering (Turner 2010). Question content was developed based on previous research findings and EPIS framework constructs while allowing for flexibility in participant responses (Aarons et al., 2011; Akin & Gomi, 2017; Dorsey et al., 2017; Ganser et al., 2017; Taussig & Raviv, 2013). Interviews were completed via web-conferencing software (i.e., Zoom Video Communications). Clinicians were first asked to provide detailed background information including years of experience, type of licensure, clinical setting, percent of caseload working with youth in foster care, and percent of caseload working with trauma-related disorders. Interview questions then included probes for experiences working with youth in foster care with trauma-related symptoms. Then, providers were asked what barriers and facilitators they encountered in treating trauma in youth in foster care across inner contexts (e.g., clinician theoretical orientation), outer contexts (e.g., working with caseworkers), bridging factors (e.g., community-academic partnerships), and innovation (e.g., the ways clinicians adapt their typical

practice/interventions to meet the needs of foster care youth). Additional questions asked participants what specific treatment models and strategies they used. Participants were probed for adaptations they might be making to treatment models. Interviews also included a question of participant opinions of what would be most beneficial to support the treatment of youth in foster care (Appendix C).

Procedures

Recruitment began with emails to directors of the previously identified training initiatives and posts to social media. Recruitment materials included a description of the study and eligibility criteria (i.e., is a mental health provider, works with youth in a foster care placement, has treated youth in foster care for trauma-related symptoms) and an electronic link to the quantitative survey link. The electronic link led to a page for providing informed consent as well as study eligibility criteria. Participants then completed the electronic survey and consent to be contacted for follow-up qualitative interviews. Responses were collected via secure, anonymous data collection software (i.e., Qualtrics). Responses were regularly monitored to ensure appropriate collection of data. After completing the survey, participants were redirected to a link not connected to the data collection survey where they could enter a raffle for one of ten $50 gift cards.

Participants were then randomly selected to complete qualitative interviews. They were first contacted to schedule a remote, video-conference meeting through Zoom. Participants were read a copy of the consent form and then they were asked to provide verbal consent. At the end of each interview, respondents received a $25 electronic gift card for their time. A brief validity check was performed with participants at the end of each interview by summarizing the main

points for participant verification. All interviews were recorded and transcribed by trained undergraduate research assistants under the supervision of the first author.

Expert Consultation

Before disseminating the quantitative survey, two experts in mental health care treatment for foster care-involved youth were consulted. Experts received a copy of the quantitative survey and qualitative interviews for review. They made recommendations to increase the specificity and clarity of the survey (e.g., distinguish between experiences treating clients in foster care versus other clients with trauma). They also recommended that the list of barriers and facilitators be more consistently formulated based on the EPIS framework to be more generalizable and congruent with implementation literature trends. All expert recommendations were implemented in both the quantitative and qualitative components of the project.

Pilot Testing

A pilot study was completed with three mental health providers with experience treating youth in foster care. A list of clinicians was provided by expert consultants and then were randomly selected for contact. Pilot participants were given a copy of the quantitative interview to complete. They described overall the study as “important,” “informative,” and “easy.” Recommendations were made to increase the clarity of some questions (e.g., define barriers and facilitators multiple times), but all pilot participants described the study as understandable and reasonable. All recommended changes were made to the survey.

Data Analytic Approach

As the purpose of the quantitative study is exploratory in nature, no effect sizes could be predicted due to the paucity of research on this topic. So, a power analysis was not conducted. Instead, prior studies were identified that attempted similar aims on different topics (e.g.,

provider interventions used to treat children with autism, provider perceptions of trauma therapy for maltreated youth; Adams et al., 2017; Allen & Johnson, 2012; Garland et al., 2010). Based on the prior studies of representative samples of providers, the estimated goal sample size was 150 participants.

All data analyses were completed using IBM SPSS Statistics Subscription Package for MAC Os. Statistical significance was defined as $p < .05$ with appropriate controls for experiment-wise error rate. Initial analysis revealed two participants who had completed only the informed consent and then discontinued the survey. These responses were removed from the dataset as they included no data points. Twenty participants (approximately 13% of sample) provided partial responses, with missing values on one or more items. 15 participants (10.1% of sample) provided no response on one or more of the demographic item questions. Approximately 88.7% (n = 133) of the initial sample completed the rates of trauma treatment model usage measure, and approximately 86.7% (n = 130) of the sample completed presence of barriers, difficulty of working with foster care youth, types of barriers, and EBPAS items. A Missing Values Analysis was conducted via Little's (1988) test of Missing Completely at Random (MCAR). Results were not significant $\chi 2(1612, N = 148) = 1421.06$, $p = 0.92$, suggesting that there were no indications the data were not MCAR. To further verify these results, all analyses were run using listwise deletion and statistical results maintained similar patterns (i.e., same correlations remained statistically significant, correlation coefficients remained in the same direction with minimal changes in magnitude). Pairwise deletion was subsequently used in all statistical analyses. Bivariate correlations were conducted to assess associations between rates of use of different treatment models and the rates of use treatment models with EBPAS subscale and total scores.

Quantitative Survey

Quantitative data were analyzed to establish frequency and descriptive statistics for demographic information, treatment models and strategies, barriers and facilitators, EBPAS scores (i.e., across subscales). Scores on the EBPAS were averaged across subscales (i.e., Requirements, Appeal, Openness, and Divergence). A total EBPAS score was calculated by averaging subscale scores (i.e., Requirements, Appeal, and Openness) with the Divergence subscale reverse scored. Open response questions (i.e., number of clients treated in foster care, number of clients treated with trauma, and occupation title) were coded into numerical responses (e.g., removing the word "about" from a response of "about 50") and occupational categories (i.e., social worker, counselor, therapist, administrator, psychologist, academic). Bivariate correlations were calculated between the frequency of use of all treatment models endorsed as "sometimes" or "often" by more than 20% of the sample that completed the measure (i.e., n = 26). Bivariate correlations were also calculated between EBPAS subscale and total scores and frequency of use of treatment models. Correlations were run between all treatment models endorsed as used "often" or "sometimes" in at least 20% of the sample (i.e., n = 26).

Qualitative Interviews

Qualitative interviews were conducted and reviewed to reach saturation (N = 15), the point in which no new information or themes were observed in subsequent interviews (Guest et al., 2006). Undergraduate research assistants then created a de-identified transcript of each interview which another research assistant cross-checked for accuracy.

The present study followed qualitative best practices outlined by Syed & Nelson (2015). Template analysis was used which is a form of thematic analysis that emphasizes an initial coding structure that may be flexibly modified to fit the content of the qualitative data (Brooks et

al., 2015). An initial template was constructed based on the EPIS framework, including concepts related to inner context, outer context, bridging factors, and innovation. Codes were added, removed, and modified based on emergent interviews identified during an immersive, interactive coding process. A team of two researchers (i.e., two doctoral graduate students with experience in qualitative analysis) engaged in open coding, using QSR N*Vivo 12 coding software, interviews, and trading and re-coding previously coded transcripts. A coding manual was developed as a "living document" and modified as needed based on emergent themes identified by the two qualitative coders. The coding manual was developed iteratively (i.e., codes could be modified before completion of initial coding), and coders meet weekly to review the addition, reduction, and modification of new codes. Additionally, coders met bimonthly to review coding progress and to engage in open coding (i.e., where coders reviewed an uncoded manuscript together) to maintain consistency in coding decisions. See Table 2 for the final codebook.

The reliability of our final coding scheme was measured by swapping transcripts coded by the other coder and blindly coding those documents. In addition, coders were randomly assigned to review half of the themes for consistency and clarity. With this process, we achieved 94% reliability. Themes were reviewed in collaborative meetings until coders reached consensus on final themes, and blindly coded transcripts were reviewed for discrepancies which were then resolved amongst the coding team. At the end of these steps, all discrepancies were resolved, and the coding scheme was finalized.

Results

Demographics

Table 3 displays demographic data for the overall quantitative sample (N = 148). The majority of practitioners were female (92%) and between the ages of 35-44 (39%) or 25-34

(35%) years. Participants' racial and ethnic backgrounds were primarily White (87%), followed by Black (7%), Other (3%), Asian (1%), and American Indian or Alaska Native (0.7%). Participants were primarily not Hispanic/Latinx (91%), and most held a master's degree (85%). The majority were licensed as a Professional Counselor (LPC; 40%) or Clinical Social Workers (LCSW; 32%). Most participants worked in community mental health (27%), private practice (25%), or other settings (15%). The vast majority of participants practiced in Southern regions (65%), followed by the Northeast (17%), Midwest (12%), and West (7%). More than half (55%) of participants identified their theoretical orientation as cognitive-behavioral, followed by integrative or holistic (12%), psychodynamic (10%), humanistic (7%), and behavioral (5%). Participants tended to primarily serve school-age children (41%) and adolescents (32%) versus young children (10.8%) and adults (15.5%). The average percentage of participants' caseloads that consisted of youth in foster care was between 1-10% (16% of sample), 11-20% (16% of sample), 21-30% (14% of sample), and 91-100% (12% of sample; Table 3).

Table 4 shows the full demographic data for the qualitative sample (n = 15). A majority of the sample was female (86.7%) and held a master's degree (86.7%). All participants (100%) held a license to provide mental health services, and the most-endorsed clinical setting was community mental health care (40%), followed by child advocacy centers (20%) and private practice (20%). Many participants were licensed as social workers (LCSW; 46.6%) and counselors (LPC; 30%). Almost half of participants practiced in the Southern region of the United States (46.6%), followed by the Northeast (26.7%), West (13.3%), and Midwest (13.3%). The average percentage of clinicians' caseloads that included youth in foster care was 43.7%, and the number of youth primarily being treated for traumatic stress was 77.2%.

Quantitative Results

Frequency of Use of Trauma Treatment Models

Table 5 displays the percentage of use of trauma treatments when working with youth in foster care. The treatments most often endorsed as being used "often" were TF-CBT (65%), client-centered therapy (39%), individual mind-body skills (38%), and family therapy (37%). Treatments most often endorsed as being used "never" for youth in foster care were Intergenerational Trauma Model (98%), Cue-Centered Therapy (96%), and Preschool PTSD Treatment (95%).

Results of bivariate correlation analyses revealed multiple associations between treatment model use. The use of TF-CBT was positively correlated with the use of combined CBT ($p <$ .05), PCIT ($p < .01$,), and Cognitive Processing Therapy (CPT; $p < .01$). TF-CBT use was negatively correlated with the use of play therapy (p <. 05). Client-centered therapy was associated with the use of mind-body skills ($p < .01$)., family therapy ($p < .01$), combined CBT ($p < .01$), art therapy ($p < .01$), and psychoanalysis ($p < .01$). The use of mind-body skills was positively correlated with the use of client-centered approaches ($p < .01$), family therapy ($p <$ .01), play therapy ($p < .01$), art therapy (p < .01), psychoanalysis (p < .01), and CPT (p < .01). Family therapy was correlated with the use of play therapy ($p < .01$), CPP ($p < .01$), combined CBT ($p < .01$), art therapy ($p < .01$), and psychoanalysis ($p < .01$). Play therapy was positively correlated with the use of CPP ($p < .01$), combined CBT ($p < .01$), and art therapy ($p < .01$). CPP was correlated with the use of combined CBT ($p < .01$). Combined CBT was positively correlated with art therapy use ($p < .01$). Art therapy was associated with the use of psychoanalysis ($p < .01$) and CPT ($p < .01$; Table 6).

Barriers, Facilitators, and Level of Difficulty Working with Youth in Foster Care

The vast majority of participants reported encountering barriers when working with clients in foster care (98%) and less than half reported encountering facilitators (39%; Table 7).

The majority of participants reported that treating trauma in youth in foster care was harder than treating their typical caseload ("much harder" = 27.7%, "somewhat harder" = 57.7%), with only three participants describing working with foster care youth as easier than their typical caseload. The vast majority of participants also described treating trauma in youth in foster care as harder than treating trauma in other clients ("much harder" = 23.1%, "somewhat harder" = 60.8%; Table 8).

Types of Barriers and Facilitators Encountered when Treating Youth in Foster Care

Inner contextual factors (i.e., assessment of symptoms, clinician preferences, values and practices, and agency policies and support) were primarily endorsed as facilitators (36.2-68.5% of sample), with some clinicians identifying them as barriers (2.3-22.3% of sample). Some outer contextual factors were primarily identified as barriers (i.e., foster child factors, biological caregiver factors, working with caseworkers and court systems; 59.2-86.2% of sample). Foster parents were identified as both barriers and facilitators (86.2% and 46.2% of sample, respectively). Approximately one-quarter of the sample (29.2%) reported funding and access to training as barriers, while most clinicians indicated their access to training was a facilitator (67.7% of sample). Bridging factors (i.e., community-academic partnerships) were not widely endorsed as barriers or facilitators (15.4% and 24.6%, respectively). Innovation factors (i.e., treatment models) were widely endorsed as facilitators (78.5%) rather than barriers (10%). The vast majority of participants indicated "other" barriers (88.5%) and some facilitators (26.8%). Open responses of other barriers and facilitators include mental health stigma, negative

experiences with mental health treatment in the past, changes in placements disrupting service delivery, inefficient referrals and support to attend services, positive results from alternative treatment approaches, and benefits of agency prioritization of youth in foster care. See table 9 for full results.

Evidence-Based Practice Attitudes Scale Results

Results for the overall EBPAS score indicate that providers in the present study viewed EBPs and EBTs positively and are widely willing to utilize manualized treatments in their practice (M = 2.86, SD = 0.53). EBPAS subscales indicated that participants would be most likely to adopt an EBP or manualized treatment if it intuitively appealed to them (M = 3.20, SD = 0.69) or if they were open to utilizing new practices and interventions (M = 2.71, SD = 0.73). Participants were also somewhat likely to utilize an EBP or manualized treatment if required by their supervisor, agency, or state (M = 2.45, SD = 1.07). Scores on the Divergence subscale were somewhat elevated (M = 3.09, SD = 0.58), indicating participants viewed their practice as typically divergent with academic researchers and EBTs. See Table 10 for full results on EBPAS individual items and Table 11 for subscale scores.

Bivariate correlations revealed significant positive correlations between overall EBPAS scores and TF-CBT ($p < .01$), PCIT ($p < .05$), and CPT ($p < .05$), indicating that clinicians who had more positive attitudes toward EBPs, manualized treatments, and evidence-based interventions were more likely to report using TF-CBT, PCIT, and CPT. The Openness subscale was also associated with the use of TF-CBT ($p < .01$), PCIT ($p < .05$), and CPT ($p < .05$), suggesting that providers who weremore open to trying new practices were more likely to report using those models. The Appeal Subscale was positively related to TF-CBT ($p < .01$), PCIT ($p < .05$), and EMDR ($p < .01$) use, indicating that providers who were more likely to utilize EBPs

and manualized interventions tended to use those models frequently. Clinicians who were more likely to utilize EBPs if they are required by authority figures (i.e., Requirements scale) tended to report using TF-CBT ($p < .05$) and CPT ($p < .05$). The Divergence subscale was positively correlated with family therapy ($p < .01$), art therapy ($p < .01$), play therapy ($p < .01$), and CPP ($p < .01$), and negatively correlated with TF-CBT ($p < .01$) and PCIT ($p < .01$) use. This suggests that therapists who view their typical practice as divergent from research-based interventions were more likely to use interventions such as family therapy ($p < .01$), art therapy ($p < .01$), play therapy ($p < .01$), and CPP ($p < .01$). In contrast, clinicians who view their typical practice as convergent with research and manualized treatments were more likely to use TF-CBT ($p < .01$) and PCIT ($p < .05$). See table 12 for full results.

Qualitative Results

The following sections summarize each of the ten themes and 21 subthemes across EPIS constructs (i.e., inner context, outer context, bridging factors, and innovation) identified through our template coding approach. Primary themes are identified in ***bold and italics***, and subthemes are identified in *italics*. A comprehensive list of themes can be seen in Table 13. I also analyzed qualitative results by clinician region of residence (i.e., West, Midwest, South, and Northeast) and by determinant type (i.e., barrier and/or facilitator). See Table 13 for detailed results. Representative quotes for each subtheme are located in Table 14.

Inner Context

We identified multiple themes related to inner contextual factors (see Table 13). Participants frequently spoke about factors related to ***clinician characteristics*** (100% of sample). All participants discussed the *assessment of symptoms* when working with youth with trauma symptoms in foster care. The majority described barriers (74% of references), including

difficulty completing a comprehensive assessment with youth in foster care due to lack of background information, feeling pressure that treatment targets should be focused on stabilization and decreasing disruptive behaviors to avoid placement disruptions, difficulty discerning if current symptoms are related to psychopathology or a developmentally-appropriate reaction to trauma, and insufficient assessment (e.g., DSM 5 criteria) methods for young children and children who have experienced severe complex trauma. Some clinicians described facilitators (26% of references) related to assessing symptoms, such as sometimes receiving a comprehensive history from caseworkers and court documents or having access to documents that might not typically be shared with clinicians (such as school and medical records).

Participants also often spoke about their approach to *patient-client advocacy* (60% of sample). A little more than half of references were facilitators (57%), and many were barriers (43%). Facilitators referenced included having an opportunity to advocate on clients' behalf in court to both build rapport, working to facilitate smooth changes in placements (e.g., following up with schools to ensure 504 plans are implemented when clients transfer), and facilitating access to comprehensive resources like wrap-around services. Barriers discussed were clinicians being asked to speak outside of their scope of practice in court, such as making recommendations on placements, being asked to facilitate visitation, and feeling that permanency in placements is contingent on rapid reductions in symptoms.

Clinician theoretical approach was widely spoken about as both a facilitator (44% of references) and a barrier (56% of references). Participants described using various treatment models, such as motivational interviewing, TF-CBT, solution-focused therapy, play therapy, EMDR, PCIT, CPP, and other trauma-related models. The vast majority of clinicians describe using a highly blended approach, borrowing from numerous treatment manuals and methods, to

treat trauma in youth in foster care. Many references were made to focusing treatment on rapport-building, and clinicians described spending increased time on rapport when initiating services for youth in foster care. Most clinicians described themselves as having a specialty in working with youth in foster care and seeking out training to develop their expertise with the population. Barriers to theoretical approach included court systems making recommendations for specific therapy models (e.g., PCIT) when therapists either were not trained in the model or could not facilitate the model (e.g., parents have no contact with their child when a family intervention is recommended). Many clinicians also referenced the barrier that they do not or strongly prefer not to work with offending caregivers, even if child welfare pursues reunification.

The vast majority of participants discussed ***organizational characteristics*** (93% of sample) related to treating trauma in youth in foster care. *Agency policies and support* were widely described as facilitators (66% of references) versus barriers (34%). Many references were made to working in supportive agencies and with encouraging supervisors and clinic directors. Some participants spoke about receiving breaks from agency policies (e.g., productivity requirements) to allow for supplemental paperwork, collaboration, and consultation related to working with youth in foster care. Others discussed how agency policies and models (e.g., medical models, integrated care settings) are not ideal for complex foster care cases or how agency requirements (e.g., session limits, productivity expectations, scheduling processes) impede the therapeutic process.

Some participants (40%) of the sample described challenges *balancing confidentiality across multiple systems*. References included challenges due to clinicians having access to more information about client history and case information than foster parents, requiring additional monitoring and care when making treatment plans and writing case notes. Others reported

challenges to obtaining appropriate documentation to release information to collaborating partners (e.g., schools, wrap-around services) due to different regulations on who maintains guardianship for youth in foster care depending on the state and situation.

Staffing and turnover was discussed by one-third of the sample. References were split between barriers (51%) and facilitators (49%). Barriers included overburdened caseloads, a lack of therapists trained in trauma treatments, and difficulty maintaining comprehensive treatment teams due to turnover. Facilitators described included state-wide funding initiatives to retain therapists and agency emphasis on increasing staffing to reduce caseload burden.

Outer Context

All participants spoke about ***client characteristics*** that influence their treatment of youth in foster care. Each participant referenced *foster child characteristics*, primarily as barriers (77%) versus facilitators (23%). Discussion centered around how youth in foster care have often been in therapy repeatedly and may be burned out, mistrusting, or not desire to attend services in the first place. Additionally, many participants talked about youth in foster care having attachment-related problems at much higher rates than youth in other care settings, which may lead to inappropriate rapport with clinicians (overly attached or uncaring) and challenges in identifying the most critical symptoms to treat in therapy first. Many therapists felt uncomfortable attempting to address attachment-related concerns with youth who still were not in permanent placements and may have their current caregiving relationship ended in the future. Therapists also described challenges utilizing treatment models with youth who view trauma disclosure as what led to their removal from biological caregivers as they worry that further disclosure will lead to additional removals or termination of rights. The vast majority of

references related to facilitators centered around the idea of foster care youth as a highly resilient, open, and eager-to-learn population.

Foster parent characteristics were discussed by all participants, primarily as barriers (68% of references). Many participants described "two types" of foster parents, those that view their primary job as providing shelter and safety, reserving mental health concerns for permanent placements, and those that are extremely eager to support mental health treatment efforts for youth in care. Some participants referenced working with foster parents as a challenge because they tend to be overburdened with multiple children and have limited ability to attend sessions with their foster child. Multiple participants described the challenges of working with foster caregivers due to concern that the placement will be disrupted if symptoms increase briefly, as is typical for many clients during trauma treatment. Facilitators were foster parents' eagerness to support their foster children, their expertise navigating the multiple systems in which foster care youth intersect, and their ability to model healthy parenting strategies.

Biological parent factors were reported by most of the sample (93%), with the majority being barriers (68%) rather than facilitators (32%). Barriers included biological caregivers not wanting to hear trauma narratives, challenging child descriptions of trauma, and mistrusting mental health professionals, especially if a previous provider reported the abuse or neglect that caused the removal from the home. Other barriers included biological parents often having fewer resources and their own mental health difficulties, which can interfere with treatment attendance or following child welfare requirements for reunification. Facilitators included an increased sense of "commitment" of biological caregivers, as they desperately want reunification with their children, while foster parents may go into the relationship expecting the placement to end at

some point. Additional facilitators include court-mandated attendance to therapy, which reduced no-shows.

Some participants described the role of ***funding***, particularly external funding (47% of sample) and payment for services (73% of sample). Most references to *external funding* were barriers (52%), including substantial grant-writing requirements and concerns that external funding will be reduced. Facilitators (48%) were the wide availability of grants and other funding mechanisms for treating youth in foster care. *Payment for services* was described as a facilitator (53%) and a barrier (47%). Clinicians stated that youth in foster care typically receive government-subsidized insurance upon entering into care, thus eliminating lapses in coverage or a total lack of insurance. However, Medicaid reimbursement for services is often much lower than private insurance rates and does not cover the substantial work required before session (e.g., obtaining consent, tracking down caseworkers) and after session (e.g., coordinating with other service systems).

Participants frequently referenced the role of the ***service environment*** in relation to the treatment of youth in foster care. All participants discussed the process of working with *caseworkers*, primarily as barriers (66%) rather than facilitators (34%). Many references were made to the difficulty of getting in touch with caseworkers, obtaining critical background information, and receiving pertinent treatment information (e.g., biological parental rights have terminated). Other barriers referenced include caseworkers not using a trauma-informed approach or advocating against reunification with biological parents. Facilitators primarily center around caseworkers as an ideal liaison between service systems when given sufficient resources and manageable caseloads. Some clinicians even referenced certain caseworkers as the most trusted adult in many youths' lives and as critical agents of change during the therapy process.

Fourteen of fifteen participants described working with *court systems*. Most barriers (70%) included the pressure and anxiety associated with foster care youth attending court, judges viewing therapy as a "magic wand," and courts ruling that foster care youth receive specific treatment models (e.g., TF-CBT, PCIT) even when not appropriate for treatment needs and goals. Clinicians sometimes spoke of the benefits (30% facilitators) court systems may provide, such as carefully considering clinician input regarding therapeutic goals and how those relate to placements, supporting access to treatment through implementing resources (e.g., no-cost treatment), and developing and implementing specialty courts for youth in foster care (e.g., safe babies court).

All participants discussed working with the *foster care system*, primarily as barriers (89%). Most references described the challenges of working with youth in a system with too few foster homes where changes in permanency are inevitable. In particular, therapists referenced difficulty determining if working on attachment issues, relational problems, or even trauma from a change in placement is appropriate or feasible when youth are sure to be removed from their current placement at some point. Other clinicians described experiencing a push for reunification due to a lack of adoptive and foster homes rather than that being the ideal placement for youth. Additionally, participants stated that, due to a lack of foster placements, youth are often required to change not only placements but also schools, doctors, therapists, and other service providers due to their distance from the new placement. An emphasis on trauma-informed training across the system was the primary facilitator discussed.

Nine participants (60% of sample) described *policies and legislation*, primarily as barriers (77%). References included the challenges of policies implemented on a broad level impeding youth wellbeing. For example, one participant described that their state requires

visitation for all youth under the age of 12 until parental rights are terminated, even if biological parents frequently no-show or the child becomes extremely agitated after each visit. Others described how initiatives to increase familial placements led to closing essential services such as group homes and residential placements for youth with severe mental health problems. Facilitators included recent changes in state-wide policies to support access to mental health and medical care.

79% of the sample described *systemic considerations*, such as racism, sexism, poverty, and stigmatization of mental health difficulties. Multiple participants described the challenges of a mismatch between youth race and foster home race, as youth may feel there is no room for their personal culture and identity in some foster homes. Others described how foster parents might require youth to attend religious services, despite differing youth religious beliefs or how youth may struggle to adapt to substantial changes in socioeconomic status when moving placements. Many clinicians also reported that stigmatization against mental health problems and substance use might interfere with biological parents' access to resources and subsequent progress toward reunification. Facilitators (21%) described specific training and programs to support diversity, equity, and inclusion across the foster care system.

Access to training was most often described as a barrier (60%), with participants reporting little access to training related to working with youth in foster care, navigating the foster care system, and treating trauma in youth in the foster care system. Many participants reported widespread availability of training in numerous interventions (e.g., TF-CBT, PCIT, CPP) but little support for logistical challenges such as lodging, professional leave, childcare, or reimbursement for billing requirements. Others indicated that youth in foster care are rarely referenced in training once they can attend them.

Bridging Factors

Twelve participants discussed the facilitators (67%) and barriers (33%) related to ***collaboration with other agencies***. Many references were made to the presence and benefit of collaborative relationships with other agencies and service providers to support the needs of youth in foster care. Others described how collaboration allows for referrals to providers with specialty training (e.g., youth under 5) or higher care levels (e.g., residential treatment). Barriers that the clinicians referenced were primarily related to the frustration of collaborative relationships, not having sufficient resources, or not having room in their caseloads to make referrals when needed. Similarly, about two-thirds of the sample described their involvement with ***community-academic partnerships***, primarily as facilitators (79% of references). Most of these facilitator references described existing partnerships with research centers, universities, and hospitals that support evidence-based training in trauma treatments. Content of barriers (21% of references) included, although community-academic partnerships are beneficial, they often require additional effort from clinicians in the form of supplemental paperwork, administration of research measures, and attendance at conference calls.

Innovation

Most participants (93% of sample) discussed how ***attributes of trauma treatments*** impacted their provision of mental health services to youth in foster care. Many clinicians described difficulty (barriers = 64% of references) adhering to manualized interventions with fidelity because additional sessions were needed to build rapport and establish future safety. Others indicated great difficulty identifying a trusted adult to share trauma narratives, such as in TF-CBT, or needing sessions focused on therapeutic disclosure because youth may be reluctant to share trauma histories due to fears of subsequent removals or termination of parental rights.

Clinicians also described trouble utilizing manualized treatments due to uncertainty about the length of treatment and concerns about beginning trauma exposure and services being terminated in the middle of the most difficult, triggering treatment modules. Additionally, some providers referenced the need to spend more time reviewing emotion regulation, healthy coping, and positive relationships as youth in foster care tend to have more difficulty identifying and utilizing those skills. Overall, therapists described the treatment models they use as effective and efficient and indicated most challenges are related to a lack of permanency, youth mistrusting adults, and an increased time spent modeling and discussing how healthy emotional wellbeing looks.

Discussion

The present study used a mixed-method approach to understand how clinicians treat trauma symptoms when working with youth in foster care, a particularly vulnerable group with high rates of traumatic stress (Greeson et al., 2011). Through quantitative surveys and qualitative interviews, I identified what specific therapeutic approaches clinicians tend to use when working with youth in foster care, what providers' attitudes are toward EBTs, which barriers and facilitators impact the treatment of trauma, and how providers adapt existing treatment models to fit perceived barriers and facilitators. Questions were considered through the lens of the EPIS framework, specifically the exploration phase (Aarons et al., 2011). To date, this project is the first of its kind to surveys mental health providers regarding their experiences, practices, and challenges related to treating youth experiencing trauma symptoms while in foster care. Given the paucity of research in this area, the goal of this study was to provide an exploratory analysis of provider practices, attitudes, and challenges when working with youth in foster care.

Participants represented a diverse group of mental health providers residing across geographically diverse regions (e.g., southern rural areas, metropolitan northeast areas).

Providers held various education and licensure types (e.g., master's level, Ph.D.; LCSW, LPC, Psychologist). Most clinicians indicated having multiple years of experience serving youth in foster care (i.e., more than six years). Most providers reported using a cognitive-behavioral theoretical orientation (55%), congruent with the rising popularity and use of cognitive-behavioral models (Cook et al., 2010; Gaudiano, 2008). This may also be related to recruitment methods that may have overrepresented providers who use cognitive-behavioral models (e.g., EBT training initiatives). Most providers held master's level degrees, which is in line with national surveys of mental health providers serving children in community settings (National Science Foundation, 2017). Participants tended to work in community mental health (27%) and private practice (25%) settings. Both the quantitative and qualitative samples overrepresent providers from southern regions of the country (64% and 47%, respectively), which is likely due to increased responsiveness and dissemination of this project from southern-based training initiatives. Results should be considered with an increased focus on experiences for providers in the southern United States.

Results indicated that providers tend to utilize a wide range of trauma treatment models when working in youth in foster care, and the vast majority (91% of the sample) endorsed utilizing at least one EBT to treat trauma symptoms (i.e., TF-CBT). Providers in the present study also found working with youth in foster care as more challenging than working with other clients, even clients with significant traumatic stress symptoms. Furthermore, clinicians in the present study outer contextual variables as challenges (i.e., foster child attributes, foster caregiver attributes, biological caregiver attributes, and working with caseworkers) rather than inner contextual or innovation factors (e.g., supervisor support, fit of existing treatment models). Indeed, providers indicated both quantitatively and qualitatively that most of the challenges they

encounter are related to broader, systemic issues such as lack of stable foster care placements and overburdened caseworkers. In contrast, clinicians said inner contextual and innovation factors were the most beneficial to their work treating trauma symptoms in youth in foster care. Finally, providers in the present sample held positive attitudes toward EBTs and reported being willing to use manualized treatments in their practice. The a priori hypothesis made in the present study was that providers with higher scores on the EBPAS would be more likely to endorse using interventions with substantial empirical support (e.g., TF-CBT). Findings tended to support this hypothesis, where providers with higher overall scores on the EBPAS were more likely to report using TF-CBT, PCIT, and CPT, all well-supported empirical treatments. In sum, providers from the present study were open to utilizing EBTs, using at least one EBT to treat trauma in foster care youth, and encountering most difficulties when managing the challenges related to the multiple systems foster care youth intersect with.

Findings and Implications of Specific Aims

Providers' Reported Frequency of Using Trauma Treatment Models When Serving Youth in Foster Care

The first specific aim of this study was to examine the frequency of use of therapeutic approaches and strategies by clinicians treating trauma symptoms in youth in foster care. TF-CBT was the treatment most frequently endorsed as used "often" or "sometimes." This finding is in line with research indicating that TF-CBT is one of the most frequently recognized and implemented EBTs in the treatment of child trauma (Allen & Johnson, 2012; Wherry et al., 2015). However, this finding may be surprising given the sample characteristics (i.e., primarily working in community mental health, using a variety of non-EBT approaches). The high rates of TF-CBT use may be congruent with providers' attitudes toward EBTs broadly, as EBPAS scores

in the present study were even higher than community samples and may reflect a willingness to use EBTs like TF-CBT.

Although the high rates of using TF-CBT may be reflective of provider practices and attitudes when treating youth in foster care in general, it is essential to consider that the findings may also be related to the nature of the sample. Participants expressed positive opinions toward EBTs and may be more likely to utilize a widely disseminated EBT than typical providers serving youth in foster care. This is further supported by relatively low rates of endorsement of other therapeutic models commonly used by community providers (e.g., play therapy, art therapy, family therapy), as other community clinician samples indicate rates of usage for these models as high as 61% (Urban et al., 2020; Wherry et al., 2015). Alternatively, EBPAS score findings may indicate that providers perceive the treatments they use as evidence-based, despite limited empirical evidence for interventions such as nondirective play therapy, as providers in previous studies also frequently identified treatments that have limited empirical support as EBTs (Wherry et al., 2015). So, providers may believe they are using EBTs when they are not and would also report positive attitudes toward EBTs, if they participated in a study such as this one.

Despite the frequent endorsement of TF-CBT use, providers in this study qualitatively referenced conflicting feelings about engaging in a trauma treatment like TF-CBT with youth in foster care. As an example, a critical principle of TF-CBT is to begin therapy services only after trauma exposure has ceased (Cohen et al., 2008), and this may be unachievable when youth reside in a system that, by nature, will typically lead to additional changes in caregivers and subsequent potential traumatic events (Cook et al., 2005; Ko et al., 2008). However, it is essential to note that TF-CBT developers propose that the model may be used with clients

experiencing ongoing traumas with certain adaptations, though there are few empirical evaluations of TF-CBT with clients experiencing ongoing traumas (Cohen et al., 2013; Murray et al., 2013).

Surprisingly, rates of PCIT use were lower than previously reported in child advocacy centers and community samples (Allen et al., 2012; Allen & Johnson, 2012; Wherry et al., 2015), which is intriguing given that PCIT is also a widely disseminated, manualized intervention, like TF-CBT. Some providers described using PCIT when working with foster care youth in the qualitative interviews, but references centered on decreases in disruptive behaviors rather than trauma symptoms. There is some empirical support for the use of PCIT in maltreated youth with trauma symptoms (Timmer et al., 2010; Urquiza & Timmer, 2014), but it is noteworthy that PCIT is not a model that includes trauma processing. Providers in the present sample may not be using PCIT, despite being trained or having access to training, due to PCIT's lack of emphasis on decreasing trauma symptoms. These findings may also be related to the practice settings endorsed in the sample, as most endorsed working in community mental health or private practice settings, and the referenced studies regarding PCIT usage primarily include providers working in child advocacy centers. Finally, providers may not consider using PCIT when primarily treating trauma symptoms, which the questions of this study focused on.

Relationships Between Treatment Models and Providers' Reported Use of Them

TF-CBT use was correlated with the use of PCIT and CPT, which may be related to the fact that all three treatments are manualized EBTs rooted in cognitive and behavioral theories (Cohen et al., 2006; McNeil& Hembree-Kigin, 2010; Resick et al., 2016) and all have been widely disseminated in various practice settings across the country (Beveridge et al., 2015; Chard et al., 2012). The correlation between TF-CBT, PCIT, and CPT also may reflect the

tendency of providers to use treatment models that align with their primary theoretical orientation (e.g., cognitive-behavioral) or are used within their peer network (Stewart et al., 2012; Tan, 2002).

TF-CBT use was also negatively correlated to family therapy and play therapy. This may be reflective of the structure of TF-CBT, which is primarily individualized and talk-focused, although family and play elements are encouraged (Cohen et al., 2006). So, providers using TF-CBT may have less opportunity to use family and play therapy approaches. Alternatively, this may show a tendency for providers who use cognitive behavioral interventions to avoid interventions developed based on other psychological theories, such as attachment or systems' theories (Gyani et al., 2014; Powell et al., 2013). The negative correlation between TF-CBT and family and play therapy are also in line with responses on qualitative interviews, as providers tended to report using either multiple cognitive-behavioral treatments or various psychodynamic or holistic models.

Overall, psychodynamic and holistic model rates of use tended to be correlated with one another (e.g., mind-body skills correlated with art therapy and psychoanalysis). This finding seems intuitive, as congruence with provider theoretical orientation is one of the most critical factors clinicians utilize when choosing intervention models (Gyani et al., 2014). It is important to note that, in the present study, some providers chose to utilize both cognitive-behavioral and psychodynamic or holistic models. Slightly more than half of participants described their primary theoretical orientation as cognitive-behavioral, and more than half of participants reported using a variety of non-CBT models such as client-centered therapy, mind-body skills, and play therapy. So, there was undoubtedly overlap in providers who reported primarily using a cognitive-behavioral theoretical orientation and psychodynamic and holistic treatment models.

This is incongruent with previous literature indicating compatibility with primary theoretical orientation is a key determinant of model use (Gyani et al., 2014; Stewart et al., 2012). Additionally, this may reflect that some providers in this sample are willing to diverge from their primary theoretical orientation when using treatment models.

Interestingly, CPP was correlated with combined CBT use, family therapy, play therapy, but not psychoanalysis. As CPP is an attachment-based, psychodynamic intervention for childhood trauma, it is intriguing that CPP use was correlated to CBT use (Lieberman et al., 2015). CPP may be uniquely positioned as both an empirically supported intervention for childhood trauma and an intervention rooted in psychodynamic theory (Silverman et al., 2008). It is possible that providers who primarily utilize CBT models are more willing to utilize CPP, as it has empirical support, which has been demonstrated as a key factor for clinicians who work from a cognitive-behavioral framework (Gyani et al., 2014; Powell et al., 2013). Alternatively, it may reflect the penetration of CBT principles across theoretical orientations, where providers who do not primarily utilize a CBT framework still often endorse utilizing CBT components rather than full CBT models (Becker-Haimes et al., 2019; Benjamin Wolk et al., 2016; Garland et al., 2010). Indeed, CPP is an efficacious model that may be ideal for dissemination and implementation efforts, particularly among providers utilizing theoretical frameworks other than cognitive-behavioral. CPP integrates psychodynamic principles that are already widely used in community settings, particularly for child-serving providers, and requires fewer deimplementation efforts for some providers who may be less willing to diverge from their primary theoretical orientation (Beidas et al., 2015; Beidas et al., 2017; Garland et al., 2010; Smith et al., 2020).

Barriers and Facilitators to the Treatment of Youth in Foster Care Across EPIS Constructs

The present study examined the barriers and facilitators providers encounter across the exploration phase of EPIS constructs. Participants reported working with youth in foster care as more difficult than working with youth in other living arrangements or other youth with trauma-related symptoms. The finding that working with youth in foster care is more difficult than working with "typical" clients is perhaps unsurprising, given the high rates of trauma exposure and multiple system involvement (Geenan & Powers, 2007; Greeson et al., 2011). Providers describing working with youth in foster care with trauma as more difficult than working with other trauma clients underscores the difficulty of treating this population. Treating traumatic stress is a taxing job for mental health professionals, leading to an increased risk for the development of numerous adverse effects, such as vicarious trauma, burnout, increased substance use, and turnover. Negative outcomes are especially prevalent for providers working in the child welfare system and treating complex trauma resulting from severe child abuse (Armes et al., 2020; Bourke & Craun, 2014; Dagan et al., 2016; Itzick & Kagain, 2017; Sprang et al., 2011). Clinicians in this sample describing their work with foster care youth as even more challenging than usual highlights the importance of utilizing research and clinical findings to identify effective treatment models and provide supportive mechanisms that may reduce stress and burnout (Armes et al., 2020; Miller et al., 2017).

Notably, providers in this sample primarily endorsed a variety of outer contextual variables as barriers. Conversely, they frequently endorsed inner contextual variables as facilitators. Findings indicated that providers encounter many barriers in outer contextual variables to the treatment of youth in foster care. This finding is somewhat surprising, given that the vast majority of implementation efforts target inner contextual factors (e.g., therapist attitudes) or innovation factors (e.g., attributes of specific treatment models; Moullin et al.,

2019). However, the focus of inner contextual factors in implementation efforts may reflect a tendency for researchers to seek to adapt inner contextual, innovation, and bridging factors rather than outer contextual factors. Outer contextual factors tend to be much more challenging to modify and require substantial involvement from other contexts (e.g., policymakers within the child welfare system; Durlak & DuPre, 2008; Greenhalgh et al., 2004; Johnson et al., 2019). The focus on outer contextual barriers may also correlate to the emphasis of both quantitative and qualitative measures on system involvement and navigation when working with youth in foster care. Clinicians may be more likely to focus on day-to-day challenges (e.g., support from supervisors) when not prompted to consider broader systemic challenges like in the present study (Zbukvic et al., 2020). Furthermore, providers whose work intersects with the child welfare system may be more aware of systemic issues than other providers, as lack of sufficient child welfare system resources is often cited a critical barrier to the implementation of innovative services methods and interventions (Greeson et al., 2015; Luongo, 2007). In sum, outer contextual variables pose substantial challenges to the successful treatment of youth in foster care who are experiencing trauma symptoms. So, it is necessary to consider outer contexts when developing implementation efforts, rather than assuming barriers to implementation can be resolved entirely with only inner contextual-level changes.

Attitudes of Providers Toward Evidence-based Treatments and Their Utilization

Participants widely endorsed a willingness and openness to utilize evidence-based treatments and typically described their clinical work as congruent with empirical evidence. Results on the EBPAS were somewhat higher than national norms, although participants in this sample reported substantially higher scores on the Divergence subscale (Aarons et al., 2010). When compared to national norms, providers in the present sample viewed their clinical practice

as divergent from EBT use despite having positive attitudes toward EBTs broadly. These results may suggest a lack of utilization of EBTs and empirical evidence in everyday clinical practice. However, results from both the quantitative and qualitative surveys indicate that providers are utilizing at least one EBT when working with youth in foster care, and many participants endorsed utilizing more than one EBT.

Furthermore, qualitative interview participants often spoke about the role of existing manualized EBTs (e.g., TF-CBT) in the treatment of youth in foster care. Scores on all other EBPAS subscales were comparable or higher than national norms, indicating an openness to utilize EBTs, especially when interventions are found to be intuitively appealing or required by supervisors or agencies. While highly speculative, the results may reflect that providers in the present sample are open and eager to utilize EBTs, they are unable or unwilling to do so due to extraneous factors (e.g., lack of evidence for youth in foster). It is also possible that providers view other factors of their clinical practice, rather than the models they use, as divergent from empirical evidence. Future studies should seek to replicate and better understand this relationship.

Relationship Between Evidence-Based Treatment Attitudes and Intervention Model Usage

Several statistically significant relationships were revealed between provider EBPAS scores and the use of trauma treatment models when working with youth in foster care. Specifically, there was a negative association between two evidence-based, manualized interventions (i.e., TF-CBT and PCIT) and Divergence scores. This finding is perhaps intuitive, as providers using evidence-based treatments in their practice already are likely to identify their clinical practice as convergent with empirical research (Aarons et al., 2010). Interestingly, although CPT use was correlated with TF-CBT and PCIT use, no statistically significant results

were found between CPT and Divergence scores. This may be due to the relatively small sample size, especially the number of clinicians who endorsed CPT use (n = 46). Conversely, higher Divergence subscale scores were positively associated with higher rates of family, play, and art therapy, and CPP use. Family therapy, non-directive play therapy, and art therapy have more limited evidence for the treatment of trauma, which may explain the positive association with a scale measuring Divergence from empirical evidence (Dorsey et al., 2014; Silverman et al., 2008). However, it is important to note that many evidence-based treatment models for trauma utilize family involvement, playtime, and artistic activities (Cohen & Mannarino, 2008; McNeil & Hembree-Kigin, 2010; Lieberman et al., 2015). The relationship between CPP use and Divergence scores is intriguing, as CPP is both empirically supported and psychodynamically based. Providers may be unaware of the evidence for the use of CPP. Perhaps this also illustrates how the terms evidence-based, manualized, and cognitive-behavioral are often spoken of interchangeably, although some non-CBT and non-manualized treatment models have empirical support for improving trauma symptoms (e.g., CPP, EMDR; Lieberman et al., 2006; Rodenburg et al., 2009).

Scores on EBPAS Appeal subscale scores were correlated with TF-CBT, PCIT, and EMDR use. While the mechanisms of TF-CBT and PCIT are reasonably well understood (Deblinger et al., 2011; Lewey et al., 2018), the “active ingredients” of EMDR are more unclear. Some evaluations suggest that EMDR primarily operates via exposure and the bilateral movements are extraneous, while others propose more complex, cognitive and neurological processes where bilateral movements are integral (Lee & Cuijpers, 2013; Lohr et al., 1999; Gunter & Bodner, 2008; Perkins & Rouanzoin, 2002). Given this, it is interesting that clinicians who said they would be more likely to use an intuitively appealing EBT were more likely to

utilize EMDR, an EBT that is not well understood (Landin-Romero et al., 2018). Providers that utilize EMDR may find the treatment intuitively appealing on a personal or emotional level. This may reflect a tendency of providers to rely more on intuitive personal appeal rather than a clear, simplistic scientific explanation of how an EBT works.

Strategies and Adaptations Made by Mental Health Providers

In the present study, providers' quantitative responses indicated overall satisfaction with the trauma treatment models they use and primarily described the models as facilitators. However, it is important to note that the quantitative survey did not directly ask about specific adaptations providers make in their clinical practice, just if they make adaptations or not. In qualitative responses, providers tended to speak broadly about the success and benefits of treatment models. However, in specific responses most providers described barriers when referencing treatment model use for youth in foster care.

First, multiple providers referenced the challenges of completing models that require a trauma narrative (e.g., TF-CBT) due to a lack of a trusted adult in foster care youths' lives and youth fearing that accounting their trauma history will lead to future changes in placement or termination of parental rights. This is particularly concerning, as providers who serve youth not in foster care already report a reluctance to utilize exposure components of TF-CBT which may lead to attenuation in therapeutic benefit (Allen & Johnson, 2012). This finding is even more pronounced among therapists with a theoretical orientation other than CBT, as clinicians trained in non-directive approaches may believe younger children lack the verbal ability to describe their trauma (Allen & Johnson, 2012). Taken together, dissemination and implementation efforts of TF-CBT should both emphasize the importance of directive and exposure-based components to produce desire therapeutic benefit and address adaptations to identify appropriate trusted adults

in foster care youth's lives (e.g., caseworkers). Fortunately, the TF-CBT manual for foster care youth addresses these issues in-depth, although it is unclear whether the adaptations have been tested empirically with foster care samples or if this manual is currently being used in implementation efforts (Deblinger et al., 2016).

Second, many providers also referenced challenges when engaging in feeling identification and development of healthy coping skills across a number of treatment models. Providers' reported challenges may align with previous research suggesting that modifications to treatment manuals may be necessary for clients exposed to complex trauma, like many youth in foster care (Cohen & Mannarino, 2011; Cohen et al., 2012; Spinazzola et al., 2005). Modifications have been made to TF-CBT to increase the emphasis on relaxation, affect expression, emotion regulation, and cognitive coping in samples with complex trauma and were found to be effective (Cohen et al., 2012). However, other studies support the use of standard TF-CBT without modifications for foster care populations (Dorsey et al., 2014). There do not appear to be other treatment manuals that specifically reference the challenge of feeling identification and healthy coping in relation to foster care populations, although there are many treatment models and approaches that specifically address complex trauma and impacts on emotional development (Arvidson et al., 2011; DeRosa & Pelcovitz, 2006; Lawson & Quinn 2013; Lieberman et al., 2015).

Third, numerous references were made to the challenges of treatment delivery when changes in placement are highly unpredictable, and clinicians may have little to no notice that foster care clients were being moved and would no longer be receiving services. Notably, providers also referenced that youth in foster often would benefit from more sessions than typical clients, which creates a substantial tension between providing high-quality care and

accommodating youth's living arrangements. The only treatment manual we found specifically for the treatment of youth in foster care (i.e., TF-CBT) requests an increase in treatment length to approximately 25 sessions (Deblinger et al., 2016). According to many providers in the present study, a treatment manual such as this would not be feasible with the vast majority of foster care youth they serve.

Finally, multiple clinicians referenced the importance of addressing broader, systemic issues such racial trauma. Clinicians noted that this was especially important in foster families with a mismatch in foster caregiver and foster youths' racial, ethnic, or religious backgrounds. Providers indicated that many foster care youth reference the current political climate where issues of diversity, equity, and inclusion are at the center of the American society, including mental health treatment (Bor et al., 2018; Weine et al., 2020). The importance of addressing issues of marginalization in therapy is underscored by the systemic inequalities highlighted in the child welfare system. Youth from marginalized backgrounds are much more likely to experience child welfare involvement and removal from the home than other youth (Dunbar & Barth, 2008; Hill, 2007; Magruder & Shaw, 2008; Wells et al., 2009). This is notable in the context of trauma treatment, as marginalization and oppression are often referenced as forms of trauma (Bryant-Davis & Ocampo, 2005; Comas-Diaz et al., 2019; Helms et al., 2012). Clinicians may need additional guidance to support youth who are separated from their racial, ethnic, or religious communities and navigating the systemically oppressive child welfare system.

Implications for Future Implementation/Research/Practice Efforts

The findings from the present study may be used to inform future implementation and clinical practice efforts. First, providers described working with foster care youth as challenging, even more challenging than working with other clients with trauma symptoms. Additionally,

providers in the present study typically expressed positive views and openness toward using EBTs. Fndings highlight the importance and potential benefits that may be reaped from targeted, specific efforts to address the barriers providers encounter when working with youth in foster care.

It is encouraging news that most providers from the present study are using at least one EBT when working with youth in foster care. While providers may be using EBTs, it is unclear to what degree they maintain fidelity to critical model components. Previous findings indicate that providers may be reluctant to utilize exposure components (e.g., trauma narratives) due to concerns that they will be overly distressing and lead to dropout, or due to a lack of confidence in skills to deliver exposure components appropriately (Ascienzo et al., 2019; Becker et al., 2004; Devilly & Huther, 2007). This may be particularly true of providers serving youth in foster care, as participants from the present sample reported increased concern for increasing emotional distress in youth in foster care. Providers were often concerned they may not be able to complete the full therapeutic model due to changes in placement or may exhibit an increase in disruptive behaviors, which may lead to disrupted placement. Additionally, some providers chose not to use trauma narration due to inability to identify a trusted adult.

It may be beneficial to target future intervention adaptation efforts toward TF-CBT, specifically due to its pre-existing widespread use. Perhaps the greatest challenge of access to evidence-based treatment is the gap in research in clinical practice (Atkins et al., 2016; Dodge 2009). Harnessing an already-implemented intervention may substantially reduce barriers to actual EBT utilization for community providers. Furthermore, there is some support for standard TF-CBT for working with youth in foster care (Dorsey et al., 2014). Based on the perspectives of providers in this study and recent updates to the TF-CBT implementation manual for youth in

foster care, it is essential to test the benefit of specific adaptations empirically (e.g., increased focus on emotion identification and affect regulation, increased session length). Furthermore, it may be important to incorporate adaptations that address the barriers providers endorsed when working with foster care youth, such as placement instability, a lack of a trusted adult, and the need for brief interventions to ensure treatment completion for youth.

Some providers, particularly those who utilize holistic, integrative, or psychodynamic approaches, endorsed the use of CPP when treating youth with trauma symptoms in foster care. CPP may be an ideal intervention for working with youth in foster care under the developmental age of 5, as it is both an evidence-based treatment with psychodynamic foundations. This type of treatment model may appeal to providers who do not typically use a cognitive-behavioral approach in their work and are unlikely to use TF-CBT with fidelity to the model. Future studies would benefit from understanding the potential benefits of using CPP with youth in foster care. While there is promise for the use of CPP, CPP has empirical evidence only for children under the age of 5, requires a lengthy training (i.e., typically 18 months) to become fully rostered, and often includes long treatment lengths, typically lasting around 20-25 sessions (Lieberman et al., 2005; Norona & Aker, 2016). Although CPP might be a preferred intervention for some providers, outer contextual variables may continue to limit access to this intervention for foster care youth, even if widely disseminated and implemented.

Providers appear particularly amenable to the use of EBTs, given the somewhat elevated EBPAS overall scores. However, the increased Divergence scores are perplexing. Results from previous evaluations reveal that higher Divergence subscale results are often associated with more years of experience, being from a marginalized ethnic background, and obtaining education in a field other than psychology (Aarons et al., 2010). However, the present study did not

complete statistical tests for these relationships, and it is uncertain how demographic variables might predict higher Divergence scores in the present sample. Future evaluations should seek to understand how demographic and other variables are related to EBPAS subscale scores. Understanding the variables that impact provider perceptions of evidence-based treatments could be used to guide future dissemination and implementation efforts.

There is promising evidence for the role of treatment model adaptations and understanding of predictive variables to support clinicians treating youth in foster care. However, providers in the current study widely endorsed more barriers related to outer contextual variables (e.g., changes in placement) than specific treatment models or inner contextual variables, and efforts to support clinicians serving youth in foster care may be better facilitated by adaptations to outer contextual challenges or with outer contextual challenges in mind.

For example, one of the most frequently referenced barriers was changes in placement within the foster care system. Telehealth delivery of mental health services might mitigate the impact of placement changes on trauma treatment for youth in foster care. Providers often referenced that the primary barrier to accessing services due to a change in placement was foster care youth longer living close to the treatment location. As telehealth delivery use has skyrocketed in the wake of the COVID-19 pandemic, mental health providers and families are likely much more familiar and proficient with telehealth service delivery (Racine et al., 2020; Sharma et al., 2020; Zhou et al., 2020). Through telehealth, foster care youth would be able to maintain services with the same therapist despite changes in placement, which would increase the number of sessions clinicians progress through treatment manuals and minimize disruptions in rapport for foster youth. However, despite the promise of telehealth for increasing

accessibility to underserved populations, it is unclear how trauma treatment models, particularly those for younger children, may translate to telehealth delivery.

Briefer treatment methods might also be beneficial when working with foster care youth. There are a number of treatment delivery approaches that offer flexible, effective mental health services, including single-session interventions (Bloom, 2001; Cameron, 2007). Single session interventions have been shown to be efficacious for adult populations, including the treatment of trauma symptoms (Campbell et al., 2012; Schleider & Weisz, 2017; Van Emmerick et al., 2002). Brief interventions have also been shown to be effective with child and adolescent populations in improving internalizing symptoms and attachment difficulties (Ollendick et al., 2009; Perkins 2006; Schleider et al., 2020; Schleider & Weisz, 2017). Indeed, single session interventions for children and adolescents have been proposed as a service delivery model to increase access and reduce disparities to mental health services (Gee et al., 2015). There are mixed findings for the efficacy of single session interventions in treating child traumatic stress, with some studies showing reductions in traumatic stress symptoms and others showing no benefit (Kenardy et al., 2008; Stallard et al., 2006). It's important to note that there appear to be no evaluations of single session interventions with foster care youth. So, there is potential promise for the role of single session interventions to provide accessible, brief mental health services to youth in foster care, but more research is needed.

While the potential of treatment adaptations and novel treatment delivery approaches are exciting, mental health providers described their most significant and frequent challenges as those within the outer context, such as issues with the foster care system itself, difficulties coordinating with overburdened caseworkers, and problems effectively collaborating with court systems. Although implementation science methods may be worthwhile in addressing clinicians'

challenges, changes to service delivery methods and the systems themselves might prove most feasible in treating youth in foster care.

Although broad systems-level changes are lofty, perhaps an emphasis on outer contextual barriers is more beneficial to both mental health providers and foster care youth than inner contextual changes alone. While model and service delivery adaptations may substantially reduce the barriers clinicians encounter when working with youth in foster care, advocacy for widespread change at policy and systems levels is needed. In sum, treatment adaptations may be beneficial for youth in foster care. Perhaps the most beneficial changes are to support efforts to reduce racial disparities in out of home placements, increase the number of foster homes, identify policies and legislation that impair mental health for foster care youth, reduce caseworker workload, and build collaborative relationships with court systems to support education and advocacy efforts.

Methodological Strengths and Limitations

This investigation had several methodological strengths, including (a) use of multiple types of recruitment methods to obtain the most diverse sample of clinicians possible, (b) use of a well-established implementation framework that is particularly well-suited for considering variables across multiple services contexts, like those encountered by youth in foster care, (c) use of best practices in qualitative data analysis to develop a comprehensive understanding of provider experiences, and (d) representation in both quantitative and qualitative components from providers across the country and with highly varied licensure types (e.g., LCSW, LPC, Ph.D.).

The present study also had several limitations. First, although the sample was widely geographically diverse, this sample is not nationally representative. There may be alternative

findings in various geographical areas that are not represented in the present sample. Second, this sample was limited in its educational and ethnic diversity. While many disciplines and ethnic backgrounds were represented, most participants were White with a social work degree. Third, the present study was exploratory in nature, and practices such as power analysis could not be used to ensure the sample was large enough to detect statistically significant differences. Fourth, there were a number of participants who only provided partial responses (approximately 13% of the sample). The reduction in responses on measures, especially those assessing treatment model use, barriers and facilitators, and the EBPAS, may have influenced the outcomes in the present analysis. Fifth, this sample included only mental health providers serving youth in foster care and did not include the perspectives of foster children, foster parents, biological parents, caseworkers, judges, or other stakeholders involved in the child welfare system. Finally, the present study does not include clinical outcome data such as symptom improvement or placement stability, and mental health providers may have different perceptions of treatment effectiveness and appropriateness than what might be evidenced by clinical outcome data.

Future research

Future research should seek to understand foster child, foster parent, caseworker, biological parent, and other stakeholders' perspectives of trauma treatment for youth in foster care. It is also important that future evaluations weigh the benefits and feasibility of methods for addressing challenges related to treating youth in foster care. For example, considering the benefit and feasibility of treatment model adaptations versus changes to service delivery versus changes to system policies and legislation. It is also important that future studies obtain a larger, nationally representative sample to better understand the perspective of providers serving youth in foster care. Similarly, future studies should seek a more diverse sample in terms of gender,

ethnicity, and educational attainment to better reflect the service providers who treat youth in the foster system. Subsequent evaluations would benefit from analyzing the relationship between evidence-based practice attitudes and treatment model utilization across demographic variables and against national norms of providers serving the community in general. Finally, future evaluations would benefit from continuing to utilize the EPIS framework to fully identify implementation needs, develop an implementation plan, actually implement change to support providers serving youth in foster care, and plan for sustainment at the outset of implementation.

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Tables and Figures

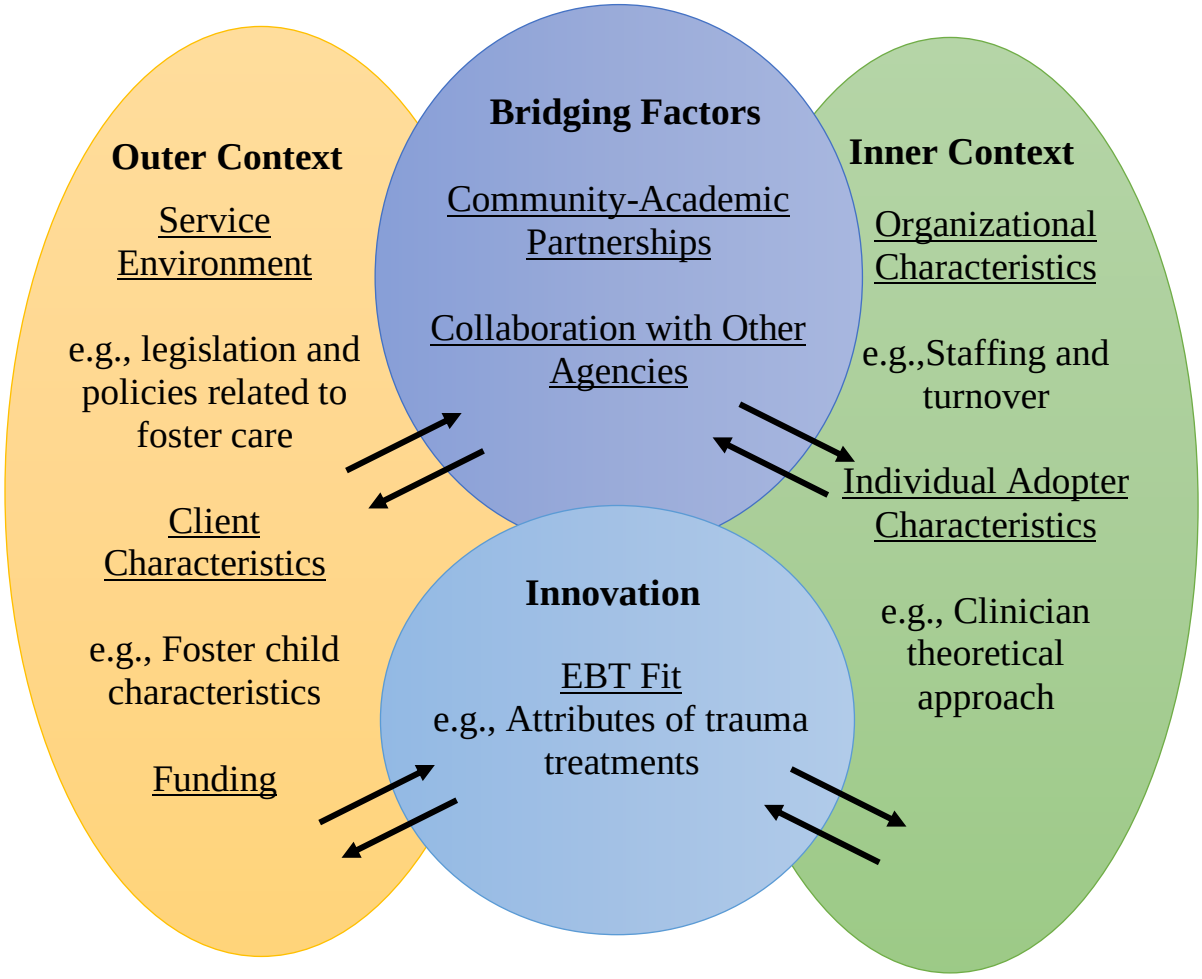

Figure 1. *EPIS Conceptual Framework for Exploration Phase with Example Themes from the Present Study*

Table 1

Professional Organizations, Social Media Groups, and Training Initiative Contacted for Recruitment

National Child Traumatic Stress Network	
Association for Behavioral and Cognitive Therapies	Child Maltreatment Special Interest Group
	Dissemination and Implementation Science Special Interest Group
	Parenting and Families SIG
International Society for Traumatic Stress Studies	Child Trauma Special Interest Group
	Family Systems Special Interest Group
Listservs	Foster Care and Adoptive Community Listserv
	National Association of Social Workers
	Trauma-Focused Cognitive Behavioral Therapy Directory Listserv
	Parent-Child Interaction Therapy Directory Listserv
	Child-Parent Psychotherapy Directory Listserv
Psychology Today with criteria "adoption" and "child or adolescent"	
Training Initiatives	Project BEST: Bringing Evidence Supported Treatments to South Carolina Children and Families
	Program on Adolescent Traumatic Stress (PATS)
	Arkansas Building Effective Services for Trauma (ARBEST)
	North Carolina Child Treatment Program (NC CTP)
	University of Kentucky Child and Adolescent Trauma Treatment Training Institute (CATTTI)
	Connecticut Center for Effective Practice
	Harborview Center for Sexual Assault/Traumatic Stress
	Project BEST: Bringing Evidence Supported Treatments to South Carolina Children and Families
	Program on Adolescent Traumatic Stress (PATS)
	Arkansas Building Effective Services for Trauma (ARBEST)
	North Carolina Child Treatment Program (NC CTP)
Facebook	The Trauma Treatment Collective

Table 1 (Continued)

Professional Organizations, Social Media Groups, and Training Initiative Contacted for Recruitment

Facebook	Trauma-Informed Mental Health Professionals
	Child, Adolescent, and Family Therapists and Counselors
	Mental Health Professionals Group
	Therapists Supporting Therapists
	The Trauma Treatment Collective

Table 2

Major themes and subthemes within the EPIS framework related to trauma treatment with youth in foster care

EPIS Framework Concept	Major theme	Subthemes
Inner Context	Clinician Characteristics	Assessment of Symptoms
		Patient-Client Advocacy
		Theoretical Approach
	Organizational Characteristics	Agency Policies and Support
		Balancing Confidentiality Across Multiple Systems
		Staffing and Turnover
Outer Context	Client Characteristics	Foster Child Characteristics
		Foster Parent Characteristics
		Biological Parent Characteristics
	Funding	External Funding
	Client Characteristics	Payment for Services
	Service Environment	Caseworkers
		Court Systems
		Foster Care System
		Policies and Legislation
		Systemic Considerations
	Access to Training	
Innovation	Attributes of Trauma Treatments	
Bridging Factors	Collaboration with Other Agencies	
	Community-Academic Partnerships	

Table 3

Demographic Results for the Full Quantitative Sample

		All Participants (n = 148)	
		n	*%*
Age	25-34	52	35.1%
	35-44	57	38.5%
	45-54	28	18.9%
	55-64	4	2.7%
	65-74	7	4.7%
Gender	Female	136	91.9%
	Male	9	6.1%
	Non-binary	3	2.0%
Race	American Indian or Alaska Native	1	0.7%
	Asian	2	1.4%
	Black or African American	11	7.4%
	Other	5	3.4%
	Prefer not to say	1	0.1%
	White	128	86.5%
Ethnicity	Hispanic or Latinx	13	8.8%
	Not Hispanic or Latinx	135	91.2%
Level of Education	Doctorate	22	14.9%
	Master's degree	126	85.1%
Employment	1-20 hours per week	12	8.1%
	20-30 hours per week	10	6.8%
	Full time	126	85.1%
Clinical Setting	Child Advocacy Center	19	12.9%
	Community Mental Health Center	40	27.2%
	Detention Center/Prison	1	0.1%
	Hospital	14	9.5%
	Integrated Behavioral Healthcare Center	1	0.1%
	Other	22	15.0%
	Private Practice	37	25.2%
	School or Educational Setting	13	8.9%
	Missing/Item Skipped	1	0.7%
Licensure Type	Licensed Associate Counselor (LAC)	6	4.05%
	Licensed Clinical Social Worker (LCSW)	47	31.76%
	Licensed Marriage and Family Therapist (LMFT)	4	2.70%
	Licensed Master Social Worker (LMSW)	9	6.08%
	Licensed Professional Counselor (LPC)	59	39.86%
	Psychologist PhD	14	9.46%
	Psychologist PsyD	3	2.03%
	Missing/Item Skipped	1	0.7%
Region of Residence	Midwest	17	11.6%
	Northeast	25	17.0%
	South	95	64.6%
	West	10	6.8%
	Missing/Item Skipped	1	0.7%

Table 3 (Cont.)

Demographic Results for the Full Quantitative Sample

		All Participants (n = 148)	
Years of Experiences	0-2 years	6	4.08%
	2-4 years	17	11.56%
	4-6 years	18	12.24%
	6-10 years	40	27.21%
	10-15 years	30	20.41%
	15-20 years	15	10.20%
	20-25 years	11	7.48%
	25-30 years	6	4.08%
	4-6 years	18	12.24%
	6-10 years	40	27.21%
	More than 30 years	4	2.72%
	Missing/Item Skipped	1	0.7%
Primary Client Population	Adolescents (13-17 years)	47	31.76%
	Adults (18-65 years)	23	15.54%
	School-age children (6-12 years)	60	40.54%
	Young children (under 5)	16	10.81%
	Missing/Item Skipped	2	1.4%
Primary Theoretical Orientation	Behavior Therapy	7	4.7%
	Cognitive-Behavioral	82	55.4%
	Humanistic	11	7.4%
	Integrative or Holistic Therapy	18	12.2%
	Psychodynamic	15	10.1%
	Missing/Item Skipped	15	10.1%
Percentage of Caseload in Foster Care	0%	3	2.0%
	1-10%	24	16.2%
	11-20%	23	15.5%
	21-30%	21	14.2%
	31-40%	15	10.1%
	41-50%	11	7.4%
	51-60%	7	4.7%
	61-70%	1	0.7%
	72-80%	9	6.1%
	81-90%	5	3.4%
	91-100%	18	12.2%
	Missing/Item Skipped	14	9.5%

Table 4
Demographic Results for Qualitative Sample

		All Participants (n = 15)	
		n	*%*
Gender			
	Female	13	86.7%
	Male	1	6.7%
	Non-binary/Intersex	1	6.7%
Level of Education			
	Doctorate	2	13.3%
	Master's degree	13	86.7%
Clinical Setting			
	Child Advocacy Center	3	20.0%
	Community Mental Health Center	6	40.0%
	Hospital	2	13.3%
	Other	1	6.7%
	Private Practice	3	20.0%
Education			
	Licensed Social Worker (LMSW/LCSW)	7	46.6%
	Licensed Marriage and Family Therapist (LMFT)	1	6.7%
	Licensed Professional Counselor (LPC)	5	30.0%
	Psychologist PhD	2	13.3%
Licensure Status			
	Licensed	143	97.3%
	Not Licensed	4	26.7%
Region of Residence			
	Midwest	2	13.3%
	Northeast	4	2.7%
	South	7	46.6%
	West	2	13.3%
Percentage of Caseload	In Foster Care	15	43.7%
	Being Primarily Treated for Trauma	15	77.2%
		n	*Years*
Years of Experience in	Mental Health Care	15	12.3
	Working with Children	15	13.7
	Treating Child Trauma	15	11.8
	Working with Youth in Foster	15	10.3

Table 5
Rates of Trauma Treatment Model Usage When Working with Youth in Foster Care

	All Participants (*n*=133)					
	Often		Sometimes		Never	
	n	*%*	*n*	*%*	*n*	*%*
TF-CBT	87	65%	34	26%	12	9%
Client Centered Therapy	52	39%	34	26%	47	35%
Individual mind-body skills	51	38%	22	17%	60	45%
Family Therapy	49	37%	50	38%	34	26%
Individual client-centered play therapy	32	24%	34	26%	67	50%
CPP	26	20%	18	14%	89	67%
Combined Parent-Child CBT	22	17%	24	18%	87	65%
Art Therapy	22	17%	46	35%	65	49%
Individual psychoanalysis	18	14%	17	13%	98	74%
PCIT	16	12%	19	14%	98	74%
CPT	13	10%	33	25%	87	65%
EMDR	12	9%	18	14%	103	77%
Integrative Treatment of Complex Trauma	11	8%	10	8%	112	84%
Grief and Trauma Interventions	9	7%	14	11%	110	83%
Trauma-Focused Integrative Play Therapy	9	7%	15	11%	109	82%
ABC	4	3%	7	5%	122	92%
Somatic Experiencing	4	3%	5	4%	124	93%
TIMBER	4	3%	10	8%	119	89%
AF-CBT	3	2%	9	7%	121	91%
Risk Reduction Through Families Therapy	3	2%	5	4%	125	94%
Trauma Resiliency Model	3	2%	8	6%	122	92%
PE-A	2	2%	7	5%	124	93%
Intergenerational Trauma Model	2	2%	1	1%	130	98%
Cue-Centered Therapy	1	1%	4	3%	128	96%
Preschool PTSD Treatment	0	0%	6	5%	127	95%

Table 6

Correlations Between Rates of Treatment Model Use

	1	2	3	4	5	6	7	8	9	10	11
1. TF-CBT	-	-	-	-	-	-	-	-	-	-	-
2. Client centered	-.064	-	-	-	-	-	-	-	-	-	-
3. Mind-body skills	-.075	.425**	-	-	-	-	-	-	-	-	-
4. family therapy	-.169*	.317**	.391**	-	-	-	-	-	-	-	-
5. Play therapy	-.186*	.311**	.257**	.292**	-	-	-	-	-	-	-
6. CPP	-.079	-.029	.039	266**	.336**	-	-	-	-	-	-
7. Combined CBT	.191*	.245**	.169	.370**	.287**	.311**	-	-	-	-	-
8. Art therapy	-.074	.490**	.391**	.322**	.366**	.122	.293**	-	-	-	-
9. Psychoanalysis	-.030	.281**	.388**	.256**	.166	.067	.192	.286**	-	-	-
10. PCIT	.237**	-.049	-.066	.017	-1.00	-.052	-.044	-.154	-.081	-	-
11. CPT	.203**	.076	.223**	.048	.159	-.001	.057	.230**	.055	.137	-
12. EMDR	.042	.034	.053	.126	.059	.043	.071	.074	.055	.050	-.029

* Correlation significant at the 0.05 level (2-tailed)

** Correlation significant at the 0.01 level (2-tailed)

Note: TF-CBT= Trauma-Focused Cognitive Behavioral Therapy, Client centered= Client centered therapy, CPP= Child Parent Psychotherapy, Combined CBT= Combined Cognitive Behavioral Therapy, PCIT= Parent Child Interaction Therapy, CPT= Cognitive Processing Therapy, EMDR= Eye Movement Desensitization and Reprocessing

Table 7

Presence of Barriers and/or Facilitators When Working with Youth in Foster Care

	All participants (n = 130)			
	Yes		No	
	n	%	*n*	%
Have you encountered things that make your job harder when treating trauma symptoms with a client in foster care?	127	97.7%	3	2.3%
Have you encountered things that makes your job easier when treating trauma symptoms with a client in foster care?	50	38.5%	80	61.5%

Table 8

Level of Difficulty of Working with Youth in Foster Care Compared to Other Clients

	All participants (n = 130)									
	Much harder		Somewhat harder		The same		Somewhat easier		Much easier	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Compared to your typical caseload, how much harder or easier is it to treat trauma symptoms in clients in foster care?	36	27.7%	75	57.7%	16	12.3%	3	2.3%	0	0.0%
Compared to other clients with trauma, how much harder or easier is it to treat trauma symptoms in clients in foster care?	30	23.1%	79	60.8%	18	13.9%	3	2.3%	0	0.0%

Table 9
Types of Barriers and Facilitators Across EPIS Constructs

		All participants (n = 130)			
Epis Construct	Barrier/Facilitator Category	Barrier		Facilitator	
		n	%	*n*	%
Inner Context	Assessment of Symptoms	29	22.3	47	36.2
	Clinician Preferences, Values, and Practices	3	2.3	89	68.5
	Agency Policies and Support	21	16.2	68	52.3
Outer Context	Foster Child Factors	108	83.1	48	36.9
	Foster Caregiver Factors	112	86.2	60	46.2
	Biological Caregiver Factors	91	70.0	25	19.2
	Working with Caseworkers	91	70.0	45	34.6
	Working with Court Systems	77	59.2	16	12.3
	Funding	38	29.2	35	26.9
	Access to Training	42	32.3	88	67.7
Bridging Factors	Community-Academic Partnerships	20	15.4	32	24.6
Innovation	Treatment Models	13	10.0	102	78.5
	Other	115	88.5	35	26.9

Note. Percentage may not sum to 100% as participants could mark all categories as both a barrier and facilitator or neither.

Table 10
Evidence-Based Practice Attitudes Responses to Individual Items and Total Subscale Scores

		All participants (n = 130)									
	Subscale	To a Very Great Extent		To a Great Extent		To a Moderate Extent		To a Slight Extent		Not at all	
		n	%	n	%	n	%	n	%	n	%
I like to use new types of therapy/ interventions to help my clients.	3	22	16.9	36	27.7	59	45.4	13	3.9	0	0
I am willing to try new types of therapy/interventions even if I have to follow a treatment manual.	3	33	25.6	54	41.9	37	28.7	5	3.9	0	0
I know better than academic researchers how to care for my clients.	4	0	0	12	9.2	35	26.9	53	40.8	29	22.3
I am willing to use new and different types of therapy/interventions developed by researchers.	3	33	25.4	57	43.9	31	23.9	9	6.9	0	0
Research based treatments/interventions are not clinically useful.	4	3	2.3	1	1.0	4	3.1	24	18.5	98	75.4
Clinical experience is more important than using manualized therapy/interventions.	4	4	3.1	20	15.4	38	29.2	48	36.9	20	15.4
I would not use manualized therapy/interventions.	4	3	2.3	2	1.6	9	7.0	29	22.5	86	66.7
I would try a new therapy/intervention even if it were very different from what I am used to doing.	3	28	21.7	44	34.1	32	24.8	21	16.3	4	3.1
For questions 9–15: If you received training in a therapy or intervention that was new to you, how likely would you be to adopt it if:											
	Subscale	To a Very Great Extent		To a Great Extent		To a Moderate Extent		To a Slight Extent		Not at all	
		n	%	n	%	n	%	n	%	n	%
it was intuitively appealing?	2	50	33.8	55	37.2	16	10.8	6	4.1	1	.7

Table 10 (Continued)

Evidence-Based Practice Attitudes Responses to Individual Items and Total Subscale Scores

	Subscale	To a Very Great Extent		To a Great Extent		To a Moderate Extent		To a Slight Extent		Not at all	
		n	%	n	%	n	%	n	%	n	%
it "made sense" to you?	2	61	41.2	50	33.8	12	8.1	4	2.7	1	.7
it was required by your supervisor?	1	25	16.9	34	23.0	37	25.0	20	13.5	11	7.4
it was required by your agency?	1	25	16.9	37	25.0	35	23.6	21	14.2	9	6.1
it was required by your state?	1	31	20.9	47	31.8	29	19.6	13	8.8	8	5.4
it was being used by colleagues who were happy with it?	2	36	24.3	60	40.5	20	13.5	10	6.8	1	0.7
you felt you had enough training to use it correctly?	2	77	52.0	38	25.7	10	6.8	4	2.7	0	0

Note. 1=Requirements, 2=Appeal, 3= Openness, 4= Divergence

Table 11
Evidence Based Practice Attitudes Scale Subscale and Total Scores

	All Participants (*n =130*)	
	M	*SD*
Requirements	2.45	1.07
Openness	2.71	0.73
Appeal	3.20	0.69
Divergence	3.09	0.58
Total EBPAS	2.86	0.53

Table 12
Correlations Between Rates of Use of Treatment Models and EBPAS Subscale and Total Scores

			All Participants (*n* = 130)				
	M	SD	Openness	Divergence	Appeal	Requirement	Overall
1. TF-CBT	2.56	.66	.331**	-.253**	.286**	.224*	.401**
2. Client centered	2.04	.87	-.127	.161	-.035	-.112	-.164
3. Mind body skills	1.93	.91	.008	.150	.109	-.089	-.039
4. Family therapy	2.11	.79	-.026	.251**	.048	-.044	-.093
5. Play therapy	1.74	.83	-.069	.324**	-.113	.066	-.046
6. CPP	1.53	.80	-.032	.247**	-.035	-.014	-.091
7. Combined CBT	1.51	.77	.037	.131	-.038	-.013	-.036
8. Art therapy	1.68	.74	.090	.275**	.002	-.068	.220
9. Psychoanalysis	1.40	.72	.008	.077	.164	-.071	.004
10. PCIT	1.38	.69	.200*	-.188*	.188*	.074	.223*
11. CPT	1.44	.67	.194*	-.005	.135	.192*	.214*
12. EMDR	1.32	.63	.048	-.056	.257**	.072	.108

* Correlation significant at the 0.05 level (2-tailed)
** Correlation significant at the 0.01 level (2-tailed)
Note: TF-CBT= Trauma-Focused Cognitive Behavioral Therapy, Client centered= Client centered therapy, CPP= Child Parent Psychotherapy, Combined CBT= Combined Cognitive Behavioral Therapy, PCIT= Parent Child Interaction Therapy, CPT= Cognitive Processing Therapy, EMDR= Eye Movement Desensitization and Reprocessing

Table 13
Qualitative Themes by Interviewee and Determinant Type

EPIS Construct	Theme	*N*	% of mentions by interviewee type				% of mentions by determinant type[a]	
			West	Midwest	South	Northeast	Facilitators	Barriers
Inner Context	Assessment of Symptoms	15	2	2	7	4	26	74
	Patient-Client Advocacy	9	1	2	4	2	57	43
	Theoretical Approach	15	2	2	7	4	44	56
	Agency Policies and Support	14	1	2	**7**	4	66	34
	Balancing Confidentiality Across Multiple Systems	6	1	0	4	1	0	100
	Staffing and Turnover	5	0	2	2	1	49	51
Outer Context	Foster Child Characteristics	15	2	2	7	4	23	77
	Foster Parent Characteristics	15	2	2	7	4	32	68
	Biological Parent Characteristics	14	2	2	6	4	32	68
	External Funding	6	0	1	4	1	48	52
	Payment for Services	10	1	2	4	3	53	47
	Caseworkers	15	2	2	7	4	34	66
	Court Systems	14	1	2	7	4	30	70
	Foster Care System	15	2	2	7	4	11	89
	Policies and Legislation	9	1	1	4	3	23	77
	Systemic Considerations	10	1	2	4	3	21	79
	Access to Training	12	1	2	5	4	40	60
Innovation	Attributes of Trauma Treatments	14	2	2	6	4	41	59

Table 13 (Cont.)
Qualitative Themes by Interviewee and Determinant Type

			% of mentions by interviewee type				% of mentions by determinant type[a]	
EPIS Construct	Theme	*N*	West	Midwest	South	Northeast	Facilitators	Barriers
Bridging Factors	Collaboration with Other Agencies	11	1	0	6	4	67	33
	Community-Academic Partnerships	8	1	1	4	4	79	21

Note. Sample sizes for interviewee type are as follows: 2 Midwest, 2 West, 4 Northeast, 7 South(N = 15 total). [a]These percentages do not always sum to 100% because some mentions of a given theme were not coded as a barrier or a facilitator.

Table 14
Representative Quotes of Experiences Treating Youth in Foster Care Themes

Theme	Representative Quote
Assessment of Symptoms	"The foster parent may not know any of that information and sometimes that's very imperative to know background information and I've had times where the biological parents or like their parental rights have been terminated, so there's no way for me to get in touch. So, a lot of the times I'm working with like half the information that I would typically know from a biological parent."
Patient-Client Advocacy	"My advocacy level goes up when I'm working with kids who are in foster care. That is definitely true, because a lot of ties they've had school changes…And so, I think I am more likely to be in contact with the school and following up to make sure that 504 plans are in place, that evaluations happen…"
Theoretical Approach	So, I would say I'm trauma informed as a whole…I think I put a lot of emphasis on rapport building, trust, felt safety, emotional safety, and client lead, and... expressive interventions that may not be verbal as much as possible. For some kids in foster care, they may be more guarded, and distrustful of adults in their lives, and I have found that really making it child lead as much as possible and establishing felt safety and making that a continuous effort has been the most fruitful as far as kids participating in therapy, feeling like they've been heard, and then also making changes and progress through their trauma.:
Agency Policies and Support	"If I need tools and stuff, my agency is really good about it. I just go and say "hey, if at some point someone could get me this book I learned about" or you know, anything that will help me use my treatment models, um, they're really willing to do that."
Balancing Confidentiality Across Multiple Systems	"Sometimes the consent process is a little tricky. I may actually need someone from Child Protective Services there to sign the paper or we have to send paperwork back to a bio parent even though they're not the one who is bringing the kiddo in. So occasionally that process can be tricky."
Staffing and Turnover	"You know with any community behavioral health site; you've got folks who gain their expertise and earn their independent licensure and then they move on from you and quit."
Foster Child Characteristics	They have had multiple people ask them various questions to where by the time they get to trauma therapy, and they're very shut down. They have had multiple providers and they haven't been providing quality treatment or evidence-based treatment. So, you're re-doing the errors of making up for a lot of previous clinical errors that have been made by clinicians.
Foster Parent Characteristics	"…I can kind of put them in a box, to a degree. So, I get the foster parents who are highly structured and behavioral, who have very big expectations of the kid, the kid can't always meet, and so the relationship is a little bit tumultuous. Because the kiddo keeps testing and is struggling with their own regulation and their own triggers... And it's usually a bit more of a struggle to get that buy-in around the impacts of complex trauma as the underlying explanation for what the child's going through…it's usually more difficult for me or for the other clinicians to get some movement with that category of foster parent. At the opposite end of the spectrum, you've got the "I'm gonna love this kid, and we're gonna have fun", where they just see their role as giving the child the nurturing that that they did not get. And that's always lovely. That's always a great starting point, you know cause then you can sure things up and get a little bit more structure and routine, predictability, but you can't, you can't make the other kind of foster parent love the kid, you know?"

Table 14 (Continued)

Representative Quotes of Experiences Treating Youth in Foster Care Themes

Theme	Representative Quote
Biological Parent Characteristics	"A lot of parents themselves have had abuses happen to them that went untreated. Homelessness is a very big problem, so all of those impact the parent, and then obviously are gonna impact the work you do with them. A lot of parents need their own mental health support and may have other issues going on…that could be a big barrier to successful treatment, is biological parents' insight or even emotional capacity."
External Funding	"With my agency, every time they have to do a lot of grants and as clinicians, we have to do so many additional things like paperwork just to make sure that we're keeping up with the standards of grants. And that can be hard as a clinician because it increases your workload or your documentation hours. It can be exhausting."
Payment for Services	For middle managed systems like community agencies, they primarily have Medicaid reimbursement, and Medicaid can be more difficult to get reimbursed for, and maybe pay lower, and they have more recoupment because of different requirements they need for documentation. So, I think there's more of a financial strain, and because there's a financial strain, finances probably take not complete priority, but are definitely a big part of the picture…and maybe not having to have clinicians carry 30 to 60 cases to have a caseload and can actually spend the time that's necessary for these families
Access to Training	" I do think that my agency has done a phenomenal job of training, follow through on training, and ensuring your use of the different models and supporting us in accessing resources and trainings within those models. I think they are careful about who they select for EBPs. And then they are also they are really good at making sure we have access to all the resources within those EBPs."
Working with Caseworkers	"Barriers, they don't call you back. You always have to call their supervisor to get any kind of movement...They are overworked, and their caseloads are really high. Sometimes they don't have the answers, sometimes their documentation is incomplete. Or they don't follow through on the things they need to be doing. They mix up kids when they are talking to you about different cases... A facilitator would be that there is so much documentation that if you get your hands on it, they can request records on anything at any time. Because the department has access to child's mental health or physical health records. So, gaining access to some of those pieces can be supportive through Child Protective Services."
Working with Court Systems	"Court systems oftentimes are well intentioned but know enough to be dangerous. And so sometimes they make recommendations or even put into court orders things that are not actually helpful or might even be counterproductive to the therapeutic process or to providing the family what they need. Sometimes they can be really open to education and conversation about why that's not appropriate and fine with changing it. Other times, they're really hard to access and aren't really interested in what you have to say and so that can be really troublesome. For example, like I mentioned before, if they say that you have to do PCIT (Parent-Child Interaction Therapy) with a biological caregiver who doesn't have contact that's not gonna work…so helping them know and understand these ins and outs…"
Foster Care System	"The biggest challenge, placement. Because that's basic needs. Food, water, shelter. When you are missing one, your body is always in crisis. Always in fight or flight. It never settles and so if you don't have. If you know that at any moment your placement can be taken away, you are always in fight or flight. And it's hard for a child to cope with hat or to work on anything else of they are trying to get those basic needs met…we can't move forward until we get that first level taken care of… it's definitely going to be difficult to treat everything else their dealing with if they can't get past placement."

Table 14 (Continued)

Representative Quotes of Experiences Treating Youth in Foster Care Themes

Theme	Representative Quote
Policies and Legislation	"Our state had a consultant come in and assess different datapoints for our foster care system in our state and they- kind of their recommendations and policy results were that it's best for a child to be in a family setting...which is definitely, on the surface, true, but what that led to is a mass shuttering of group homes and shelters…So, it really put a stress- a strain on the system statewide for placements."
Systemic Considerations	"In terms of more institutional external kinds of concerns, just the ways that police BIPOC families, as a society even as a state, the ratio of kids in foster care who are minority status…it's a major issue. It needs to be better acknowledged and planned for... There's so much there that just needs a lot of attention…"
Attributes of Trauma Treatments	"TF-CBT is so much more cognitively based…and typically, when I've worked with teens, middle school age children too, they were not willing to share their trauma narrative with their foster parent. That might not be the safest person in their life to share their trauma narrative with. So, the involvement from the parents at that point is drastically different than with CPP. So, because the parents are involved the entire time, or the current caregiver is involved the entire time in CPP in TF-CBT I'm doing much more on the foster child on finding healing for themselves than I am for finding healing for the dyad in CPP."
Collaboration with Other Agencies	"Yeah, we definitely have a lot of partners. Um, we work a lot with CPS (Child Protective Services), um other trauma places that's near, um, where I live. We definitely all kind of partner up. We refer- we make referrals out to each other. I definitely think there's more of a supportive kind of vibe going on with all the related agencies."
Community-Academic Partnerships	"I think our agency, but also our area is a pretty well-educated and evidence based. We have lots of medical centers and universities around us and so there's a lot of support and encouragement and education that has been done over decades with these systems .which probably makes it easier…"

Appendix

Appendix A

Demographic Questionnaire

1.	Age:	_____
2.	Gender	Male Female Non-binary Genderfluid Other
3.	Race:	American Indian/Native American African American Asian Pacific Islander White Other:
4.	Ethnicity:	Hispanic or Latinx Not Latinx
5.	Highest level of education:	High school diploma Some college Associate degree Bachelor's degree Advanced degree Master's degree Doctoral degree
6.	Employment status:	Unemployed Employed 1-20 hours per week Employed 20-30 hours per week Employed full time
7.	Occupation:	_____
8.	Clinical Setting	Community Mental Health Center Private Practice Hospital Child Advocacy Center Integrated Behavioral Healthcare Center Detention Center/Prison

		Other
9,	What region of the United States do you reside in?	West Midwest South Northeast
10.	Are you licensed?	Yes No
11.	If yes, what type of licensure?	Licensed Professional Counselor (LPC) Licensed Marriage and Family Therapist (LMFT) Licensed Associate Counselor (LAC) Licensed Clinical Social Worker (LCSW) Licensed Master Social Worker (LMSW) Psychologist PhD Psychologist PsyD Psychiatrist
12	How many years have you been in the field of mental health care?	_____
13.	What is the primary population you work with?	Young children (under 5) School-age children Adolescents Adults Elderly
14.	Have you ever provided mental health treatment for trauma symptoms to a child or adolescent who was in a foster care placement at any time during the course of treatment?	Yes No
14.	What is your primary clinical theoretical orientation?	Psychodynamic Cognitive-Behavioral Humanistic Behavior Therapy Integrative or Holistic Therapy
15.	What percentage of your caseload includes youth in a foster placement	_____
16.	What percentage of your caseload includes trauma cases?	_____
17.	Approximately how many clients have you worked with who were in a foster placement during the course of therapy?	_____

18.	What are the primary diagnoses you see in your clinical practice with youth in foster care?	Depression Anxiety Trauma or Stressor-Related Disorders Disruptive Behavior Disorders Bipolar Disorders Substance Use Disorders Neurodevelopmental disorders ADHD
19.	Approximately how many clients have you treated specifically for trauma or other stressor-related disorders?	_____

Appendix B

Treatment Models and Strategies

Thinking about your experiences working with youth in foster care with trauma symptoms, which of the following treatment models and/or strategies did you utilize?

Treatment Model	**Brief Description**	**Frequency of Use**
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	TF-CBT includes approximately 12-16 parallel, mostly separate child and parent sessions, with parents receiving the same elements as their children. Treatment elements include psychoeducation about trauma exposure and posttraumatic stress, coping skills (e.g., affect identification/modulation, relaxation, cognitive coping); imaginal exposure (i.e., explicitly recalling details, thoughts, and feelings about traumatic experiences often through drawings, writing, or other creative mechanisms); in vivo exposure (i.e., through confronting innocuous trauma reminders); cognitive restructuring of maladaptive, trauma-related cognitions; and safety skills training. Parents are also taught parenting skills (e.g., praise, contingency management, etc.).	Never – Sometimes- Often
Prolonged Exposure for Adolescents (PE-A)	PE-A is a trauma treatment for adolescents. In the first phase, therapists build rapport, explain the treatment rationale, introduce breathing retraining, and provide psychoeducation. The second phase initiates in-vivo exposure, which consists of confronting safe, trauma-related situations and is completed as homework assignments. During sessions, therapists conduct imaginal exposure, which involves repeated revisiting and recounting of the trauma memory. Clients are asked to talk or write about the trauma, and then the therapist helps them process the memory and modify negative trauma-related perceptions that contribute to maintenance of PTSD symptoms.	Never – Sometimes- Often
Combined Parent-Child Cognitive Behavior Therapy	Adaptation of TF-CBT specifically adapted for physical abuse.	Never – Sometimes- Often
Eye Movement Desensitization and Reprocessing (EMDR)	EMDR therapy is a psychotherapy treatment that was originally designed to alleviate the symptoms of trauma. During the EMDR trauma processing phases, guided by standardized procedures, the client attends to emotionally disturbing material in brief sequential doses that include the client's beliefs, emotions, and	Never – Sometimes- Often

	body sensations associated with the traumatic event while simultaneously focusing on an external stimulus. Therapist directed bilateral eye movements are the most commonly used external stimulus, but a variety of other stimuli including hand-tapping and audio bilateral stimulation are often used.	
Integrative Treatment of Complex Trauma	ITCT-A is an evidence-based, multi-modal therapy that integrates treatment principles from the complex trauma literature, attachment theory, the self-trauma model, affect regulation skills development, and components of cognitive behavioral therapy. A key aspect of ITCT-A is its regular and continuous monitoring of treatment effects over time. This involves initial and periodic evaluation of the youth's symptomatology in a number of different areas, as well as assessment of his or her ongoing level of support systems and coping skills, family/caretaker relationships, attachment issues, and functional self-capacities. The client's social and physical environment is also monitored for evidence of increased stressors or potential danger from revictimization or broader community violence.	Never – Sometimes- Often
Individual Client-Centered Play Therapy (CCPT)	CCPT focuses on facilitating an environment of safety, acceptance, and empathic understanding in order to unleash the child's natural tendency toward self- and other-enhancing growth. In CCPT, the therapist trusts the child's inner direction to move toward positive growth within facilitative relationships. CCPT Is most effective when a therapist can provide, and a child can perceive, an environment and relationship accepting of the child's internal world, a relationship that leads toward personal integration and functionality.	Never – Sometimes- Often
Individual mind-body skills	Mind-body skills includes treatment strategies such as psychoeducation, deep breathing exercises, guided meditation, and other relaxation techniques. Various types of meditations (e.g., "ice cream meditation" or progressive muscle relaxation may be utilized. The goals of session are typically to practice techniques for use at home.	Never – Sometimes- Often
Individual psychoanalysis	The treatment component involves sessions during which the patient is encouraged to talk freely about personal experiences, including feelings, fantasies, relationships, childhood, parents and siblings, dreams, and so on. With children, play is the method of expression until they get older and can talk more freely. Child analysis involves the analyst playing and	Never – Sometimes- Often

	talking with the child; as the child grows older, the talking increases and the play tends to decrease.	
Art therapy	Through integrative methods, art therapy engages the mind, body, and spirit in ways that are distinct from verbal articulation alone. Kinesthetic, sensory, perceptual, and symbolic opportunities invite alternative modes of receptive and expressive communication, which can circumvent the limitations of language. Visual and symbolic expression gives voice to experience, and empowers individual, communal, and societal transformation	Never – Sometimes- Often
Cognitive Processing Therapy (CPT)	CPT is a specific type of cognitive behavioral therapy that helps patients learn how to challenge and modify unhelpful beliefs related to the trauma. In so doing, the patient creates a new understanding and conceptualization of the traumatic event so that it reduces its ongoing negative effects on current life. Next, the patient begins more formal processing of the trauma(s) by writing a detailed account of the worst traumatic experience, which the patient reads to try to break the pattern of avoiding thoughts and feelings associated with the trauma.	Never – Sometimes- Often
Child-parent Psychotherapy (CPP)	CPP is an intervention model for children aged 0-5 who have experienced trauma. Therapeutic sessions include the child and parent or primary caregiver with goals to support and strengthen the relationship between the child and caregiver as a vehicle for restoring the child's cognitive, behavioral, and social functioning. An initial assessment phase in CPP provides an opportunity to gather information about the caregiver and child's trauma history and symptoms, observe the caregiver-child relationship, and develop a plan for the course of treatment. Weekly joint child–parent sessions are conducted which focus on changing maladaptive behaviors, increasing emotion regulation, supporting developmentally appropriate interactions, and guiding the child and caregiver to create a joint narrative of the traumatic events while working toward their resolution.	Never – Sometimes- Often
Client-Centered Therapy	Client-Centered Therapy consists of treatment sessions that utilize Rogerian principles such as active listening, reflection, establishment of an empathic and trusting therapeutic alliance, and unconditional support. The trauma is discussed briefly, and therapists provide participants with information on common reactions to trauma. Participants are asked to	Never – Sometimes- Often

	keep a diary documenting daily difficulties, feelings, and thoughts. Participants are asked to direct the content of sessions and to discuss any trauma- or nontrauma-related difficulties. Therapists encourage positive coping techniques and provide psychoeducation about healthy sexuality and personal safety. In the final sessions, therapists review lessons learned from treatment.	
Family Therapy	Family therapy is a structured form of psychotherapy that seeks to reduce distress and conflict by improving the systems of interactions between family members. Concerning trauma, family therapy is often used in two ways. The first focuses on the after-effects of an individual's experience of trauma, addressing the impact of the trauma on family relationships. The second focuses on family therapy's role in assisting partners and other family members in helping the traumatized person heal. Depending on the type of trauma, family therapists may use whole family sessions to address and process the traumatic events experienced by one or more family members.	Never – Sometimes- Often
Parent-Child Interaction Therapy (PCIT)	PCITs a dyadic therapy where parents are initially taught relationship enhancement and discipline skills that they are actually going to be practicing in session and at home with their child. In subsequent sessions, most of the session time is spent coaching caregivers in the application of specific therapy skills. Therapists typically coach from an observation room with a one-way mirror into the playroom, using a "bug-in-the-ear" system for communicating to the parents as they play with their child. More recent advances in technology have allowed for coaching via video feed from another room which has reduced the need for adjoining clinical spaces. Concluding each session, the therapist and caregiver together decide which skills to focus on most during daily 5-minute home practice sessions the following week.	Never – Sometimes- Often
Attachment and Biobehavioral Catchup (ABC)	ABC intervenes to help parents behave in nurturing ways when their children are distressed. Second, to target children's self-regulatory issues, including difficulty regulating physiology, emotions, and behavior, ABC helps parents follow their children's lead. This has been referred to as "serve and return interactions", and as contingent responsiveness. The third target of ABC is reducing frightening behavior, such as yelling, grabbing roughly, and intruding in the child's space, because such behavior undermines children's ability to develop organized attachments, and develop adequate regulatory capabilities. The	Never – Sometimes- Often

	focus of the ABC intervention is squarely on changing parental behaviors.	
Alternative for Families: A Cognitive-Behavioral Therapy (AF-CBT)	AF-CBT targets (1) diverse individual child and caregiver characteristics related to conflict and intimidation in the home, and (2) the family context in which aggression or abuse may occur. This approach emphasizes training in intra- and interpersonal skills designed to enhance self-control and reduce violent behavior. During AF-CBT, school-aged children (5-15) and their caregivers participate in separate but coordinated therapy sessions, often using somewhat parallel treatment materials. In addition, children and parents attend joint sessions together at various times throughout treatment. This approach seeks to address individual and parent-child issues in an integrated fashion.	Never – Sometimes- Often
Cue-Centered Therapy (CCT)	CCT is a manualized protocol consisting of 15 sessions. The primary goal of CCT is to build strength and resilience by empowering the child through knowledge regarding the relationship between their history of trauma exposure and current affective, cognitive, behavioral, or physiological responses. Children and parents learn about the significance of traumatic stress, how adaptive responses become maladaptive, how to cope with rather than avoid ongoing stress, and the importance of verbalizing their life experiences. In CCT, youth and caregivers are taught how to recognize and effectively manage maladaptive responses that occur in response to traumatic reminders (cues).	Never – Sometimes- Often
Grief and Trauma Intervention (GTI)	GTI is designed for children ages 7 to 12 with posttraumatic stress symptoms due to witnessing or being a direct victim of trauma. The techniques used in the sessions are grounded in cognitive-behavioral therapy (CBT) and narrative therapy and include narrative exposure to the trauma (through drawing, discussing, and writing), development of an in-depth, coherent narrative while eliciting the child's thoughts and feelings, development of positive coping strategies, and making meaning of losses.	Never – Sometimes- Often
Risk Reduction Through Families Therapy (RRFT)	RRFT is an integrative, ecologically informed, and exposure-based approach to addressing co-occurring symptoms of PTSD (and other mental health problems), substance use problems, and other risk behaviors often experienced by trauma-exposed adolescents. RRFT is novel in its integration of these	Never – Sometimes- Often

	components, given that standard care for trauma-exposed youth often entails treatment of substance use problems separate from treatment of other trauma-related psychopathology. The pacing and ordering of RRFT components are flexible and determined by the needs of each family and symptom severity in each domain. Substance use (as relevant) and posttraumatic stress (PTS) symptoms are monitored throughout treatment to help track progress and guide clinical decision making.	
Preschool PTSD Treatment (PPT)	PPT is a manualized, 12-session cognitive-behavioral therapy protocol to treat very young children with posttraumatic stress disorder (PTSD). The sessions are either with the therapist working individually with the child (with the parent observing via a video feed) or with the parent and child together. Components of sessions include: Psychoeducation about posttraumatic stress disorder (PTSD); A focus on defiant behavior and discipline plans following trauma; identification of feelings and in young children; relaxation exercises as new coping skills; narrative techniques for recall of traumatic events; In-office and homework exposure exercises; development of developmentally appropriate safety plans; relapse prevention session; attunement of parents to children's internalized phenomena through observation of sessions and reflection with the therapist; involvement of caregivers in every aspect of treatment; direct discussion of reluctance to attend therapy; and time for caregivers to discuss their personal issues if appropriate.	Never – Sometimes- Often
Intergenerational Trauma Treatment Model (ITTM)	ITTM is a 21-session, manualized intervention designed to ameliorate the impact of chronic trauma on children's development. Treatment proceeds in three phases: psychoeducational group sessions for parents; individual sessions to address parental trauma impact; and finally, child and parent intervention to address trauma-related behaviors and symptoms and promote stronger parent-child relations. Unique features of the ITTM include attention to intergenerational patterns of trauma transmission and a focus on parents as the key agents of change for their children.	Never – Sometimes- Often
Somatic Experiencing Model (SE)	SE is a body-oriented approach to the treatment of trauma and other stress disorders. SE supports regulation of the autonomic nervous system, which underlies every aspect of a person's physical, emotional, and psychological functioning. The SE approach offers a framework to assess and support	Never – Sometimes- Often

	nervous system resilience and shift from fight, flight, or freeze states to a more flexible response. SE provides skills and tools appropriate to a variety of health professionals such as mental health clinicians, medical providers, physical and occupational therapists, nurses, bodyworkers, addiction treatment professionals, first responders, teachers/educators, and others.	
Trauma-Focused Integrated Play Therapy (TFIPT)	TFIPT is a program that utilizes a combination of directive and nondirective approaches in order to advance structured, goal-oriented therapy for abused children and their families. This model includes a focused interest in facilitating, encouraging, and allowing nondirective play therapy which often leads to children's discovery and utilization of posttraumatic play. Posttraumatic play appears to be a child's natural way to introduce gradual exposure, narrative formation, and trauma processing. Incorporating the curative factors of expressive therapy techniques (e.g., play, art, and sand therapy techniques) as valuable therapy components in and of themselves, rather than as a way to primarily engage or teach children or advance other goals, is also a distinctive feature of this approach.	Never – Sometimes- Often
Trauma Resiliency Model (TRM)		Never – Sometimes- Often
Trauma Interventions using Mindfulness Based Extinction and Reconsolidation (TIMBER)	TIMBER is a translational mindfulness-based cognitive-behavioral therapy (CBT) for PTSD and uses elements of Yoga, CBT, and Mindfulness-Based Graded Exposure Therapy, and integrates them in a self-help format with the more recent neurobiological understanding of trauma learning and trauma memories. TIMBER uses a balanced combination of both extinction (i.e., gradual diminishing of a conditioned response over time as a person learns to uncouple a response from a stimulus) and re-consolidation of memory approaches (i.e., retrieval of memories to strengthen, add, or remove information, and then update them). These are two fundamental learning methods that play crucial roles in maintenance of trauma memories.	Never – Sometimes- Often

Appendix C

Barriers and Facilitators Encountered by Foster Care Therapists

Please answer the following questions while thinking about your experiences treating children or adolescents who were residing in a foster care placement at the time of treatment. Please also only consider youth in foster care you were treating for trauma-related symptoms.

1. Have you encountered things that make your job more difficult when treating trauma symptoms with a client in foster care?

   Example: Client changing placements and no longer being close to where you practice
   Y or N
2. Have you encountered things that make your job easier when treating trauma symptoms with a client in foster care?

   Example: Your state provides increased reimbursement for treating youth in foster care
   Y or N
3. Compared to your typical caseload, how much harder or easier is it to treat trauma symptoms in clients in foster care?

   Much harder
   Somewhat harder
   The same
   Somewhat easier
   Much easier

4. Compared to treating other clients with trauma symptoms, how much harder or easier is it to treat clients in foster care?
   Much harder
   Somewhat harder
   The same
   Somewhat easier
   Much easier

5. When thinking about things that have made your job more difficult when treating trauma symptoms with a client in foster care, which of the following represent those things (select as many as are applicable)

   Client Factors
   Examples:
   - Difficulty getting clients to trust me
   - Clients are unwilling to participate in therapy

- Lack of reliable transportation
- Clients have previous negative experiences with therapy
- Clients change placements frequently and are unable to attend therapy

Foster Caregiver Factors

Examples:

- Foster caregivers are overburdened by other responsibilities (e.g., appointments)
- Foster caregivers do not want to participate in therapy
- Foster caregivers are more concerned with other symptoms besides trauma

Biological Caregiver Factors

Examples:

- Biological caregivers do not have support for their responsibilities are able to make therapy sessions a priority
- Biological caregivers are not motivated to participate in therapy
- Biological caregivers are not concerned about trauma symptoms
- Biological caregivers are not allowed to participate in therapy

Assessment of Symptoms

Examples:

- Difficulty assessing trauma symptoms
- Difficulty finding measures or diagnostic tools to assess trauma symptoms
- Difficulty determining what is causing symptoms (e.g., trauma or substance use)

Working with Caseworkers

Examples:

- Caseworkers have different priorities
- Caseworkers do not provide information needed for treatment

Working with Court Systems

Examples:

- Court system has different priorities
- Time constraints due to court proceedings
- Extra time and paperwork required (e.g., court update letters)

Clinician Factors

Examples:

- Working with clients in foster care is outside of my expertise
- Working with clients with trauma is outside of my expertise
- I prefer not to work with clients in foster care
- Difficulty hearing about abuse experiences
- I feel burned out working with clients in foster care

Training

Examples:

- Training in treatment models that would help treat trauma in youth in foster care are not easily available to me

- I cannot find/am not aware of treatment models that would help treat trauma in youth in foster care
- Training on the child welfare system is not easily available

Treatment Models

Examples:

- Treatment models I typically use are not appropriate for clients in foster care
- Treatment models I typically use are not appropriate for treating trauma
- Treatment models I use to treat trauma do not address issues faced by clients in foster care

Agency Factors

Examples:

- My agency does not provide resources for me to treat trauma symptoms
- Agency policies interfere with my ability to treat trauma symptoms in youth in foster care
- Treating youth in foster care takes extra time that is not accounted for in my productivity expectations

Funding Factors

Examples:

- There is not enough funding for me to get training or materials for treating children in foster care
- There is not enough funding to support my work treating trauma

External Support Factors

Examples:

- I do not have support from other agencies to treat trauma in children in foster care
- there is not support from academic partners to treat trauma in children in foster care

Other

6. When thinking about things that have made your job easier when treating trauma symptoms with a client in foster care, which of the following represent those things (select as many as are applicable)

Client Factors

Examples:

- Clients typically trust me
- Clients are willing to participate in therapy
- Clients have support to attend therapy sessions/have consistent transportation
- Clients have had good experiences in the past with therapy

Foster Caregiver Factors

Examples:

- Foster caregivers have support for their responsibilities as foster parents and are able to make therapy sessions a priority
- Foster caregivers are motivated to participate in therapy
- Foster caregivers are concerned about trauma symptoms
- Foster caregivers are supportive of therapy goals

Biological Caregiver Factors

Examples:

- Biological caregivers have support for their responsibilities are able to make therapy sessions a priority
- Biological caregivers are motivated to participate in therapy
- Biological caregivers are concerned about trauma symptoms
- Biological caregivers are allowed to participate in therapy

Assessment of Symptoms

Examples:

- More information is available when assessing trauma symptoms (e.g., case worker reports, reasons for removal from the home)
- Screenings completed by caseworkers make initial intakes easier
- Cause of symptoms is easier to determine due to clients being in foster care.
- I like/feel confident using assessment measures to assess trauma

Working with Caseworkers

Examples:

- Caseworkers provide clients support in attending and participating in therapy
- Caseworkers are supportive of my work as a therapist
- Caseworkers have the same priorities as therapists

Working with Court Systems

Examples:

- Court system has the same priorities for treatment
- Time constraints due to court proceedings are beneficial for treatment

Clinician Factors

Examples:

- Working with clients in foster care is within my expertise
- Working with clients with trauma is within my expertise
- I prefer to work with clients in foster care
- I find it rewarding to work with clients in foster care

Training

Examples:

- Training in treatment models that would help treat trauma in youth in foster care are easily available to me
- I have found/am aware of treatment models that would help treat trauma in youth in foster care
- Training on the child welfare system is easily available

Treatment Models

Examples:

- Treatment models I typically use are appropriate for clients in foster care
- Treatment models I typically use are appropriate for treating trauma
- Treatment models I use to treat trauma address issues faced by clients in foster care

Agency Factors

Examples:

- My agency provides resources for me to treat trauma symptoms
- Agency policies assist with my ability to treat trauma symptoms in youth in foster care

Funding Factors

Examples:

- There is enough funding for me to get training or materials for treating children in foster care
- There is enough funding to support my work treating trauma

External Support Factors

Examples:

- I do have support from other agencies to treat trauma in children in foster care
- There is support from academic partners to treat trauma in children in foster care

Other

Appendix D

Evidence-Based Practice Attitudes Scale (EBPAS)

Evidence-Based Practice Attitudes Scale (EBPAS)

	Subscale	Not at all	To a Slight Extent	To a Moderate Extent	To a Great Extent	To a Very Great Extent
1. I like to use new types of therapy/interventions to help my clients.	3					
2. I am willing to try new types of therapy/interventions even if I have to follow a treatment manual.	3					
3. I know better than academic researchers how to care for my clients.	4					
4. I am willing to use new and different types of therapy/interventions developed by researchers.	3					
5. Research based treatments/interventions are not clinically useful.	4					
6. Clinical experience is more important than using manualized therapy/interventions.	4					
7. I would not use manualized therapy/interventions.	4					
8. I would try a new therapy/intervention even if it were very different from what I am used to doing.	3					
For questions 9–15: If you received training in a therapy or intervention that was new to you, how likely would you be to adopt it if:						
9. it was intuitively appealing?	2					
10. it "made sense" to you?	2					
11. it was required by your supervisor?	1					
12. it was required by your agency?	1					
13. it was required by your state?	1					
14. it was being used by colleagues who were happy with it?	2					
15. you felt you had enough training to use it correctly?	2					

Note: Subscale 1 - Requirements; 2 - Appeal; 3 - Openness; 4 - Divergence.

Appendix E

Qualitative Interview Guide

*Good morning/afternoon and thank you so much for taking the time to complete an interview with me. **Small talk to make the informant more comfortable.*

I'd like to begin with a brief overview. The purpose of this interview is to understand therapists' experiences when treating youth in foster care with trauma symptoms. We are conducting interviews with therapists across the country to learn more about their perspectives. I will ask you a series of questions related to your experiences with foster care youth with trauma symptoms.

You have elected to complete this interview via secure web conferencing/phone. Please remember that you have the option to instead complete the interview via secure web conferencing/phone. All interviews will be audio recorded and later transcribed for analysis. Participation should take no longer than 45 minutes. You will receive a $25 electronic gift card for your time which will be sent to you electronically without any references to the study.

Your participation in this interview is completely voluntary. You may choose to discontinue the interview at any time and may refrain from responding to any questions that you do not wish to answer. All interviews will be de-identified and will be presented as aggregate results in any subsequent papers or publications. Quotes may be utilized but will not include the participant's name. No quotes that include identifying information will be utilized for any future papers or publications.

Do you have any questions?

Would you still like to proceed with the interview?

I am going to start by asking some background questions. Remember that you can skip any questions that you do not want to answer. Do you have any questions before we begin?

Interviewer Name:
Interview Date:
Start Time: Stop Time:
Type of Interview: __ web conference __ telephone
Gender:
Title in Your Organization:
    Year at current organization:
    Type of organization:
    On-site or off-site
Highest educational degree
Year of degree
Type of degree
Region of Practice

Licensure Status:
Years of Experience:
In mental health care:
Working with children and adolescents between 0-18:
Working with children and adolescents who have experienced trauma:
Working with children and adolescents in foster care:
What percentage of your caseload includes clients in foster care:
What percentage of your caseload includes clients being treated for trauma symptoms:

Before we get started, I would like to review a few of our guidelines for this interview:

- *I am here to learn from you. You, as the therapist, are the expert.*
- *All ideas are valid and accepted. There are no right or wrong answers to questions. All that matters is that you provide your genuine opinions and perspectives.*
- *All opinions and perspectives will be heard equally.*
- *I am here to obtain your opinions and perspectives. Therefore, I won't provide my own opinions.*
- *Again, you may choose to skip any questions or discontinue at any time.*

Section 1: Experiences Treating Youth in Foster Care with Trauma Symptoms

1. What have your experiences been like treating youth in foster care with trauma symptoms?
   (Additional probes: How is treating youth in foster care different than treating youth in other living arrangements? How often do you see clients from this population who require treatment for trauma symptoms? What types of living arrangements are these clients in (foster care, kinship care, fictive kinship care)?

2. How do you typically approach trauma treatment in your clinical practice? How does that differ for youth in foster care? How does it remain the same?
   (Additional probes: ask about each probe specifically)
   - Referral process
   - Intake and assessment/diagnosis
   - Case conceptualization
   - Initiation of therapy sessions

3. What types of treatment models and strategies do you utilize when treating trauma symptoms? Do those strategies differ for clients in foster care?
   (Additional probes: ask about each probe specifically)
   - Primary theoretical orientation
   - Specific models used
   - Specific strategies used
   - Appropriateness of those models/strategies for youth in foster care

4. What types of adaptations or modifications do you make to your typical clinical practice when working with clients in foster care experiencing trauma symptoms?

(Additional probes: ask about each probe specifically)
- Referral process
- Intake and assessment/diagnosis
- Case conceptualization
- Initiation of therapy sessions
- Specific models used
- Specific strategies used
- Treatment termination

5. What have your experiences been like working with foster caregivers of clients with trauma symptoms? How are those experiences different from working with other clients?

6. Do you use treatment models that allow you to work with "offending" caregivers? If so, how does this impact your treatment of youth in foster care with trauma symptoms?

Section 2: Barriers and Facilitators

1. What barriers (i.e., things that make your job harder), if any, do you encounter when working with clients in foster care with trauma symptoms? How are those barriers different from the barriers you encounter with other clients? How are they the same? (Additional probes: ask about each specifically)
   - Referral process
   - Intake and assessment/diagnosis
   - Case conceptualization
   - Initiation of therapy sessions
   - Specific models used
   - Specific strategies used
   - Treatment termination

2. What facilitators (i.e., things that make your job easier), if any, do you encounter when working with clients in foster care with trauma symptoms? How are those barriers different from the barriers you encounter with other clients? How are they the same? (Additional probes: ask about each specifically)
   - Referral process
   - Intake and assessment/diagnosis
   - Case conceptualization
   - Initiation of therapy sessions
   - Specific models used
   - Specific strategies used
   - Treatment termination

3. What special considerations, if any, are needed when treating trauma symptoms in youth in foster care?

4. As a therapist, what would be most helpful or beneficial to facilitate your work treating trauma symptoms in youth in foster care?

5. As a therapist, what do you think will be the greatest challenges in terms of continuing to treat trauma symptoms in youth in foster care?

6. What could be done to help continue your work treating trauma with children in foster care or to make it more effective?

7. What else would you like for me to know about treating trauma symptoms in youth in foster care?

Thank you. This concludes the interview. From our discussion, I have gathered the following main points during the interview:

1. ___
2. ___
3. ___
4. ___

Is there anything else you would like to add that we have not discussed?

Thank you again for your time and your insights. We will be transcribing and coding this interview in order to identify common themes or patterns across interviews. This will help us to learn more about the process of treating trauma with youth in foster care and how to support the clinicians who do this important work, like yourself.

Appendix E

UNIVERSITY OF ARKANSAS

To:	Allison B Smith BELL 4188
From:	Douglas J Adams, Chair IRB Expedited Review
Date:	12/22/2020
Action:	**Exemption Granted**
Action Date:	12/22/2020
Protocol #:	2011296200
Study Title:	Treating Foster Care Youth with Trauma-Related Symptoms: A Mixed-Methods Study of Therapies Used and Therapies Adapted

The above-referenced protocol has been determined to be exempt.

If you wish to make any modifications in the approved protocol that may affect the level of risk to your participants, you must seek approval prior to implementing those changes. All modifications must provide sufficient detail to assess the impact of the change.

If you have any questions or need any assistance from the IRB, please contact the IRB Coordinator at 109 MLKG Building, 5-2208, or irb@uark.edu.

cc: Tim Cavell, Investigator