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ORIGINAL PAPER

Perceptions of Evidence-based Treatment among Youth and Caregivers Receiving Trauma Focused-Cognitive Behavioral Therapy

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Abstract

Objectives There is growing recognition that it is important to involve youth and caregivers in the implementation of evidence-based treatments (EBTs). This study explored how youth and caregivers who received trauma-focused cognitive-behavioral therapy (TF-CBT) in a public behavioral health system perceived the concept of EBT, their experience with treatment, their perceptions of TF-CBT, and whether their perceptions varied as a function of clinical improvement.

Methods Participants were eight youth (aged 10–17) and nine caregivers/legal guardians who received TF-CBT in community mental health centers. Semi-structured interviews were conducted post-treatment and symptoms were assessed at pre- and post-treatment. An integrated approach was used to analyze the interview data and the reliable change index was used to assess whether youth and caregivers' impressions varied as a function of clinical improvement.

Results Participants rarely had exposure to the term "evidence-based" and often had the misconception that *evidence* referred to personal experience. Youth and caregivers found the concept of receiving treatment supported by research appealing but did not like the specific term "evidence-based" and worried that treatment guided by research alone may not individualize to their needs. Personal stories were noted as a good way to market TF-CBT and the therapist emerged as an important advocate for promoting this treatment approach. Clinical improvement was associated with the perception of therapists as collaborative and with trauma narrative completion.

Conclusions Findings suggest that language and how therapists communicate EBTs to youth and caregivers may be important for targeted implementation strategies.

Keywords Evidence-based treatment · TF-CBT · Youth and caregiver perceptions · Implementation

Highlights

- This study used mixed methods to explore youth and caregiver perceptions of evidence-based treatments.
- Participants rarely had exposure to the term "evidence-based" and found it unappealing.
- Marketing treatment to youth and caregivers requires careful language and explanation.
- Therapists should be selective in their explanations of treatment to engage youth and caregivers.

The majority of youth in the United States will experience at least one traumatic event (e.g., witnessing violence) by age 17 (Costello et al. 2002; Fairbank 2008; Kilpatrick and Saunders 1997). Traumatic events put youth at greater risk for impaired physical, emotional, behavioral, social, and cognitive development (DeCandia et al. 2014; Felitti et al.

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1998; Middlebrooks and Audage 2008). Trauma-focused cognitive-behavioral therapy (TF-CBT; Cohen et al. 2006) is an evidence-based treatment (EBT) for youth experiencing significant distress following a traumatic event. It includes psychoeducation, safety planning and skills, and cognitive processing of traumatic events through the creation of a trauma narrative (Cohen et al. 2006) and has evidence of both efficacy and effectiveness for youth who have experienced trauma (Chaffin and Friedrich 2004).

Despite advances in treatment development, research has shown that youth often do not receive EBTs in general or TF-CBT in particular (Beidas et al. 2016; Kazdin and Blase 2011; Sheehan et al. 2007). The uptake of TF-CBT remains low even after the creation of the National Child Traumatic Stress Network (NCTSN) to promote the use of trauma-informed EBTs by Congress, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the US Department of Health and Human Services in 2000. This research-to-practice gap is not idiosyncratic to TF-CBT and has engendered a domestic and international research agenda around EBT implementation (McHugh and Barlow 2010).

Thus far, efforts to increase EBT use have predominantly targeted therapists (Powell et al. 2015) and organizations (Glisson and Schoenwald 2005), but have overlooked service seekers (i.e., clients) as a way to increase the use of effective treatments (Gallo et al. 2013; Santucci et al. 2012). There is growing recognition that clients should be more involved in the process of implementing EBTs (Flynn 2005; Hoagwood 2005; Sanders and Kirby 2012), and efforts to target clients may be particularly promising given evidence that client demand can affect physician prescribing practices (Daubreese et al. 2015; Mukherji et al. 2017) and medical testing (Rockwell 2017). Yet, little empirical work has focused on client feedback regarding the services received or on understanding how best to create client demand for EBTs (Gallo et al. 2015).

Direct-to-consumer (DTC) marketing is one approach that can inform client targeted implementation strategies. Marketing strategies may be used to increase demand for EBTs so that clients can request these treatments (i.e., "pull" oriented approach). This contrasts with traditional implementation efforts focused on increasing the supply of EBTs in the community by "pushing" treatment to clients through providers (Becker 2015). DTC marketing aims to increase client knowledge and mental health literacy as a tool for clients to effectively advocate for EBTs from their therapists (Becker 2015; Friedberg 2017; Gallo et al. 2013; Kreuter and Bernhardt 2009). Examples of DTC marketing include informational websites (e.g., Help Your Keiki http://helpyourkeiki.com/; Effective Child Therapy www.effectivechildtherapy.org) that provide information on EBP in client-friendly language. Friedberg (2017) recommended that DTC marketing include clear and concise messages regarding the benefits of EBTs over usual care, and campaigns that use catchy tag lines for clients to remember. Furthermore, there has been a call to researchers for clear and consensus definitions for terms like evidence-based practice (Codd III 2017), and understanding clients' preferences in language is a critical step to successfully creating consumer-demand for EBTs. Thus, more information about clients' current perceptions of the concept of "evidence-based" care is needed to better understand how to message EBTs to clients and use principles of DTC marketing to inform client-focused implementation strategy development.

To date, only a few studies have examined how healthcare clients perceive the concept of "evidence-based" care (Becker et al. 2016; Carman et al. 2010; Ringle et al. 2019; Tanenbaum 2008) and only one of these studies focused specifically on EBT for youth behavioral health problems. In a sample of 53 caregivers and adolescents, Becker et al. 2016 found that youth receiving adolescent substance use treatment defined EBT incorrectly, had misconceptions about what EBT meant, and viewed the concept negatively. Common assumptions among youth were that "evidence-based" referred to evidence based on the patient's medical history, legal evidence of substance use problem, or a therapist's prior experience (Becker et al. 2016). Youths' definitions appeared to be influenced by their own history of treatment, with adolescents who were justice-involved frequently assuming that "evidence-based" referred to legal evidence. Furthermore, when EBT was defined as a treatment approach supported by research, parents and youth perceived the approach to be inflexible and not individualized to meet their needs (Becker et al. 2016). Two other studies of adults in general and allied healthcare found similar findings (Carman et al. 2010; Tanenbaum 2008). These studies suggest that misconceptions of the concept "evidence-based" have persisted despite efforts to increase clients' knowledge of EBTs (e.g., Gruttadaro et al. 2007), although no prior studies have examined perceptions of EBT among youth and caregivers in behavioral health settings.

Given the paucity of research in this area, the goal of this study was to examine youth and caregiver perspectives of EBT to inform DTC focused marketing strategies for youth mental health concerns. Based on prior literature suggesting that therapists' attitudes are specific to interventions (Reding et al. 2014), we focused on youth and caregivers with direct experience receiving a specific EBT. We focused on youth and caregivers receiving TF-CBT given the high frequency of and negative sequelae following traumatic events in youth (Costello et al. 2002; Fairbank 2008; Kilpatrick and Saunders 1997) and therapists' perceived difficulty with the cognitive and emotional processing included within TF-CBT (Allen and Johnson 2012; Cohen et al. 2006). Our first aim was to examine youth and caregiver perspectives of the term “evidence-based” and to elicit recommendations for how to market EBTs. Consistent with prior literature, we hypothesized that youth and caregivers would have little exposure to the concept “evidence-based” (Becker et al. 2016). Next, we explored youth and caregivers’ perspectives of TF-CBT, including their experience with treatment initiation, treatment components, and satisfaction with treatment outcome, to better inform targeted implementation strategies specific to TF-CBT. Finally, we used the reliable change index to examine whether impressions of the term “evidence-based” and TF-CBT varied as a function of clinical improvement. Given the post-hoc and exploratory nature of this last aim, we did not have specific a priori hypotheses.

Method

The City of Philadelphia’s Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) was awarded a SAMHSA NCTSN Initiative Community Treatment and Service Center grant in 2012. The goal of the Philadelphia Alliance on Child Trauma Services (PACTS) was to build an array of trauma-informed care while evaluating the implementation and impact of these services on behavioral health clients (Beidas et al. 2016). TF-CBT was selected based on its established efficacy (Chaffin and Friedrich 2004), applicability to youth with diverse backgrounds (Sigel et al. 2013), and existing dissemination and implementation tools (Cohen and Mannarino 2008). Our study assumed that youth received TF-CBT as prescribed by the original treatment developer that included a standardized sequence and set of skills, which focus on increasing awareness and education of traumatic stress and decreasing symptoms and impairment from trauma.

Participants

Youth and/or their caregivers having experienced a traumatic event (e.g., witnessing a murder, sexually abused) and receiving TF-CBT through community mental health clinics participating in PACTS were recruited within a larger program evaluation to examine clinical symptom improvement after participating in TF-CBT (cf. Beidas et al. 2016). In total, 17 individual semi-structured interviews were conducted with eight youth and nine caregivers, representing 12 distinct youth-caregiver dyads receiving TF-CBT (see Table 1). Semi-structured interviews and quantitative measures were conducted with youth aged 11 and older, or with caregivers if youth were aged 10 and younger. Interviews were conducted with five youth and their caregivers ($n = 10$ distinct individuals), four caregivers who participated without their youth, and three youth who participated without their caregivers. Youth and caregivers in the same families were interviewed concurrently by interviewers in separate private rooms. The youth sample was 67% ($N = 8$) female and youth on average were aged 13.75 ($SD = 2.86$) years. Most youth identified their primary race as African American ($n = 9$, 75%), two (17%) identified as Latino, and one (8%) youth identified as mixed race. In addition to semi-structured interviews, youth and caregivers completed quantitative measures of trauma symptoms at pre-treatment, every 6 months, and post-treatment or termination. The semi-structured interviews were conducted at post-treatment and/or termination.

Table 1 Demographic information and reliable change indices for individual youth

ID	Youth interviewed	Caregiver interviewed	Age	Sex	CPSS PTSD
1	x	x	11	F	−0.95
2	x	x	11	F	−4.56^{a}
3	x	x	14	F	−1.14
4	x		17	F	−1.71
5		x	10	F	0.95
6	x		19	F	−0.19
7		x	10	F	–
8	x		13	M	−3.04^{a}
9	x	x	16	F	−4.18^{a}
10	x	x	14	M	−3.42^{a}
11		x	15	M	0
12		x	15	M	2.66^{b}

[a] RCI >1.96 indicate clinically significant change (Jacobson and Truax 1992)

[b] Indicates significant deterioration of symptoms scores; 7001 RCI not calculated due to missing data; CPSS = Child PTSD symptom scale (Foa et al. 2001)

Procedure

All procedures were approved by the University of Pennsylvania and City of Philadelphia’s Institutional Review Boards. Youth and their caregivers were recruited from a larger study evaluating the clinical outcomes for youth receiving TF-CBT, who were evaluated prior to their fourth session (baseline) and every six months until treatment termination (post; Beidas et al. 2016). Youth and their caregivers were contacted before their post-treatment assessment by study personnel and offered the option to take part in the semi-structured interview. Those who agreed were asked for informed consent and assent, and scheduled for interviews during their post-treatment assessment. Only a subset of youth and caregivers from the larger evaluation study were sampled from November 2015 to June 2016. Sampling ended when data saturation (i.e., no new themes emerged from interviews) was reached as determined by post-interview meetings between the two interviewers (L.S. and a trained clinical research coordinator). Fourteen youth and their caregivers were approached to participate ($n = 28$), of which 17 (71%) consented to participate. Twelve of the fourteen dyads approached (86%) were represented. Interviews were audio recorded, lasted 16 to 66 min ($M = 38:16$), and were transcribed by trained research assistants (description below). Participants were compensated with $50 gift cards for their time.

Measures

Child PTSD symptom scale

(CPSS; Foa et al. 2001). The CPSS is a 24-item measure that assesses Posttraumatic Stress Disorder (PTSD) symptoms within the three clusters of the DSM–IV (i.e., re-experiencing, avoidance, and arousal), which provides a PTSD symptom severity score. Items are structured on a four-point rating scale (ranging from zero "not at all or only one time" to three "always or almost always"), with higher scores indicative of greater severity. The CPSS clinical cutoff score is 11. The CPSS has demonstrated good internal consistency and reliability ($\alpha = 0.89$ for the total score; Foa et al. 2001).

Qualitative interview

The semi-structured interview consisted of open-ended questions and follow-up probes tailored to participants' responses. The interview asked participants about their broad impressions of EBT (e.g., "What would you guess the term means in your own words?"), their thoughts on strategies to market specific "evidence-based" approaches (e.g., "Where would you prefer to get information about treatment?"), and their impressions of receiving TF-CBT (e.g., "Tell me about the treatment you received."). Our goal was to elicit information regarding (a) perceptions of the term "*evidence-based,*" (b) marketing strategies for EBTs including language, modality, and to whom and where youth and caregivers would prefer look for information on treatment, and (c) impressions of TF-CBT, including their experience with treatment initiation, treatment components, and satisfaction with treatment outcome, to better inform marketing strategies specific to TF-CBT. We adapted previously developed questions asking youth about their perspectives of substance use treatment to guide the development of our interview questions (Becker et al. 2016). When soliciting impressions of "evidence-based" we defined an EBT as "a treatment that has been shown to work for kids with similar problems in research studies." This definition was consistent with prior studies (Becker et al. 2016) and the definition used in educational materials by national and state associations seeking to describe EBT to caregivers (e.g., Help Your Keiki http://helpyourkeiki.com/; Effective Child Therapy www.effectivechildtherapy.org). Parallel interview guides were developed for youth and caregivers to reflect developmentally appropriate language (and are available via R.B. at the University of Pennsylvania).

Data Analytic Strategy

Data analysis was managed in NVivo QSR 10; an iterative integrated approach including inductive and deductive reasoning was used (Bradley et al. 2007). Four team members independently coded four (two youth and two parent) transcripts to identify codes. These codes were discussed in ongoing meetings and combined with a priori codes (i.e., EBT Definition, Impressions, and Marketing) to form a codebook (Bradley et al. 2007). The codebook evolved over the course of initial coding and discussions, and included operational definitions of each code, example quotes, and guidance in when to not use codes (see Table 2). The codebook was then applied to four additional transcripts and refined throughout the data analytic process (Bradley et al. 2007). Two independent raters (K.O. and E.B.H.) coded all data. Twenty percent of the transcripts were randomly selected for double coding to determine interrater reliability (cf. Beidas et al. 2013). The raters met together to discuss, clarify, and compare codes to ensure consensus. Rater consensus was calculated using Cohen's Kappa and agreement was excellent ($\kappa = 0.97$; Landis and Koch 1977). The resulting codes were then independently read by two raters (K.O. and L.S.) to examine themes, sub-codes, and in-text examples. Unless specified, themes and examples are reflective of 50% or more of the youth and caregivers interviewed.

To assess clinical improvement, means and standard deviations for the CPSS at baseline and post-treatment were calculated. Given the small sample size, we calculated a reliable change index (RCI), which represents a standardized metric of clinical change for each youth (Jacobson and Truax 1992). The RCI is calculated by dividing the score difference of two time points by the standard error of the difference of the measure being administered. RCI values larger than 1.96 indicate statistically significant clinical change (Jacobson and Truax 1992). As a post-hoc analysis, we examined differences in youth and caregivers' "evidence-based" and TF-CBT impression themes based on significant clinical improvement.

Table 2 Qualitative codes, definitions, and examples

Code: definition	Caregiver example	Youth example
Evidence-based treatment (EBT)		
[a]EBT definition: any definition provided by the participant for "evidence-based" and familiarity with the definition or term	"You got to gather this evidence so you know exactly what's being treated." "When I think of evidence is facts, so we're going off of what you say versus what we think."	"I think it would be talking about your treatment and um I mean I guess like the evidence that it happened to you …" "Therapy based on what happened in your life."
[a]EBT impressions: participant impressions of the term "evidence-based treatment"	"Need to express and not make a parent feel like 'they just trying to use my child as a guinea pig or something like that."	
[a]EBT marketing: strategies to increase the uptake of EBTs including promotion and language	"Actually, I Google a lot of stuff … I ask friends, I ask the school … I ask for any help."	"I would ask about what is the evidence—what exactly is it that they do?"
TF-CBT		
Initiation/referral: related to the process of starting treatment and specific reasons and motivation for initiating treatment	"[Therapist] was letting me know that this could kind of help and she's pretty much explaining how good the process would be or what it would be or what's going on… And I was like if you feel like it would help her more then I'm probably all for it …. She was like I really think this would be a great thing for her."	"If it can help other people it can probably help me, so I was like I saw it in a positive way and I was like it's probably good because it helped a lot of other people that had probably been through the same thing as me, or something different, or probably worse."
Treatment components: specific components or skills learned during TF-CBT or other treatment programs	"[I learned to] listen more attentively and, you know, um, just consider [my child's] feelings sometimes." "And it really helped me learn, it's like certain things, I'm like you're scared of that? And he's like, "well yeah." Oops never knew."	"I like the triangle … I used the triangle again because I feel that was helpful. Because I get to see all my thoughts on the paper. Then I get to see I was reacting, how I felt." "Well the other therapy … they didn't do like, do as, like, as many activities …. They just want you to sit in a room and talk to them."
Trauma narrative: any mention of the trauma narrative within treatment	"I didn't realize she saw as much as she did." "Just hearing her say her part of the story and seeing her finally like getting out like I'm free … that actually helped me a lot … just made me feel better and I know she feels free."	"I feel like, I felt lighter, like emotionally lighter." "It was like, [mom] got all my feelings, and how I felt, and, um, she comforted me, and she encouraged me."
Outcome: refers to any mention of outcome of TF-CBT	"Treatment makes you really aware of your children because now you're like—now you really sit and look and are like, hmm, I gotta remember to write that down." "She taught him how to communicate and me how to be receptive to the communication because again like I said as parents we normally just judge our children, tell them what not to do, how they shouldn't feel …"	"I liked it, and felt like it helped me … And it opened my eyes to, you know, I think, outside the box now." "I think my level of understanding has changed for myself and for the people around me so I think that's a big difference."

[a]Indicate a priori codes based on Becker et al. (2016)

Results

Perceptions of Evidence-based Treatment

Youth and caregivers were asked about their broad impressions of the term "evidence-based" and their thoughts on strategies to market EBTs (examples provided in Table 2). One youth and three caregivers (23.5% of 17 interviewees) endorsed prior exposure to the term "evidence-based treatment." When participants were asked to define EBT, many caregivers used terms like "facts" and "research" and were able to express the general concept that EBTs referred to treatments supported by research. For example, one parent noted succinctly that EBT means "there's research based on things that work. It's proven to work." However, ten participants defined the concept incorrectly. A common misperception from three youth and one caregiver was that the term "evidence" referred to personal experience. For example, one youth noted that evidence referred to "what happened in your life" rather than research. Two youth did not attempt to define EBP.

After hearing our definition of EBT (i.e., a treatment that has been shown to work for kids with similar problems in research studies), five participants found the concept appealing because it indicated that the treatment was proven to work with other youth. By contrast, five other participants cautioned against using the term "evidence-based" due to possible negative reactions, like sounding too experimental or potentially harmful, or confusion in youth and caregivers. Instead, caregivers preferred an explanation of the treatment and how it would be individualized to their child.

Youth and caregivers also liked the idea of receiving treatment that worked for others, but worried that a treatment informed by research would not be individualized. As one caregiver explained:

> You can line ten apples up in a row and they can all be the same color, they're not gonna all be the same shape, they're not gonna all be the same size, so what makes this one apple stand out or get more treatment or the specific treatment? … If [the treatment] generally works as a whole, fine. But find something that works specifically for my child.

Youth and caregivers both expressed their desire to be *shown* rather than *told* a treatment has worked. Six participants noted a preference for having youth who received an EBT share "testimonials" or "their story" with other youth and caregivers in commercials, brochures, ads, reviews, or websites. One youth noted that having "an animated video … [so] people can actually see how it works rather than trying to process it" would be a good way to market EBTs. Caregivers stated that they valued information that would aid in normalizing their child's concerns. One caregiver noted that using the term "similar … or similarities … things they've been through: symptoms, background, stories" would help with treatment engagement.

Ten participants reported that they currently receive treatment referral information from trusted family and friends, providers (e.g., pediatricians), and by doing their own informal research on the internet (e.g., Google). One youth noted that she gets information in school from "my counselor." When asked for additional preferred sources of information, youth and caregivers identified schools, pediatricians' offices, hospitals, and churches. Caregivers noted that they would rely on information provided in school newsletters, parent focus groups in school, or reviews of therapists or agencies online. One caregiver stated, "I go onto the internet because people leave real reviews."

Perceptions of TF-CBT

We solicited from youth and caregivers their perceptions of their experience receiving TF-CBT to inform marketing strategies specific to TF-CBT. Youth and caregivers noted (a) external motivation for initiating services, (b) the importance of the therapeutic relationship, (c) the focus of skill development in TF-CBT, (d) the significance of the trauma narrative, and (e) perceived outcomes in both youth and caregiver following TF-CBT.

Both youth and caregivers noted external motivation for initiating TF-CBT. Four caregivers indicated that child service agencies such as the Department of Human Services or Juvenile Court were involved in decision-making. Four youth reported that their participation in TF-CBT was their caregivers' decision.

Once in treatment, youth and caregivers expressed the importance of the therapeutic relationship and trusting their therapist to engage in TF-CBT. For example, one mother narrated the dialogue she had with her child's therapist and noted, "She was like, 'I really think this would be a great thing for [your child]' so I said OK, I trust your judgment." Another caregiver stated that "because knowing [therapist] for so many years … I knew that she was going to look for good help for [my child]." Youth and caregivers also valued knowing that TF-CBT has worked with other kids and youth appreciated having a choice in treatment participation. Furthermore, youth appreciated receiving encouragement from their therapist to engage in treatment. One youth reported that "expressing my feeling to [my therapist], she's like 'you can do this, you can do that' so me expressing my feelings … it built up how confident I could be."

Youth and caregivers were asked to recall specific treatment components and skills they learned within TF-CBT. The most commonly recalled components were: relaxation ($n = 14$, 82.4%), trauma narrative ($n = 12$, 70.6%), youth psychoeducation ($n = 8$, 47.1%), caregiver psychoeducation ($n = 3$, 17.6%), self-monitoring ($n = 3$, 17.6%), cognitive restructuring ($n = 1$, 5.9%), and personal safety skills ($n = 1$, 5.9%). Youth and caregivers noted their preference for learning skills in session over talk or play therapy. One caregiver voiced her displeasure with previous treatment that focused mostly on playing in session: "the girl was still going through trauma … [and] a lot of stress, and … she would just go over there to play." Another caregiver reported satisfaction when her child learned skills in session:

> Well, with the family [therapy] it was just more so conversation. With [TF-CBT], it was conversation, it

> was skills, … it wasn't just, OK, I'm telling you my business … With [TF-CBT], it was skills like, OK, this is how you feel, alright, this is how you do this to help you with that.

Eight (66.7%) of the 12 youth had completed the trauma narrative at the time of the interview. One youth described the trauma narrative as:

> We gotta write out our trauma, … for an example, if we were raped … we would have to write all that out and … then our family comes in … and we would talk to them and explain to them what happened and just basically open up.

Both youth and caregivers indicated the importance of having a caregiver involved in therapy, especially in the trauma narrative.

Five youth and five caregivers who completed the trauma narrative often described associated improvements in their family functioning and communication. For example, the same youth who described the trauma narrative above also commented on changes, including insight into their own behavior:

> I liked that … I got to write out my trauma … because it was a release … I took something off my back … And then I opened up to my family, telling them about it. I mean, it was an option to do that. I decided to do that because there were some things that I wanted my family to know and to let them know why the reason that I act like this. And the reason why I do the things that I do and the things that I did. And … it brought my family relationship a little better with me because I broke their trust at one point … they didn't trust me … because I was stealing from them and I was doing … things that weren't appropriate so they just didn't trust me. So, it brought my family closer to me. I basically just like the trauma narrative part, writing that out.

Three caregivers also reported gaining a new perspective into their child's experience of the traumatic event through the trauma narrative. Similarly, youth reported that their caregivers were able to understand their perspective in a new and helpful way: "It was, like, [my mom] got all my feelings, and how I felt, and … she comforted me, and she encouraged me." Youth and caregivers also reported a sense of release after choosing to share or hearing their child's narrative. One mother noted that:

> Just hearing [my daughter] say her part of the story and seeing her finally like getting it out like I'm free… that actually helped me a lot because I thought her mind had the story like raw, horrifying as it is in my head and it just—just made me feel better and I know she feels free.

In addition to improved family functioning and communication, both youth and caregivers reported that youth were more open and willing to talk about their feelings after TF-CBT. Caregivers also noted decreases in outbursts, tantrums, and oppositional behavior through consistency in rules as well as increased awareness of their child's perspective. Youth reported being more focused on the future and were able to identify reasons for their oppositional behaviors after the traumatic event. For example, one youth noted that "some of the things I wrote on there, I never really thought about … I never really thought about that these reasons were the reasons why I was doing the things that I was doing."

TF-CBT Perceptions and Clinical Improvement: Post Hoc Analysis

We used the RCI to examine whether youth and caregiver impressions of TF-CBT varied as a function of outcome. Youth-reported PTSD symptoms on the CPSS averaged 20.9 ($SD = 11.2$; $N = 12$) at baseline and 13.5 ($SD = 10.4$; $N = 11$) at post-treatment. At baseline, 92% ($N = 11$) of youth had a clinically significant CPSS PTSD score, as compared to 55% ($N = 6$) of youth at post-treatment. Individual change as measured by RCI is presented in Table 1. Four (33.3%) of the 12 youth evidenced clinically significant positive change from baseline to termination evaluation. Seven (58.3%) of the 12 youth did not evidence significant clinical change and one (8.3%) evidenced clinically significant deterioration.

Examination of EBT impressions did not reveal differences based on clinical change, with youth and caregivers consistently noting that knowing it has worked for others was a good way to market EBTs. TF-CBT experience in the four youth with positive clinical change revealed that all these youth described creating a trauma narrative and doing so with therapists guiding them at a comfortable pace. Specifically, one youth reported that "it was kind of hard for me because I didn't want to talk. Well, we would go little by little, if I didn't want to do the book [trauma narrative] today we would do something different." Additionally, the youth that experienced significant improvements shared that they were given a choice in sharing their narrative with caregivers. One youth noted that her therapist explained to her, "And now you have two options whether you want to read it or not … she was telling me that I have to read it to [my mother] because that'll be where it's complete and I won't have to think about it anymore and poof it's gone.

When I finally read it to [my mother] and got through it I felt so relieved."

Discussion

The current study elucidated the perspectives of youth and their caregivers receiving TF-CBT in a public behavioral health system. Our goal was to identify youth and caregivers' impressions of the concept of "evidence-based" treatment and optimal strategies to market EBTs, as well as their specific experiences with TF-CBT to inform targeted implementation strategies. First, and consistent with prior studies (Becker et al. 2016; Carman et al. 2010; Tanenbaum 2008), findings suggest that youth and caregivers are unfamiliar with the concept of "evidence-based" treatment and have negative impressions of the approach. Specifically, caregivers and youth had concerns that treatment guided by research would adhere to a rigid, one-size-fits-all approach. These findings suggest that efforts to market treatments to clients may miss the mark if they focus on terms emphasizing evidence and research. Second, testimonials emerged as a preferred method for marketing EBTs; suggesting that future implementation strategies targeting youth and caregivers consider using the lived experiences of clients who have benefited from treatment. Third, the role of the therapist as a broker in youth and caregiver engagement in EBT was paramount. Finally, our exploratory aim revealed that impressions of EBT did not vary as a function of clinical change in response to TF-CBT, suggesting that our findings were robust across youth, and that clinical improvement in TF-CBT was associated with receipt of a trauma narrative and perceptions of the therapist as collaborative, highlighting these treatment elements as key areas to emphasize in future implementation efforts.

Consistent with previous studies, youth and caregivers had no previous exposure to the idea that "evidence-based" referred to research evidence (Becker et al. 2016). This finding suggests that youth and caregivers, particularly in under-resourced settings, are not receiving targeted information to increase their knowledge of EBTs. Furthermore, youth and caregivers expressed confusion and apprehension toward the term "evidence," suggesting that researchers may be taking for granted the clarity and general utility of the term "evidence-based." Indeed, the field of psychotherapy has recently been challenged to refine the terms used to describe the broader principles of evidence-based practice as an overarching process (Codd III 2017) in order to more clearly emphasize that research evidence is merely one facet and should be accompanied by clinical expertise and consideration of client preferences (American Psychological Association 2006; Institute of Medicine 2001). Our results suggest that definitions of EBTs, which historically have focused solely on evidence of effectiveness and efficacy in research trials (e.g., Help Your Keiki http://helpyourkeiki.com/; Effective Child Therapy www.effectivechildtherapy.org), could benefit from similar modifications to emphasize the potential for individualization. Caregivers also cautioned against using the term "research" to describe the source of evidence as it implied a negative experimental approach to treatment (e.g., Henrietta Lacks; Skloot 2011) and a shift away from individualizing treatment to the needs of their children. The former notion may be particularly salient within our sample, which was predominantly African American, a population that has exhibited a mistrust of research (e.g., Kennedy et al. 2007). These findings can potentially be used to inform the development of messaging around EBTs and evidence-based practice, by emphasizing the need for youth and caregivers to hear how their own preferences and the therapists' expertise will inform treatment delivery and impact the effectiveness of the treatment.

Sharing testimonials and stories of youth with similar backgrounds and experiences was the most common suggestion for EBT marketing. Consistent with this notion, youth and caregivers who improved after TF-CBT noted that hearing from their therapist that TF-CBT had worked with other kids helped them feel more confident about the treatment. Specific examples of clinical change after TF-CBT can help ground youth and caregivers in what to expect from treatment, and emphasizing that session time will be spent learning skills rather than talking or playing may help therapists "sell" TF-CBT to youth and caregivers. Additionally, youth were referred to services by external child service agencies, suggesting that one potential marketing strategy may be to target and train child service agency workers in how to communicate with youth about TF-CBT. For example, having caseworkers serve as "brokers" for EBTs by promoting and referring youth and their caregivers to agencies that provide EBTs may be an intermediary step to ensuring youth receive evidence-based care (Fitzgerald et al. 2015).

Consistent with previous research, the importance of the therapist in promoting TF-CBT to youth and caregivers and establishing trust stood out as a clear theme (Cunningham et al. 2015). Therapists were able to gain caregivers' trust by communicating with them regularly and including them as an integral part of treatment. Youths' trust was gained through the therapist providing choices in treatment to engage in skills, especially skills that require more time and emotional investment (e.g., trauma narrative). This finding is consistent with recent evidence that a positive therapeutic relationship is especially important for TF-CBT (Ormhaug et al. 2014). Increasing therapeutic trust through open communication and increasing youth and caregiver knowledge may be important implementation strategies.

As the mental health field enters an era of considering how to best market psychosocial treatments to clients, the role of professionals such as therapists, brokers, and treatment developers must begin to evolve to address the ongoing barriers to EBT use. Marketing strategies should foster increasing client knowledge and demand (Becker 2015; Friedberg 2017), but may need to be translated by therapists who understand and believe in the value of research evidence and can communicate the benefits to clients. However, a knowledgeable therapist may not know the most effective way of communicating the need for research evidence to clients (Trogen 2017). Targeted therapist trainings on how to initiate and sell EBTs to clients will be essential to creating client demand. Several suggestions to market EBTs to youth and caregivers emerged from our findings, including having trusted online sites for reviews of therapists and treatments (Ranard et al. 2016). Another suggestion was to create videos of the therapy process to provide youth and caregivers an overview of treatment. These videos could be made specific to each treatment and used in initial sessions to elicit misconceptions and barriers, and to increase engagement in treatment. Furthermore, revisiting the goal of marketing EBTs may be useful, given that findings from this and other studies have suggested that clients have misconceptions and negative impressions of the term "evidence-based." It may be more beneficial to foster client knowledge of specific interventions (e.g., TF-CBT) rather than "evidence-based" treatments or evidence-based practice (Okamura et al. 2018; Reding et al. 2014).

Limitations

The findings from the current study should not be taken without limitations. First, given our small sample size, generalizability of our findings may be limited. Furthermore, coding was done broadly and did not focus on distinguishing the difference between youth- and parent-report. Second, only a subsample of the youth and caregivers receiving TF-CBT in the larger evaluation study participated in the qualitative interview, which may have inadvertently affected results. However, we heard recurrent themes throughout the interviews indicating that we had reached saturation and that new themes were unlikely to emerge with additional interviews. Future studies may wish to sample a broad population receiving more than one specific treatment to further generalize the current study's findings. Another artifact of our sample relates to the nature of referral for youth and caregivers to TF-CBT treatment and their motivation for seeking treatment. More specifically, caregivers noted that they were referred to treatment by external agencies such as Child Welfare, and youth noted that they entered treatment based on caregiver decision. Yet, when asked how they would get trusted information regarding treatment, both youth and caregivers noted family members, friends, trusted providers, and the internet (e.g., Google). Therefore, future research should explore how the mechanisms through which clients get connected with treatment relates to treatment perspectives. Moreover, it is important to note that only 33% of youth evidenced clinically significant improvement. This may have happened for several reasons including the time at which participants were sampled (i.e., three youth had not yet completed the trauma narrative) and the overall complexity of community mental health with high attrition rates and multimorbidity. Therefore, findings related to clinical improvement should be interpreted with caution. Finally, as with any cross-sectional study, the findings do not imply any causal relationships.

Despite these limitations, the current study provided insight into youth and caregivers' perceptions of the concept of "evidence-based" treatment and TF-CBT in a sample of ethnic minority youth. Perhaps the most noteworthy finding to emerge from our study was the therapist's role in encouraging youth and caregivers to initiate EBT. Future research should continue to investigate the role of the therapist in promoting EBT utilization by identifying effective strategies therapists can employ to market EBTs. One avenue may be having a bank of testimonials or videos explaining the therapy process. Another method may be to explore youth and caregivers' perspectives of treatment through other dissemination modalities such as peer support specialists and advocacy groups. An additional issue that became clear through this investigation is perhaps an overreliance on the terms "evidence-based" and "research." What may be additionally important in conveying to clients that a treatment has worked is incorporating client characteristics and therapist clinical expertise, which is aligned with the comprehensive definition of evidence-based practice employed by leading national organizations (American Psychological Association 2006; Institute of Medicine 2001). Given the growth of the client-driven healthcare market (Rockwell 2017), identifying client perspectives will continue to be a worthwhile endeavor for EBT implementation.

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designed and executed the study, assisted with data analyses, and collaborated with the writing of the paper.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional (University of Pennsylvania and the City of Philadelphia) and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

References

Allen, B., & Johnson, J. C. (2012). Utilization and implementation of trauma-focused cognitive–behavioral therapy for the treatment of maltreated children. *Child Maltreatment*, *17*, 80–85.

APA Presidential Task Force on Evidence-Based Practice (2006). Evidence-based practice in psychology. *The American Psychologist*, *61*(4), 271.

Becker, S. J. (2015). Direct-to-consumer marketing: a complementary approach to traditional dissemination and implementation efforts for mental health and substance abuse interventions. *Clinical Psychology: Science and Practice*, *22*, 85–100.

Becker, S. J., Spirito, A., & Vanmali, R. (2016). Perceptions of 'Evidence-Based Practice' among the consumers of adolescent substance use treatment. *Health Education Journal*, *75*, 358–369.

Beidas, R. S., Adams, D. R., Kratz, H. E., Jackson, K., Berkowitz, S., Zinny, A., & Evans, A. (2016). Lessons learned while building a trauma-informed public behavioral health system in the City of Philadelphia. *Evaluation and Program Planning*, *59*, 21–32.

Beidas, R. S., Edmunds, J. M., Cannuscio, C. C., Gallagher, M., Downey, M. M., & Kendall, P. C. (2013). Therapists perspectives on the effective elements of consultation following training. *Administration and Policy in Mental Health and Mental Health Services Research*, *40*(6), 507–517.

Bradley, E. H., Curry, L. A., & Devers, K. J. (2007). Qualitative data analysis for health services research: developing taxonomy, themes, and theory. *Health Services Research*, *42*, 1758–1772.

Carman, K. L., Maurer, M., Yegian, J. M., Dardess, P., McGee, J., Evers, M., & Marlo, K. O. (2010). Evidence that consumers are skeptical about evidence-based health care. *Health Affairs*, *29*, 1400–1406.

Chaffin, M., & Friedrich, B. (2004). Evidence-based treatments in child abuse and neglect. *Children and Youth Services Review*, *26*, 1097–1113.

Codd, III, T. (2017). Protecting the scientific lexical canon. *The Behavior Therapist*, *40*, 185–191.

Cohen, J. A., & Mannarino, A. P. (2008). Disseminating and implementing trauma focused CBT in community settings. *Trauma Violence & Abuse*, *9*, 214–226.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York, NY: Guilford Press.

Costello, E. J., Erkanli, A., Fairbank, J. A., & Angold, A. (2002). The prevalence of potentially traumatic events in childhood and adolescence. *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies*, *15*, 99–112.

Cunningham, C. E., Rimas, H., Chen, Y., Deal, K., McGrath, P., Lingley-Pottie, P., & Corkum, P. (2015). Modeling parenting programs as an interim service for families waiting for children's mental health treatment. *Journal of Clinical Child & Adolescent Psychology*, *44*, 616–629.

Daubresse, M., Hutfless, S., Kim, Y., Kornfield, R., Qato, D. M., Huang, J., & Alexander, G. C. (2015). Effect of direct-to-consumer advertising on asthma medication sales and healthcare use. *American Journal of Respiratory and Critical Care Medicine*, *192*, 40–46.

DeCandia, C. J., Guarino, K., & Clervil, R. (2014). *Trauma-informed care and traumaspecific services: A comprehensive approach to trauma intervention*. Washington, DC: American Institute for Research.

Fairbank, J. A. (2008). The epidemiology of trauma and trauma related disorders in children and youth. *PTSD Research Quarterly*, *19*, 1–7.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., & Edwards, V., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*, 245–258.

Fitzgerald, M. M., Torres, M. M., Shipman, K., Gorrono, J., Kerns, S. E., & Dorsey, S. (2015). Child welfare caseworkers as brokers of mental health services: a pilot evaluation of project focus Colorado. *Child Maltreatment*, *20*, 37–49.

Flynn, L. M. (2005). Family perspectives on evidence-based practice. *Child and Adolescent Psychiatric Clinics of North America*, *14*, 217–224.

Foa, E. B., Johnson, K. M., Feeny, N. C., & Treadwell, K. R. (2001). The Child PTSD symptom scale: a preliminary examination of its psychometric properties. *Journal of Clinical Child Psychology*, *30*, 376–384.

Friedberg, R. D., & Bayar, H. (2017). If it works for pills, can it work for skills? Direct-to-consumer social marketing of evidence-based psychological treatments. *Psychiatric Services*, *68*, 621–623.

Gallo, K. P., Comer, J. S., & Barlow, D. H. (2013). Direct-to-consumer marketing of psychological treatments for anxiety disorders. *Journal of Anxiety Disorders*, *27*, 793–801.

Gallo, K. P., Comer, J. S., Barlow, D. H., Clarke, R. N., & Antony, M. M. (2015). Direct-to-consumer marketing of psychological treatments: a randomized controlled trial. *Journal of Consulting and Clinical Psychology*, *83*, 994–998.

Glisson, C., & Schoenwald, S. K. (2005). The ARC organizational and community intervention strategy for implementing evidence-based children's mental health treatments. *Mental Health Services Research*, *7*, 243–259.

Gruttadaro, D., Burns, B., Duckworth, K., & Crudo, D. (2007). *Choosing the right treatment: what families need to know about evidence-based practices*. Arlington, VA: National Alliance on Mental Illness.

Hoagwood, K. E. (2005). Family-based services in children's mental health: a research review and synthesis. *Journal of Child Psychology and Psychiatry*, *46*, 690–713.

Institute of Medicine (2001). *Crossing the quality chasm: a new health system for the 21st century*. Washington, DC: National Academy Press.

Jacobson, N. S., & Truax, P. (1992). Clinical significance: a statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, *59*(1), 12–19.

Kazdin, A. E., & Blase, S. L. (2011). Rebooting psychotherapy research and practice to reduce the burden of mental illness. *Perspectives on Psychological Science*, *6*, 21–37.

Kennedy, B. R., Mathis, C. C., & Woods, A. K. (2007). African Americans and their distrust of the health care system: healthcare for diverse populations. *Journal of Cultural Diversity*, *14*, 56–60.

Kilpatrick, D. G., & Saunders, B. E. (1997). *Prevalence and consequences of child victimization: results from the National Survey of Adolescents: Final report*. Washington, DC: US Department of Justice, Office of Justice Programs.

Kreuter, M. W., & Bernhardt, J. M. (2009). Reframing the dissemination challenge: a marketing and distribution perspective. *American Journal of Public Health*, *99*(12), 2123–2127.

Landis, J. R., & Koch, G. G. (1977). An application of hierarchical kappa-type statistics in the assessment of majority agreement among multiple observers. *Biometrics*, 363–374.

McHugh, R. K., & Barlow, D. H. (2010). The dissemination and implementation of evidence-based psychological treatments: a review of current efforts. *American Psychologist*, *65*, 73–84.

Middlebrooks, J. S., & Audage, N. C. (2008). *The effects of childhood stress on health across the lifespan*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Mukherji, P., Janakiraman, R., Dutta, S., & Rajiv, S. (2017). How direct-to-consumer advertising for prescription drugs affects consumers' welfare: a natural experiment tests the impact of FDA legislation. *Journal of Advertising Research*, *57*(1), 94–108.

Okamura, K. H., Hee, P. J., Jackson, D., & Nakamura, B. J. (2018). Furthering our understanding of therapist knowledge and attitudinal measurement in youth community mental health. *Administration and Policy in Mental Health and Mental Health Services Research*, *45*, 699–708.

Ormhaug, S. M., Jensen, T. K., Wentzel-Larsen, T., & Shirk, S. R. (2014). The therapeutic alliance in treatment of traumatized youths: relation to outcome in a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, *82*, 52.

Powell, B. J., Waltz, T. J., Chinman, M. J., Damschroder, L. J., Smith, J. L., Matthieu, M. M., & Kirchner, J. E. (2015). A refined compilation of implementation strategies: results from the Expert Recommendations for Implementing Change (ERIC) project. *Implementation Science*, *10*, 1–14.

Ranard, B. L., Werner, R. M., Antanavicius, T., Schwartz, H. A., Smith, R. J., Meisel, Z. F., & Merchant, R. M. (2016). Yelp reviews of hospital care can supplement and inform traditional surveys of the patient experience of care. *Health Affairs*, *35*, 697–705.

Reding, M. E., Chorpita, B. F., Lau, A. S., & Innes-Gomberg, D. (2014). Providers' attitudes toward evidence-based practices: is it just about providers, or do practices matter, too? *Administration and Policy in Mental Health and Mental Health Services Research*, *41*, 767–776.

Ringle, V. A., Walsh, L. M., Maxwell, C. A., Smith, A. M., Grossman, R. A., Becker, S. J., & Jensen-Doss, A. (2019). Understanding of evidence-based mental health care and the perceived importance of scientific information in a sample of US adults. *Journal of Clinical Psychology*, 1–15.

Rockwell, K. L. (2017). Direct-to-consumer medical testing in the era of value-based care. *JAMA*, *317*, 2485–2486.

Sanders, M. R., & Kirby, J. M. (2012). Consumer engagement and the development, evaluation, and dissemination of evidence-based parenting programs. *Behavior Therapy*, *43*, 236–250.

Santucci, L. C., McHugh, R. K., & Barlow, D. H. (2012). Direct-to-consumer marketing of evidence-based psychological interventions: introduction. *Behavior Therapy*, *43*, 231–235.

Sheehan, A. K., Walrath, C. M., & Holden, E. W. (2007). Evidence-based practice use, training, and implementation in the community-based service setting: a survey of children's mental health service providers. *Journal of Child and Family Studies*, *16*, 169–182. https://doi.org/10.1007/s10826-006-9076-3.

Sigel, B. A., Benton, A. H., Lynch, C. E., & Kramer, T. L. (2013). Characteristics of 17 statewide initiatives to disseminate trauma-focused cognitive-behavioral therapy (TF-CBT). *Psychological Trauma: Theory, Research, Practice, and Policy*, *5*, 323.

Skloot, R. (2011). *The immortal cells of Henrietta Lacks*. New York: Crown-Random House.

Tanenbaum, S. J. (2008). Perspectives on evidence-based practice from consumers in the US public mental health system. *Journal of Evaluation in Clinical Practice*, *14*, 699–706.

Trogen, B. (2017). The evidence-based metaphor. *JAMA*, *317*(14), 1411–1412.