

MINDFULNESS THERAPY FOR SURVIVORS OF CHILDHOOD ADVERSITY:

WHAT'S THE USE?

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ABSTRACT

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Adverse childhood experiences (ACEs) warrant clinical concern due to the consequences and impacts on the survivors' biological, psychological, and social functioning. The frontline therapy for survivors of ACEs are trauma-focused therapies (TFTs), however TFTs are infrequently used by therapists. Mindfulness-based interventions (MBI) may be a promising alternative due to higher use rates among practitioners and similar treatment effects. Questions about potential barriers to using TFTs and MBIs were developed using the Promoting Action on Research Implementation in Health Services (PARIHS) framework, which purports three core factors that influence clinical uptake: context (e.g., practicing in a workplace congruent with MBIs or TFTs), evidence (e.g., knowing/believing MBIs or TFTs are effective for their clients), and facilitation (e.g., having the training and support to deliver MBIs or TFTs). Via email, this 25-question online survey was sent to 1,449 practicing therapists who see adults and/or children seeking treatment related to ACEs. A total of 68 surveys were completed. Slightly more participants endorsed using MBIs with adults (60%) and children (50%) than endorsed using TFTs with adults (53%) and children (42%) often (at least every other session) endorsed using when using TFTs and MBIs at least every other session, but these differences were not statistically significant (p 's > .2). More participants indicated experiencing strong barriers that prevent use of TFTs compared to MBIs ($\chi^2[2, N = 68] = 6.250, p = .012$), particularly context-related barriers ($p = .002$). These results could be explained by not being able to use TFTs at work due to specific population concerns. Findings may inform training/dissemination of promoting an

efficacious treatment for survivors of ACEs.

KEY WORDS: Adverse Childhood Experiences, Mindfulness-Based Intervention

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CHAPTER I

Literature Review

Mindfulness has gained incredible mainstream popularity for promoting mental health among non-clinical populations (Newsweek, 2017; Time Magazine, 2016). Mindfulness has also skyrocketed as a topic of clinical research (Goldberg et al., 2017; Khoury et al., 2013; Zoogman, Goldberg, Hoyt, & Miller, 2015) and gained ground as a therapeutic paradigm (Edwards, 2016) over the last two decades. Experts define mindfulness as “an awareness of moment-by-moment experiences that arises from purposeful attention, along with nonjudgmental acceptance of the experiences” (Matchim & Armer, 2007). Mindfulness can be classified into two parts: mindfulness practices (MPs) and mindfulness-based interventions (MBIs; Hanley, Abell, Osborn, Roehrig, & Canto, 2016; Lutz, Slagter, Dunne, & Davidson, 2008). MPs involve focusing attention on the present moment in the form of formal meditation (which often occurs in a sitting or lying position) or “active” meditation (such as walking, eating, or bathing mindfully). MPs are not considered “stand alone” treatments, and are often incorporated into other therapeutic approaches (Edwards, 2016; Michalak & Heidenreich, 2018). MBIs, on the other hand, consist of therapeutic sessions fairly standardized in content (i.e., “manualized”), often lasting 8-12 weeks, and accompanied by mindfulness-related “homework” to be completed by clients between sessions. Examples of these more structured and goal oriented MBIs which have been heavily researched are, as follows: a) Mindfulness Based Stress Reduction (MBSR; Kabat-Zinn, 2003) which was created to standardize the benefits of mindfulness in to an intervention that can be used in clinical settings b) Mindfulness-Based Cognitive Therapy (MBCT) combining the work of Kabat-Zinn into the CBT paradigm (Segal, Williams, & Teasedale, 2002), c) Dialectical

Behavior Therapy (DBT), focusing on increasing mindfulness as well as distress tolerance, emotion regulation, and interpersonal effectiveness (Linehan et al., 2006), and d) Acceptance and Commitment Therapy (ACT), which focuses on alleviating experiential avoidance through the use of mindfulness (Hayes, Strosahl, & Wilson, 1999). MPs and MBIs all have the common focus of remaining in the present moment and, in many cases, the common outcome of increased relaxation, quality of life, and resiliency in the face of environmental stress.

MPs and MBIs have been investigated in a wide range of patient populations, including survivors of trauma, with promising results (Goulao & MacLennan, 2016; King et al., 2016; Krüger et al., 2014; Polusny et al., 2015; Thompson, Luoma, & LeJeune, 2013). Though the frontline treatment for trauma is exposure-based trauma-focused therapy (e.g., Prolonged Exposure, Cognitive Processing Therapy, Trauma-focused Cognitive-Behavioral Therapy, respectively; Lenz, Bruijn, Serman, & Bailey, 2014; McLean & Foa, 2011; McLean & Foa, 2013; Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010), few practitioners use these therapies with clients seeking treatment for trauma, including ACEs (Becker, Zayfert, Anderson, 2004), and due to the study being published more than 10 years ago, information regarding the use rate of empirically supported therapies for survivors of ACEs could be updated. The present study posits that, compared to TFT, MPs and MBIs may be perceived by therapists as a more palatable treatment for patients seeking therapy in the mediation of Adverse Childhood Experiences (ACEs), and early research suggests MPs and MBIs may be effective for these patients.

Why Not Examine Use of Trauma-Focused Therapies for ACE Survivors?

Adverse childhood experiences are negative events that can, according to Dong and colleagues, “consist of trauma induced by abuse, neglect, and household dysfunction (2004).” The Center for Disease Control classifies 10 events as ACEs: emotional abuse, physical abuse, sexual abuse, witnessing domestic violence, witnessing substance abuse, living with a mentally ill family member, parental separation or divorce, having an incarcerated household member, emotional neglect, and physical neglect (Center for Disease Control and Prevention [CDC], 2016). The frontline therapy for all traumas, regardless of if they are classified as ACEs, centers on trauma-focused therapies, such as Prolonged Exposure (McLean & Foa, 2011; McLean & Foa, 2013), Cognitive Processing Therapy (Lenz et al., 2014), or Trauma-focused Cognitive Behavioral Therapy (Ramirez de Arellano et al., 2014). While these treatment approaches have proven effective in a variety of contexts (Powers et al., 2010), one study found that the vast majority, roughly 83%, of licensed psychologists do *not* use trauma-focused therapies when treating patients with PTSD (Becker et al., 2004). Clinicians surveyed in this study reported barriers to using trauma-focused therapy techniques, including discomfort with exposure therapy, and general ignorance about trauma-focused therapies. Furthermore, a study of 33 community practitioners found that independent implementation of TFTs (specifically TF-CBT) were low (Woody, Anderson & D’Souza, 2015), and follow-ups reported that implementation of specific TF-CBT methods regarding trauma narrative and restructuring maladaptive cognitions was inconsistent (Woody, Anderson, D’Souza, Baxter & Schubauer, 2015). Information regarding the types of therapeutic approaches practitioner are using with individuals seeking treatment related to ACEs is scarce and

justifies further examination. Previous studies have not examined practitioners' use of mindfulness-based therapies with individuals seeking treatment related to ACEs. MPs and MBI may be more appealing to practitioners working with this population, and a growing body of research suggests MPs and MBIs can improve biological, psychological, and social functioning for children and adult ACE survivors.

The purpose of this study is to 1) understand the extent to which therapists choose to use MPs, MBIs, and/or TFTs when providing ACE-related treatment to adults and children, and 2) investigate therapist-cited barriers to using MPs, MBIs, and TFTs when providing ACE-related treatment to adults and children. Survey questions inquiring about possible barriers are based on the Promoting Action on Research Implementation in Health Services (PARIHS) framework (Rycroft-Malone et al., 2002). Findings may inform training and dissemination of MPs, MBIs, and TFTs particularly for use in the treatment of survivors of ACEs.

Adverse Childhood Experience and Mindfulness-Based Therapy for ACE Survivors

ACEs have garnered attention from health organizations like the CDC because of their significant public health impact. ACEs are associated with increased risk of substance abuse, obesity, no-leisure time physical activity, depression, and suicide attempts (Felitti et al., 1998). The biopsychosocial consequences of ACEs are uniquely impactful due to the child's inability to regulate (physically or psychologically) the stress the ACEs cause, which are particularly dangerous because they occur during a time when the brain is constantly changing as it develops (Sciaraffa, Zeanah, & Zeanah, 2017), elaborated on below. Another unique aspect of this population is that compared to those who do not experience ACEs, adolescent ACE survivors are more likely to ruminate,

experience intrusive thoughts, and act impulsively (Min, Minnes, Kim, Yoon & Singer, 2017) and adult ACE survivors are more likely to report experiential avoidance, or an unwillingness to experience unwanted internal stimuli (e.g., thoughts or emotions; Briggs & Price, 2009). Thus, therapy for survivors of ACEs must provide more effective ways to manage distressing thoughts, feeling, and events. Mindfulness-based therapies are uniquely positioned to effectively address the maladaptive biopsychosocial sequela of ACEs *and* be broadly embraced by practicing therapists working with adult and child ACE survivors who either do not experience trauma or are looking for a method not reliant on habituating to trauma.

Biological impact. ACEs and MBIs are associated with biological, psychosocial, and social effects. Indeed, Black (2015) reviewed 32 studies of MBIs delivered to children and adolescence at risk for the development of a mental health condition, and concluded that mindfulness training leads to improved biological, psychological, and social functioning. Early childhood stress has been associated with increased amygdala activity (McCrory et al., 2011) and decreased functional connectivity between the amygdala and prefrontal cortex when processing emotional stimuli (e.g., angry faces; Javanbakht et al., 2015; Klavir, Prigge, Sarel, Paz, & Yizhar, 2017; Park et al., 2018). MBIs have been evidenced to increase the functional connectivity between the amygdala and the prefrontal cortex. Kral and colleagues (2018) found that 8 weeks of Mindfulness Based Stress Reduction (MBSR) given to a non-clinical population increased connectivity between the amygdala and prefrontal cortex when shown emotion-laden images, compared to an active control condition, suggesting that MBSR influences more emotional regulation. Furthermore, Gotink and colleagues (2016) conducted a systematic

review of 11 studies specifically addressing the effects of MBSR, four studies addressing Mindfulness Cognitive Behavior Therapy (MCBT), and four studies evaluating dispositional mindfulness, and found decreased amygdala activity and increased amygdala-PFC connectivity in response to emotional stimuli after participation in mindfulness-based interventions, specifically stating that MBSR led to changes in the amygdala consistent with emotional regulation, such as bilateral amygdala deactivation.

ACEs, and inhibition between the amygdala and prefrontal cortex, have also been associated with increased hypothalamic pituitary axis (HPA) activity, seen by elevated levels of the stress hormone, cortisol (Burghy et al., 2012; Bucci, Marques, Oh, & Harris, 2016); the same hormone that mindfulness-based interventions have been shown to decrease. Creswell and colleagues (2014) found that three days of 25-minute sessions of mindfulness meditation resulted in reduced self-reported stress and reduced cortisol reactivity to an acute stressor compared to a control condition, indicating that brief MPs may be efficacious as a short-term stress reduction practice. Longer MBIs, such as 4 weeks of MBSR, also led to reduced cortisol levels in veterans with PTSD (Bergen-Cico, Possemato, & Pigeon, 2014). Furthermore, 8-week MBSR interventions have led to lower blood pressure in response to an acute stressor among healthy individuals (Nyklíček, Mommersteeg, Van Beugen, Ramakers, & Van Boxtel, 2013), and lower cortisol and blood pressure over the course of a year following the MBSR intervention for breast and prostate cancer patients (Carlson, Speca, Faris, & Patel, 2007).

HPA overactivation in childhood is associated with diminished cognitive functioning in the areas of learning, memory, attention (Anda et al., 2006; Juster, McEwen, & Lupien, 2010; Sciaraffa et al., 2017; Vai et al., 2017); all areas mindfulness

therapy has been shown to influence. Basso and colleagues found that 8 weeks of practicing Mindfulness Meditation (MM) for 13 minutes a day resulted in enhanced attention, working memory, and recognition memory compared to the control condition (2018). Furthermore, four sessions spanning four days of MM significantly improved visuospatial processing, working memory, and executive functioning in a sample of undergraduate psychology students (Zeidan, Johnson, Diamond, David & Goolkasian, 2010). Finally, a systematic review of 15 Mindfulness Meditation Practices (MMPs) with randomized controls found that MMPs when practiced 30 minutes to an hour per day led to significant improvements in cognitive functioning, particularly working memory and executive attention (Chiesa, Calati, & Serretti, 2011).

Chronic stress in childhood is also associated with shorter telomeres, the genetic “caps” to our DNA that serve as an index to cellular aging and are associated with obesity, cardiovascular disease, and cancer (Sciaraffa et al., 2017). Schutte and Malouff conducted a meta-analysis of 4 studies of MMs (consisting of mindfully eating, Qigong exercise, Yogic mediation, and Loving Kindness meditation) and 4 studies of MBSR (for populations consisting of obesity/overweight, chronic fatigue, meditators, and caretakers for those with dementia; 2014). They found the MMs and MBSR increased telomerase activity, the enzyme that builds telomere length promoting health and mortality, with a moderate effect size ($d = .46$; 2014). Furthermore, in another study Schutte and colleagues (2016) found that trait mindfulness, reflecting the trait of non-judgmental focus on the present (Schutte et al., 2016) among other psychological characteristics such as optimism, correlates with longer telomere length in a sample of healthy participants. The practice of meditation was also found to have a relationship with the expression of

genes associated with cellular metabolism and oxidative stress responses, potentially preventing cell injury that occurs with chronic stress (Takimoto-Ohnishi, Ohnishi, & Murakami, 2012). MPs and MBIs appear to affect the very biological processes compromised by ACEs. Furthermore, this relationship does not go unnoticed by ACE survivors: a literature review conducted by Whitaker and colleagues (2014) consisting of over 2,000 adult survivors of ACEs, found that those who practiced mindfulness were identified to have a better health-quality of life.

Psychological Impact. ACEs predispose the individual to emotional instability, potentially manifesting as mental illness or disability, at a rate of three times to that of a child who has not experienced an ACE (Anda et al., 2006). For example, Sibinga and colleagues (2016) found in their study of 300 urban youth (average age of 12 years old) who experienced stressors ranging from community violence, substance use, and trauma that participation in a 12-week long MBSR program led to significantly lower symptoms of depression, somatization, negative affect, rumination, hostility, and posttraumatic symptom severity compared to control groups. Additionally, the cognitive dysfunction previously mentioned (regarding learning, memory, and attention) likely contribute to ACE survivors acting out much more often in class, struggling academically, being diagnosed with a learning disability, and being more emotionally labile compared to children without history of ACEs (Anda et al., 2006; Bethell, Gombojav, Solloway, & Wissow, 2016; Sciaraffa et al., 2017). In an MBSR intervention conducted by Black and Fernando (2014), 409 inner city students (most of whom were ethnic minorities and exposed to adverse conditions) between the grades of kindergarten and sixth grade students found that 15-minute sessions of mindfulness practices, three times a week for

five weeks promoted improvements in paying attention, self-control, class participation, and caring/respect for peers.

In adult ACE survivors, longer MBIs also improve psychological functioning. For example, Dialectical Behavior Therapy resulted in reduced PTSD symptoms in adult survivors of childhood sexual abuse, compared to a waitlist control (Krüger et al., 2014). Acceptance and Commitment Therapy (ACT) resulted in increased emotional regulation, less perceived stress, greater mental well-being, and more resiliency in young as well as older adults that survived ACEs and were experiencing persisting distress (Cameron, Carroll, & Hamilton, 2018). Furthermore, Ortiz and Sibinga found that eight weeks of MBSR decreased depression, anxiety, and PTSD symptoms in 27 female ACE survivors of a sexual nature (Kimbrough, Magyari, Langenberg, Chesney & Berman, 2010), and found that another eight week MBSR program was efficacious with 50 female survivors of ACEs, with participants experiencing less perceived stress, depression, trait and state anxiety, and PTSD symptoms (Gallegos, Lytle, Moynihan & Talbot, 2015). Studies examining mindfulness-based therapies for non-ACE-related traumas have also been promising. For example, eight weeks of MBCT (King et al., 2016) and MBSR (Goulao et al., 2016; Polusny et al., 2015) both resulted in reduced PTSD symptoms in veterans with PTSD. Less regimented than full MBIs, MPs have been efficacious in adult populations as well, with even ten minutes of training in acceptance-based coping significantly decreasing anxiety and avoidance symptoms in participants when exposed to the anxiogenic stimulus of air enriched with carbon dioxide compared to participants who practiced deep breathing (Eifert & Heffner, 2003).

Social Impact. ACE survivors are at increased risk of having an anxious and avoidant attachment style (Balistreri & Alvira-Hammond, 2016; Sitko, Bentall, Shevlin, O'Sullivan, & Sellwood, 2014), which has been associated with lifelong intrapersonal and interpersonal difficulties (Göstas, Wiberg, Engström, & Kjellin, 2012). MBIs delivered to adult survivors of ACEs appears to mitigate the aggression in romantic relationships associated with an insecure attachment style (Miga, Hare, Allen, & Manning, 2010). Additionally, women struggling with substance abuse and/or interpersonally aggressive behaviors experienced less aggression and substance use after a 20-week mindfulness program compared to women enrolled in a waitlisted control group (Wupperman, Cohen, Haller, Flom, Litt, & Rounsaville, 2015). Khaddouma and colleagues (2017) found that participation in an eight-week MBSR intervention improved relationship satisfaction among 26 couples. Trait mindfulness has been found to mediate the effects of an anxious and avoidant attachment style on psychological symptoms such as anxiety in a sample of 505 adults in the general population (Linares, Jauregui, Herrero-Fernández, & Estévez, 2016). Trait mindfulness was also associated with more adaptive responding to difficult emotions, particularly anger, in a study conducted with 33 married couples, leading to stronger reported marital quality (Wachs & Cordova, 2007).

ACE survivors are also less likely to receive a high school diploma and more likely to be unemployed and live in a household below the federal poverty line (Liu et al., 2013; Metzler, Merrick, Klevens, Ports, & Ford, 2017). MBIs have also been shown to impact stress resulting from these socioeconomic factors. For example, Fabiani and colleagues (2016) found, that among unemployed people, the MP of Awareness Training led to participants reporting higher quality of life in post-test assessments. Furthermore,

in a sample of homeless mothers and children living below the poverty line, eight weeks of MBSR has been found to be effective in reducing perceived levels of stress and increasing happiness (Alhusen, Norris-Shortle, Cosgrove, & Marks, 2017). Additionally, a 12-month Mindfulness and Social-Emotional Learning (M-SEL) Program significantly improved emotional, prosocial, conduct, and relational health in 64 eleven-year-old students, compared to 68 waitlisted controls (Waldemar et al., 2016); aspects that could potentially serve as a countermeasure to ACE survivors who feel compelled to drop out. Thus, MBIs and MPs could help alleviate symptoms associated with the effects of low socioeconomic status.

Clinical Use of Mindfulness-Based Therapy

To date, no specific study addresses how many American mental health providers are using MPs or MBIs for their clients who are survivors of ACEs, regardless of client population. One study of German psychologists suggests that therapists may be very open to using MPs and/or MBIs in session (Michalak, Steinhaus & Heidenreich 2018). Of the 62 German psychologists surveyed, 52% reported that they integrate mindfulness practices into their therapeutic work, with the norm being to incorporate mindfulness practices with 30% of their individual sessions (only 1 in 10 reported using mindfulness-based practices in every session). They found that the determining factor in respondents using MPs or MBIs was their theoretical orientation, as those aligning with psychodynamic (100%) and cognitive behavioral theories (84.6%) were more likely to use MPs or MBIs with their clients. Only 5 of the psychologists reported providing full-course group interventions, such as MBSR (2018). However, this study did not inquire about indicators for use (i.e., diagnoses or presenting problems perceived to be

appropriate for mindfulness-based interventions) and did not include therapists practicing in the United States. Currently, it is not clear to what extent practicing clinicians employ mindfulness in the treatment of ACE survivors, and, what barriers therapists may perceive to delivering MPs or MBIs to this population. Another reason why it is difficult to gauge the use rates of MPs or MBIs, as they are emerging practices, is the gap created between the dissemination of research and the implementation of research in practice; Westfall and colleagues found that due to the process of bridging the practice from scientific research, to human trial research, to clinical practice can take an average of about 17 years (2007).

The survey developed for this study questioned about potential barriers and facilitators based on the Promoting Action on Research Implementation in Health Services (PARIHS) framework (Rycroft-Malone et al., 2002). The PARIHS framework posits three core components that predict use of any evidence-based practice by real world clinicians: context, evidence, and facilitation. This model provides the structural support needed to determine why individual practitioners choose to use/not use MBIs or TFTs with survivors of ACEs. Therapists have a wide variety of reasons to potentially opt out of using mindfulness therapy: be it because they do not practice in a facility that is congruent with the mindfulness-based paradigm approach (i.e., a context-related barrier), they may prefer a different method because they do not believe/know of evidence that support the use of mindfulness with their clients (i.e., an evidence-related barrier), or they do not know enough about or haven't been trained to use mindfulness with this population (i.e., a facilitation-related barrier). This study seeks to determine

which barrier is most often noted in working with survivors of ACEs, regardless of the survivor's ages.

Firstly, therapists have to use a therapy that is appropriate within the context that they work; fitting within the time restraints, patient scheduling needs, and expectations of their work environment (e.g., the theoretical orientation of their group practice).

Michalak, Steinhaus, & Heidenreich found that therapists mindfulness techniques blended with other therapeutic paradigms, as that is how they believe them to be most efficacious within the context of their work (2018). A dissertation study conducted by Edwards (2016) echoes this, suggesting that practitioners may favor using MPs or segments of MBIs in combination with different strategies from other practices, and perceive this eclectic approach as promoting resiliency and reducing trauma-causing stress in adult survivors of ACEs, along with the perceived benefits of the other paradigms used. Thus, therapists working with ACE survivors may opt for an eclectic blend of approaches, rather than delivering a full course of mindfulness-based therapy (i.e., MBSR, MBCT) or may opt for another paradigm entirely if mindfulness-based therapy is not suited for the context of their work.

Secondly, mindfulness has been viewed as an up-and-coming approach that is relatively new to the field and has comparatively less empirical research than other trauma-focused therapies and interventions, such as narrative therapy, trauma-focused therapy, or CBT for trauma (Raney, 2014). Therapists who opt for a different therapeutic approach when working with ACE survivors may choose a therapy such as general cognitive behavioral therapy (CBT), due to its empirical support in treating depression, anxiety, psychotic, and dissociative symptoms- all of which ACE survivors are

disproportionately prone to (Anda et al., 2006; Bryant et al., 2017; Göstas et al., 2012; Juster, et al., 2010; Kong, Kang, Oh, & Kim, 2018; Sitko et al., 2014). Therapists may also prefer a different method that is more inclusive, as some studies of mindfulness practices suggest a disparity in effectiveness with minority and low-income participants compared to white, high income participants (Waldron, Hong, Moskowitz, & Burnett-Zeigler, 2018). There are also specific tenants of mindfulness therapy, such as acceptance in the face of adversity, which therapists may fear their clients would perceive as a value imposition. For example, clients holding strong Western religious beliefs (e.g., evangelical Christian) may feel as though they cannot simultaneously adhere to a mindfulness-related therapy, with origins in Eastern religion, and maintain their autonomy (Sobczak, & West, 2013). Furthermore, despite that there is no empirical consensus on populations for whom mindfulness-based interventions are contraindicated, some clinicians and theorists caution that it may not fit for all (Dobkin, Irving & Amar, 2012). For example, Germer (2005) suggested that patients who “decompensate when cognitive controls are loosened should generally not do formal sitting meditation” and those with “fragile personalities” should opt to practice brief meditation instead, potentially excluding the client from the benefits the MBI/MP in question has to offer. To answer this, Hanley and colleagues stated that typically, mindfulness-based therapy involves a self-selection process, and adverse effects rates have not been observed for those who self-select this approach (2016). Some case studies have indicated adverse effects following mindfulness training, ranging from interpersonal (e.g., family conflicts), intrapersonal (e.g., increased negativity, depersonalization), and societal effects (e.g., increased alienation) (Dobkin et al, 2012). However, Shapiro (1992) noted that “for some

individuals the adverse effects [of mindfulness training] seem to be transformed over time, and are seen not as problems, but as something from which a person can learn”.

Finally, therapists may not be using MPs or MBIs due to a lack of sufficient training or continued support (i.e., a facilitation-related barrier). Implementation research suggests that receiving an initial training in any clinical practice does not translate to clinical uptake, unless it is followed by a relatively lengthy time (often >6 months) of mentorship and support in the new practice; but supervision for therapies are difficult to come across in most places of employment, despite their dramatic effect for increasing success (Sullivan, Blevins, & Kauth, 2008). For example, when extended supervision is provided to therapists using DBT, the therapeutic quality (determined by peer supervision ratings) greatly improves (Worrall, 2012). However, there is little evidence that extended supervision is commonly taking place for mindfulness-based interventions, and no evidence regarding when and how supervision may be ideally provided for therapists using mindfulness interventions or practices with survivors of ACEs.

The current study, therefore, seeks to illuminate the current use practices of MPs, MBIs, and TFTs within the population of therapists who state that they work with survivors of ACEs. This will be done by a) examining the relative use rates and perceived barriers to using MPs, MBIs, and TFTs, b) examining if there are any predictive factors (such as theoretical orientation, degree earned, or practice time) to using MPs, MBIs, or TFTs in session, and c) examining the barriers that are cited by therapists who self-identify as working with survivors of ACEs on a framework that can be rapidly disseminated. In this study, the barriers to using MBIs and TFTs in session with survivors

of ACEs are classified via the PARIHS model, broken down in to context, facilitation, and evidence related barriers (Appendix 1).

CHAPTER II

Current Study

Three hypotheses were examined:

Aim 1: Examine the relative use of and barriers to using MPs, MBIs, and TFTs

Hypothesis 1a: Practitioners will report that they use MBIs more often than TFTs with adult and child clients seeking treatment related to an ACEs. Additionally, practitioners report that they use an MPs more often than compared to MBIs, as MPs present less of a challenge to incorporate in to other therapy approaches.

Hypothesis 1b: Practitioners will endorse fewer items as “strong barriers that prevents use” of MBIs compared to TFTs.

Aim 2: Examine predictors of use of MPs, MBIs, and TFTs

Hypothesis 2: Practitioners with 2a) a theoretical orientation more closely aligned with non-directive paradigms (i.e., humanistic, eclectic, third-wave, existential, person centered, narrative, relational, or mindfulness), 2b) more rigorous/long-term degrees (i.e., doctoral degrees), and 2c) less experience practicing (i.e., 10 or less years) will be more likely to report using MPs and/or MBIs than those with more directive theoretical orientations (i.e., cognitive behavior therapy, cognitive, psychodynamic, Adlerian, feminist, biopsychosocial, family centered, Jungian, sandtray or play), shorter degrees (i.e., master’s degrees), and more experience independently practicing (i.e., greater than 10 years). Additionally, participants with directive orientations, doctoral degrees, and less experience practicing independently will be more likely to use TFTs than

those with non-directive orientations, master's degrees, and more experience practicing independently.

Aim 3: Examine relative prevalence of evidence-, context-, and facilitation-related barriers to using MBIs, and TFTs

Hypothesis 3a: More participants will endorse evidence-related barriers as “strong barriers that prevents use” of MBIs compared to context- and facilitation-related barriers.

Hypothesis 3b: More participants will endorse evidence-related barriers as “strong barriers that prevents use” of TFTs compared to context- and facilitation-related barriers.

CHAPTER III

Method

Participants:

Recruitment included a total of 68 practicing therapists (in that they see therapy clients under their own licensure or under supervision of a licensed practitioner) who indicated that they work with survivors of ACEs and completed the survey in its entirety. A total of 1,449 email survey invitations were sent, to which 103 were accessed and 68 surveys were recorded in completion.

Procedure:

IRB approval was obtained prior to the collection of data. Potential participants were invited to the survey by email (via email listservs provided by the Association for Play Therapy after application and expressed permission, scouting on websites promoting practitioners for psychological services (i.e. psychologytoday.com, or directly from the principle investigator). This email explained the purpose of the study (i.e., to determine the types of therapeutic approaches used with survivors of ACEs), procedures (i.e., online survey consisting of 25 questions), information concerning data use, storage, confidentiality, and desired sample size ($N = 60$). The email further emphasized voluntary nature of study participation, provide notice that participants will be entered in a raffle to win a \$25 Amazon gift card, and included a link to the online survey. Participants must have provided consent electronically before they proceed to the survey.

Participants answered 11 questions pertaining to their demographics and endorsed on a Likert scale the amount of times they use MPs (10 practices listed), MBIs (Mindfulness Based Stress Reduction, Mindfulness Cognitive Behavior Therapy,

Acceptance and Commitment Therapy, Dialectical Behavior Therapy) and TFTs (Prolonged Exposure, Cognitive Processing Therapy, Trauma-Focused Cognitive Behavior Therapy, and Eye Movement Desensitization and Reprocessing). Participants also answered how many trainings they have attended regarding MPs, MBIs, and TFTs, and were finally asked on a Likert scale to endorse how many barriers they perceived in regard to using MBIs and TFTs based on circumstances identified within the PARIHS model. The survey is comprised of a total of 25 questions ranging from close-ended responses to allow for quantitative data analysis, however in specific areas, there is both Likert responses and room for commentary (see Appendix A).

Measures

All survey questions can be found in Appendix I.

Demographic information. Demographic information was gathered from participants with questions ascertaining their degree, professional setting, years of experience practicing after obtaining degree, weekly hours seeing clients, age ranges of clients, theoretical orientation, how often they ask clients whether they have experienced ACEs (always, sometimes, never), if they identify as a therapist who works with clients seeking treatment related to ACEs (yes/no), and an estimate of how many adults and children seeking treatment related to ACEs that they have treated. If participants indicated that they did not work with ACE survivors, they were informed that they were not eligible for participation and their survey ended. If participants indicated only working with adult or child clients, they were only asked questions pertaining to work with adult or child clients. If participants indicated working with both adults and children, they were presented questions about both adult and child clients. Participants were also

asked to endorse and then rank in importance the factors they consider when choosing a therapeutic method (out of a list of 11 factors including confidence in method, evidence of method, client interest in method, etc.)

Frequency of MP, MBI, and TFT Use with ACEs. Participants were asked to endorse which specific MPs they incorporate into treatment (i.e., Mindfulness Meditation, Breathing Practices, Walking exercise, Raisin exercise, Thoughtfulness Evaluations/Practices, Acceptance Practices, Guided Imagery, Body Scan Meditation, Yoga/Qi Gong, Self-Soothing with 5 Senses), and how often they incorporate MPs into treatment using a 5-point Likert scale (1: almost always (every session), 2: often (at least every other session), 3: occasionally (once or twice with a client), 4: rarely (only with certain clients under specific circumstances), 5: never). For the present study, responses were dichotomized to “almost always or often” (responses of 1-2) and “infrequent use” (responses of 3-5).

Participants were also asked to endorse which MBIs (i.e., Dialectical Behavior Therapy (DBT), Acceptance and Commitment Therapy (ACT), Mindfulness Based Stress Reduction (MBSR), Mindfulness Based Cognitive Therapy (MBCT), which TFTs (i.e., Prolonged Exposure, Imaginal Exposure, In Vivo Exposure, Cognitive Processing Therapy, Trauma-Focused Cognitive Therapy, Eye Movement Desensitization Therapy), and which other therapies (i.e., Psychodynamic, Psychoanalytic, Humanistic, Existential, Sand-tray therapy) using a 5-point Likert scale from “almost always (every session)” to “never”. For the present study, responses were dichotomized to “almost always or often” (responses of 1-2) and “infrequent use” (responses of 3-5) of MBIs, TFTs. Responses were dichotomized in to binary frequency in order for McNemar Chi Squares to be accurately ran.

Familiarity with MBIs versus TFTs. Participants were asked to endorse the kind of training they received in mindfulness-based interventions (such as MBSR, MBCT, ACT, or DBT) and trauma-focused interventions (such as CPT, PE, TF-CBT, or EMDR) from a list of 9 possible training experiences (e.g., supervised clinical training in graduate school, attended a presentation on the subject, etc.).

Barriers to using MBIs and TFTs. Participants were asked to endorse which of 13 statements describe potential context-, evidence-, and facilitation-related barriers that they experience as barriers to using MBIs and TFTs in the treatment of individuals seeking treatment related to an ACE. For each statement they endorse, they were asked to rate the prominence of that barrier on a 5-point Likert scale (1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use). For the present study, responses were dichotomized to “not a barrier” (responses of 1-3) and “strong barrier” (response of 4-5).

CHAPTER IV

Results

Sample Characteristics and Demographics.

A total of 1,449 emails were sent to potential participants, and 103 responses were recorded via Qualtrics, which is smaller than other response rates of similar studies (Becker et al., 2004; Michalak et al., 2018; Woody et al., 2015). Of the 103 surveys recorded, 68 surveys (66.0%) were filled out entirely. Of the 35 partially completed surveys, 11 (31%) participants did not advance past the first question, 10 (28.5%) participants were terminated from the survey as they did not identify as therapists who work with clients seeking treatment related to an ACE, and 14 (40%) participants terminated at various points throughout the survey before all questions for analysis were answered. The below results are derived from the 68 participant responses who completed the survey in full, with all relevant data supplied as participants were directed to answer questions based off of the client ages they endorsed working with. Participant demographic information can be seen in Table 1.

Power

Post hoc G*Power Goodness of Fit analyses were conducted and revealed that, based on estimated medium and small effect sizes $d = .30$ and $d = .10$, in which the α error probability was set at .05 coinciding with power set at $\beta = .80$, the respective sample sizes required to detect significance if an effect is present, would be $N = 108$ for an effect size of $d = .30$, and 964 if the effect size is lowered to $d = .10$ (Cohen, 1988; Faul, Erdfelder, Buchner, & Lang, 2007).

Aim 1: Examine the relative use of and barriers to using MPs, MBIs, and TFTs

Hypothesis 1a stated that practitioners will report using MBIs more often than TFTs with adult and child clients seeking treatment related to ACEs. Table 2a presents the comparative use of MBIs versus TFTs. Supplemental Table 2 provides frequency of use for each MBI for adult and child clients, and Supplemental Table 3 provides frequency of use for each TFT for adult and child clients. McNemar chi-square tests were conducted without the addition of the Yates correction (Newcombe, 1998) to compare the number of participants who endorsed using an MBI almost always (every session) or often (at least every other session) to the number of participants who endorsed using a TFT almost always (every session) or often (at least every other session) when working with adult and child clients seeking treatment for ACEs (Table 2a). There was no significant difference in endorsement rates found between using MBI and TFT for adult or child populations ($p's > .1$).

Hypothesis 1a also stated that participants will report using MPs more often than MBIs with adult and child clients seeking treatment related to ACEs. Table 2b presents the comparative use of MPs versus MBIs. Supplemental Table 1 provides frequency of use for each MP for adult and child clients. McNemar chi-square tests were conducted to compare the number of participants who endorsed using an MP almost always (every session) or often (at least every other session) to the number of participants who endorsed using an MBI almost always (every session) or often (at least every other session) when working with adult and child clients seeking treatment for ACEs (Table 2b). There was no significant difference in endorsement rates between MP and MBI use, regardless of client age ($p's > .5$).

Hypothesis 1b stated that participants will endorse fewer items as “strong barriers that prevent use” of MBIs compared to TFTs. Significantly fewer participants reported experiencing “strong barriers that prevent use” of MBIs (18 participants endorsed 20 barriers) compared to the number of participants that reported experiencing any “strong barriers that prevent use” of TFTs (28 participants endorsed 44 barriers) ($\chi^2[2, N = 68] = 6.250, p = .012$; see Table 3). This difference appeared to be primarily due to more participants experiencing “strong” context-related barriers to using TFTs compared to MBIs ($\chi^2[2, N = 68] = 9.941, p = .002$) (Table 3).

Aim 2: Examine predictors of use of and barriers to using MPs, MBIs, and TFT

Hypothesis 2a stated that participants with a non-directive theoretical orientation would be more likely to use MPs and MBIs compared to participants with directive theoretical orientation, and that participants with directive theoretical orientations would be more likely to use TFTs compared to participants with non-directive theoretical orientations. Of the 68 participants, 38 (55.9%) endorsed identifying primarily with a non-directive theoretical orientation in that there is comparatively less practitioner direction being supplied in session (humanistic, person-centered, play, multicultural, integrative; mindfulness) and 30 (44.1%) endorsed identifying primarily with a directive orientation in which therapists are expected to conduct more in-session practices (i.e., prayer, foster group discussions, demonstration of skills) or supply more material (i.e., worksheets, genograms) (CBT, existential, Adlerian, family centered, faith-based/pastoral, choice therapy, reality therapy, and relational therapy). Pearson chi-squares comparing the use of MPs, MBIs, or TFTs almost always (every session) or often (at least every other session) by participants with directive vs. non-directive orientations

revealed no significant differences, though there was a trend for participants with directive orientations to use TFTs more frequently than non-directive ($\chi^2[2, N = 68] = 3.511, p = .061$; Table 4).

Hypothesis 2b stated that participants with doctoral degrees would be more likely to use MPs, MBIs, and TFTs compared to participants with master's degrees. Of the 68 participants in the study, 14 (20.6%) obtained their doctorate degree and 54 (79.4%) obtained their master's degree. Pearson chi-squares comparing the use of MPs, MBIs, or TFTs almost always (every session) or often (at least every other session) by participants with doctoral vs. master's degrees revealed no significant differences, though there was a trend for participants with master's degrees to use TFTs more frequently than those with doctoral degrees ($\chi^2[2, N = 68] = 3.375, p = .066$; Table 4).

Hypothesis 2c stated that participants with less experience independently practicing would be more likely to use MPs, MBIs, and TFTs compared to participants with more experience independently practicing. Of the 68 participants in the study, 26 (32.8%) reported practicing for ≤ 10 years and 42 (61.8%) reported practicing for > 10 years. Pearson chi-squares comparing the use of MPs, MBIs, or TFTs almost always (every session) or often (at least every other session) by participants with < 10 years of experience vs. > 10 years of experience revealed no significant differences (p 's $> .7$; Table 4).

Aim 3: Examine relative prevalence of evidence-, context-, and facilitation-related barriers to using MBIs, and TFTs

Hypothesis 3a stated that participants will report more evidence-related barriers as “strong barriers that prevents use” of MBIs compared to context- and facilitation-related

barriers. Of the 68 participants, 7 (1.0%) participants endorsed at least one “strong” context-related barrier to using MBIs, 10 (14.7%) participants endorsed at least one “strong” facilitation-related barrier to MBIs, and 5 (7.4%) participants endorsed at least one “strong” evidence-related barrier to using MBIs (Table 5). McNemar chi-square tests comparing the percent of participants endorsing “strong” context-, facilitation-, and evidence-related barriers to using MBIs use revealed no significance differences (p 's $\geq .17$).

Hypothesis 3b stated that participants will report more evidence-related barriers as “strong barriers that prevents use” of TFTs compared to context- and facilitation-related barriers. Of the 68 participants, 8 (11.8%) participants endorsed evidence-related barriers to using TFTs, 20 (29.4%) endorsed context-related barriers to using TFTs, and 16 (23.5%) endorsed facilitation-related barriers to TFTs (Table 5). McNemar chi-square tests comparing the percent of participants endorsing “strong” context-, facilitation-, and evidence-related barriers to TFT use revealed that more participants endorsed “strong” context related-barriers compared to the evidence- ($\chi^2[2, N = 68] = 9.000, p = .002$), and facilitation-related barriers ($\chi^2[2, N = 68] = 3.556, p = .059$).

CHAPTER V

Discussion

Barriers Found to MPs, MBIs and TFTs

It was hypothesized that practitioners will report that they use MBIs more often than TFTs, and MPs more often than they use MBIs with adult and child clients seeking treatment related to an ACEs. Among participants providing ACE-related treatment to adults, a slightly greater percentage endorsed using MBIs at least every other session (60%) than endorsed using TFTs at least every other session (53.3%), however that difference was not statistically significant. The lack of significant findings potentially could be caused by the population's background or how the questions were asked via survey. Nevertheless, the relatively high use of TFTs endorsed by the sample is in contrast to what previous research has found, as Becker and colleagues found that only 16.8% of therapists surveyed use TFTs like imaginal exposure with 50% or more of their clients (2004). This may be due to the fact that "there is a growing pressure on professionals to justify their interventions and work in an evidence-based context" (Fitzgerald, Hendrickson, and Garza 2012). Our findings are also in contrast with what Michalak and colleagues found, as in their sample 11.8% of practitioners reported using full-course MBIs with over 51% of their client population. It is possible that because the sample consisted of those invited via a listserv from the Association for Play Therapy that practitioners may have been particularly likely to use mindfulness in session clients (Glazer & Stein, 2015).

It was also hypothesized that practitioners would endorse fewer 'strong barriers' for the use of MBIs versus TFTs. As hypothesized, significantly fewer barriers were

endorsed as “strong barriers that prevent use” of MBIs compared to TFTs. In particular, a higher percent of participants endorsed “strong” context-related barriers to TFT (29.4%) compared to those who endorsed “strong” context-related barriers to MBIs (10.3%).

Context barriers stem from a lack of ability to perform the method due to constraints in the environment, and the most commonly cited context barrier was an unstable client schedule; something that would seriously impact an average TFT session tailored for ACEs (Salloum, Small, Robst, Scheeringa, Cohen, & Storch, 2017).

Are there specific predictors of use of and/or barriers to using MPs, MBIs and TFTs?

It was hypothesized that practitioners with non-directive paradigms (i.e., humanistic, eclectic, third-wave, existential, person centered, narrative, relational, or mindfulness), long term degrees (doctorate degrees compared to master’s degrees), and less experience practicing (10 or less years) would endorse higher use rates for MPs and MBIs. Compared to those with a non-directive orientation, a larger number of participants with a directive theoretical orientation identified using TFTs (70% vs. 47%) and MBIs (73% vs. 53%) at least every other session, however the differences were not significant. The lack of statistical significance could be due to low power due to the small sample size. The greater use of TFTs and MBIs by those with directive orientations could be due to the fact that those with directive orientations rely on evidence-based interventions, which could include TFTs and MBIs. A similar study to the present done assessing the use rates of empirically supported treatments among clinicians treating eating disorders in Canada found that self-described CBT clinicians (who made up 53% of the directive population in this study) were more likely to use empirically supported

treatments, or aspects of empirically supported treatments (Von Ranson, Wallace, and Stevenson, 2013). It was also found that marriage and family therapists (family therapists making up 10% of the directive orientation population) are also encouraged to use evidence-based therapies (Blow and Karam, 2017).

Regarding degree length, compared to those with a master's degree, more participants with a doctoral degree endorsed using MPs at least every other session (79% vs. 69%). However, compared to doctoral level clinicians, more master's level clinicians endorsed using MBIs (63% vs. 57%, not statically significant) and TFTs (63% vs. 36%, trend toward statistical significance at $p = .07$) at least every other session. This trend could have to do again with the fact that many master's level practitioners in the population were also self-identified play therapists, who are encouraged to endorse the use of empirically supported treatments, specifically TFTs (Fitzgerald, Hendrickson, and Garza, 2012). Allen, Gharagozloo, and Johnson also found in their dissertation study that there is no significant difference in education level and the ability to accurately pick which therapy is empirically supported (2012).

Finally, a similar percentage of participants with >10 and ≤ 10 years of experience practicing independently reported using MPs, MBIs, and TFTs at least every other session. Thus, there is no evidence from this study that practice time has any influence on practitioners' use of MPs, MBIs or TFTs. This could be explained by the fact that there were also no significantly strong facilitation barriers cited by participants, meaning that no one feels incapable of being able to conduct these therapies due to insufficient training. There are also the studies to support that practitioners learn the most in

supervision (Watkins, Budge, and Callahan 2015), so perhaps it is the supervision time that determines the propensity to use empirically supported treatments.

Which of the PARHIS framework's barriers were the most prevalent among using MBIs and TFTs?

It was hypothesized that the greatest barrier to MBI use would be evidence related, compared to context- or facilitation-related. However, very few participants (<15%) endorsed any strong barriers to MBI use, regardless of the type of barrier. Again, this could be because play therapist practitioners are encouraged to mindfulness in session with their supervisors and supervisees (Glazer & Stein, 2015), so they are accustomed or encouraged to incorporate that in to their session, as well as the pressure to use an empirically supported method (Fitzgerald, Hendrickson, and Garza, 2012).

It was also hypothesized that the greatest barrier to TFT use would be evidence-related, compared to context- or facilitation-related. Contrary to hypothesis, a greater number of participants endorsed experiencing “strong” context-related barriers (29%) compared to evidence-related barriers (12%), and this difference was statistically significant. Upon further investigation, it was found that following context-related barriers were most often endorsed: client schedule stability, not being endorsed by their work environment, and that they are not conducive with practitioner's schedules. Alternatively, the following evidence-related barriers were most often endorsed: TFTs are not efficacious with minority clients/creating a potential value imposition and my clients do not have the cognitive ability to benefit from TFT, however, only 5 participants (7% of the sample) endorsed these as “strong.” This implies that, contrary to hypothesis, most practitioners may not believe that TFTs will cause a value imposition for their client

or be ineffective due to the client's cultural background or cognitive ability. This seems to fit with a dissertation study conducted by Allen, Gharagozloo, and Johnson, which found that clinicians, regardless of education level and theoretical orientation are likely to endorse the belief that TFTs are empirically supported treatments (2012).

This study found that close to half of the sample (50%-60%) reported using an MBI at least every session with adult and child clients seeking treatment related to an ACE, and also found that relatively few participants (27%) endorsed at least one "strong" barrier that prevents use of MBIs. Thus, it seems that few participant experience barriers and many report frequent use of MBIs. However, close to half of the sample (41%-53%) also reported using TFTs at least every other session with adult and child clients seeking treatment related to an ACE, and yet found that almost half of the sample (41%) endorsed at least one "strong" barrier that prevents use of a TFT. This could also be due to the pressure that play therapists, who make up many in this sample, feel the need to incorporate TFTs in to their practice (Fitzgerald, Hendrickson, and Garza, 2012), but perhaps do not feel as though (in the case that they endorsed the most common context barriers) feel that they have the client schedule stability, supportive work context, or their own schedule to stick to a heavily regimented TFT plan stereotypical for survivors of ACEs as outlined by Salloum and colleagues (2017). This theory is supported by Nelson and Steele's analysis of the likelihood for a practitioner to use a certain therapy, particularly if it is "flexible", which in the present study is identified as a context barrier, to be able to be easily applied to clinicians work settings (2008).

Implications

The most broadly reaching implication of this study found that there is a significant number of therapists who do not trauma focused therapies due to context barriers preventing use, the foremost being unstable client schedules. This information is crucial in understanding not only use rates among practitioners who identify as serving survivors of ACEs, but any trauma, as trauma-focused therapies are the frontline therapies for several trauma related diagnoses not including ACEs ranging from post-traumatic stress disorder and comorbid eating disorders (Trottier, Monson, Wonderlich, MacDonald, & Olmsted, 2017) to attending juvenile prison (Snyder, 2018). The implication of this study means that in all of the environments and settings where trauma-focused therapies are practiced, practitioners could potentially be unable to provide the fullest quality trauma-focused treatment that they could due to barriers caused by client schedules or other context-related barriers, as a significant number of participants from this study cited so.

Another implication of this study is that there is preliminary evidence to suggest that, contrary to what is commonly found in other studies (Becker et al., 2004, Michalak et al., 2018, Woody, Anderson, D'Souza, 2015; Woody, Anderson, D'Souza, Baxter, & Schubauer, 2015) there are a significant amount of the population of therapists, specifically those gathered from the listserv provided by the Association for Play Therapy, that stated they are regularly using empirically supported methods for the treatment of survivors of ACEs as previously mentioned. A larger portion of this study cited that they regularly use empirically supported treatments such as MBIs and TFTs with survivors of ACEs than previous studies, and this could be due to pressure to use an

empirically supported treatment (particularly a TFT) as cited by Fitzgerald and colleagues (2012).

Limitations

There are several limitations warranting recognition with this study. The foremost limitation is the relatively small sample size for a survey, consisting of only 68 completed surveys. While this survey size is larger than other similar studies conducted (Woody, Anderson, D'Souza, 2015; Woody, Anderson, D'Souza, Baxter, & Schubauer, 2015) using participant pools of 33 and 30 respectively, the sample size of 68 does not provide enough power to be statistically significant. There is also the concern of participation fatigue/ negligence in response. Therefore, caution should be used when interpreting the results of this study and future research should address this concern.

The second limitation to be aware of with this study is that it does not cover all modalities used with survivors of ACEs, specifically regarding newer modalities to treat trauma that are not advertised as trauma-focused, such as narrative therapy. This study primarily focused on the frontline use of trauma focused therapies, specifically those used in conjunction with cognitive behavior therapy, as research most commonly stated them to be the best modalities for survivors of ACEs, regardless of the specific ACE encountered (Korotana, Dobson, Pusch, & Josephson, 2016). Narrative therapy was excluded because research shows its primary, and very successful, efficaciousness with survivors of sexual trauma specifically, rather than the broad range of traumas that ACEs cover. However, it should be included in further studies as it is clearly a frontline therapy for an incredibly common ACE.

The third limitation lies within the survey itself, in that barriers to using MPs were not assessed in the same way as TFTs or MBIs along the Likert scale assessing the PARIHS model, which leads some ambiguity around if mindfulness practices are being purposefully avoided and does not provide answers as to why therapists choose to use MPs with survivors of ACEs. Future research should consider adding a measure to allow for comparisons on how therapists opt to use MPs, especially in conjunction with MBIs or TFTs.

Lastly, some demographic information such as age, ethnicity, and geographical location was not obtained from participants of this study, and that could be an important factor in assessing potential cultural implications on the practitioners' part as to why they may opt to use a particular therapy with survivors of ACEs compared to an empirically supported treatment, or, more specifically, one involving mindfulness. Future amendments to the survey measure should reflect questions assessing the client's personal cultural identity, and how they feel it influences their theoretical orientation of choice but their choices in using certain modalities of therapies with clients. These concerns were not addressed in the current study due to time constraints and should be addressed foremost in replication studies. It should also be noted as a limitation that there may be overlapping participant similarities as most participants were recruited over emails generated from therapeutic alignment organizations or websites where therapists could advertise directly to clients online. Regarding concerns of the issue of the survey itself, the measures should be adjusted to where a) participants can opt out more quickly if they do not identify as practitioners who serve survivors of ACEs, b) demographic data

can be collected on a dichotomous or nominal scale, and c) brevity on behalf of the survey questions in order to ensure a higher return rate.

Future Research

Research from this study indicates that context barriers are more often endorsed with TFTs compared to MBIs, and that there significantly more barriers endorsed for TFTs versus MBIs overall. Furthermore, context-related barriers represent the most common barriers to using TFT, compared to evidence- or facilitation-related barriers. This suggests that in order to help clinicians overcome barriers to TFTs, it would be most prudent to provide support in relation to context. The most commonly cited barrier within context was that client's schedules were not reliable enough to keep a highly structured session like the TFTs require. It would then be important to know, in order to ease the strain on a schedule, how to keep the efficaciousness of a TFT (particularly with a survivor of ACEs) yet incorporate the ability to be less dependent on tasks accomplished in a specific session, but perhaps measure therapeutic progress within a given framework. There is one particular framework, specified as a trauma-informed treatment network, called the Attachment, Regulation, and Competency (ARC) that has been shown to be effective with children working through PTSD related to complex trauma (Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013). This method, though it also includes a 12-session timespan like the plan laid out by Salloum and colleagues, is less reliant on meeting for designated times and completing designated parent-child activities, but instead the 12 sessions are, as the official website states "intended to be flexibly applied according to the needs of the context and population with whom it is being used (ARC Adaptations)." Therefore, it could be more effective to follow a framework rather

than a fully structured TFT, if it were still possible to maintain the efficaciousness, which studies support that the ARC framework specifically can. Future studies based on these findings, as well as the limitations of this study could be based on which paradigm marketed for survivors of ACEs (narrative therapy, TFTs, MBIs, etc.) would be the most efficacious for session times and reduces the number of potential conflicts practitioners have with this empirically supported method.

Summary

The present study sought to determine the frequency with which clinicians use MPs, MBIs and TFTs with adult and child clients seeking treatment related to an adverse childhood event. Firstly, the study found that practitioners reported using MBIs and TFTs at similar rates but report greater barriers to using TFTs. Secondly, therapists with directive orientations and master's degrees maybe more likely to use TFTs, though the study did not have sufficient power to determine statistical significance. Thirdly, there is no evidence to support that any particular barrier is endorsed disproportionately more often for MBIs, however context-related barriers are more commonly experienced than evidence-related barriers to using TFTs.

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TABLES

Table 1

Demographic Information

| Variable | N% 68(100%) |
|------------------------------------|----------------|
| Total Years Providing Therapy | |
| ≤ 2 Years | 6 (8.8%) |
| ≤ 10 Years | 20 (29.4%) |
| ≤ 20 Years | 20 (29.4%) |
| ≤ 30 Years | 10 (14.7%) |
| 30 + Years | 12 (17.6%) |
| Degree/Licensure | |
| Internship/Provisionary Licensure | 2 (2.9%) |
| Licensed Chemical Dependency | 2 (2.9%) |
| Counselor | |
| Licensed Clinical Social Worker | 7 (10.3%) |
| Licensed Marriage and Family | 2 (2.9%) |
| Therapist | |
| Licensed Master Social Worker | 1 (1.5%) |
| Licensed Mental Health Counselor | 1 (1.5%) |
| Licensed Professional Counselor | 37 (54.4%) |
| (including Supervisor status) | |
| Licensed Professional Clinical | 2 (2.9%) |
| Counselor | |
| Master of Arts in Professional | 1 (1.5%) |
| Counseling | |
| Master's in Clinical Mental Health | 2 (2.9%) |
| Counseling | |
| Master's of Education | 3 (4.4%) |
| Master's of Social Work | 2 (2.9%) |
| Nationally Certified Counselor | 1 (1.5%) |
| Ph.D in Child, Family, and School | 1 (1.5%) |
| Psychology | |
| Ph. D in Counseling Psychology | 3 (4.4%) |
| Ph. D in Counseling or Counselor | 2 (2.9%) |
| Education and Supervision | |
| Ph. D in Marriage and Family | 1 (1.5%) |
| Therapy | |
| Psy.D in Clinical Forensic | 1 (1.5%) |
| Psychology | |

(continued)

| | |
|--|------------|
| Psy.D in Clinical Psychology | 5 (7.4%) |
| Registered Play Therapist (including Supervisor status) | 7 10.3%) |
| <hr/> | |
| Professional Setting | |
| Medical Center | 1 (1.5%) |
| Primary Care | 0 (0%) |
| University Center | 5 (7.4%) |
| Private Practice | 34 (50%) |
| Non-Profit | 14 (20.6%) |
| Criminal Justice/Prison System | 2 (2.9%) |
| School | 4 (5.9%) |
| Other (Department of Defense, Tribal Organization, Contracted Therapy, For-Profit Agency) | 5 (7.4%) |
| Combined Settings | 3 (4.4%) |
| <hr/> | |
| Client Age | |
| Adult Only | 10 (14.7%) |
| Child Only | 23 (33.8%) |
| Both Children and Adults | 35 (51.5%) |
| <hr/> | |
| Weekly Therapy Hours with Adults N = 45 | |
| Less than 5 hours | 4 (8.9%) |
| 5 – 14 hours | 1 (2.2%) |
| 15 – 24 hours | 22 (48.9%) |
| 25+ hours | 18 (40%) |
| <hr/> | |
| Weekly Therapy Hours with Children N = 58 | |
| Less than 5 hours | 4 (6.9%) |
| 5 – 14 hours | 4 (6.9%) |
| 15 – 24 hours | 25 (43.1%) |
| 25+ hours | 25 (43.1%) |
| <hr/> | |
| Primary Theoretical Orientation | |
| CBT (CBT, Cognitive, Bio-Psycho- Social, Integrative Neurotherapy) | 18 (26.5%) |
| Rogerian (Humanistic, Person- Centered, Gestalt, Eclectic) | 15 (22.1%) |
| Paradigm (Adlerian, Existential) | 4 (5.9%) |
| Relation/Faith (Relational therapy, Reality therapy, Choice therapy, Family-Centered, Faith-Based) | 7 (10.3%) |
| Third Wave (ACT, Mindfulness) | 4 (5.9%) |

| | |
|---|------------|
| Other (Play, Multicultural, Integrative) | 20 (29.4%) |
|---|------------|

Table 2

Comparative use of MBI vs. TFTs N = 68

| Age Bracket | Any MBI Almost Always or Often | Any TFT Almost Always or Often | <i>McNemar Chi-Square</i> | <i>p (uncorrected value)</i> |
|--------------------|---|---|--------------------------------------|---|
| Adults (N=45) | N = 27 (60%) | N = 24 (53.3%) | 0.529 | .467 |
| Children (N=58) | N = 29 (50%) | N = 24 (41.4%) | 1.190 | .275 |

Table 3

Comparative use of MP vs. MBI N = 68

| Age Bracket | Any MP Almost Always or Often | Any MBI Almost Always or Often | <i>McNemar Chi-Square</i> | <i>p (uncorrected value)</i> |
|--------------------|--|---|--------------------------------------|---|
| Adults (N=45) | N = 28 (62.2%) | N = 27 (60%) | 0.077 | .527 |
| Children (N=58) | N= 37 (63.8%) | N = 29 (50%) | 2.909 | .081 |

Table 4

Comparing barriers to using MBIs and TFTs For All

| Barrier | MBI # | TFT # | <i>McNemar Chi-Square</i> | <i>p (uncorrected value)</i> |
|---|------------------|------------------|--------------------------------------|---|
| <i>N</i> = 68 | | | | |
| Context (among 4) | | | | |
| Number of “Strong” Barriers Endorsed Participants Reporting “Strong” Barrier | 7 7 (10.3%) | 26 20 (29.4%) | 9.941 | .002* |
| Facilitation (among 5) | | | 2.571 | |
| Number of “Strong” Barriers Endorsed Participants Reporting “Strong” Barrier | 15 10 (14.7%) | 23 16 (23.5%) | 2.571 | .109 |
| Evidence (among 6) | | | | |
| Number of “Strong” Barriers Endorsed Participants Reporting “Strong” Barrier | 10 5 (7.4%%). | 8 8 (11.8%) | 1.286 | .257 |
| Total “Strong” Barriers Endorsed Participants Reporting “Strong” Barrier | 20 18(26.5%) | 44 28 (41.2%) | 6.250 | .012* |

Table 5

Predictors of MP and MBI Use

| Variable | | | Pearson Chi- Square | p |
|-------------------------------------|--|---|------------------------------------|----------|
| | Directive (N = 30) | Non- Directive (N = 38) | | |
| MPs: Almost Always or Often | 22 (73.3%) | 26 (68.4%) | 0.195 | .695 |
| MBIs: Almost Always or Often | 22 (73.3%) | 20 (52.6%) | 3.042 | .081 |
| TFT: Almost Always of Often | 21 (70.0%) | 18 (47.4%) | 3.511 | .061 |
| | Doctoral Degree (N = 14) | Master's Degree (N = 54) | | |
| MPs: Almost Always or Often | 11 (78.6%) | 37 (68.5%) | 0.541 | .462 |
| MBIs: Almost Always or Often | 8 (57.1%) | 34 (63.0%) | 0.159 | .690 |
| TFT: Almost Always of Often | 5 (35.7%) | 34 (63.0%) | 3.375 | .066 |
| | Less Experience (≥ 10 years) (N = 26) | More Experience (10+ years) (N = 42) | | |
| MPs: Almost Always or Often | 19 (73.1%) | 29 (69.0%) | 0.126 | .723 |
| MBIs: Almost Always or Often | 16 (61.5%) | 26 (61.9%) | 0.001 | .976 |
| TFT: Almost Always of Often (57.7%) | 15 | 24 (57.1%) | 0.002 | .964 |

Table 6

Relative Barriers to Using MBIs and TFTs N = 68

| | Context | Facilitation | Evidence | Context vs Facilitation | | Context vs. Evidence | | Facilitation vs. Evidence | |
|------------|----------------|---------------------|-----------------|------------------------------------|-----------------|-----------------------------|-----------------|--------------------------------------|-----------------|
| | | | | McNemar | <i>p</i> | McNemar | <i>p</i> | McNemar | <i>p</i> |
| MBI | 7 (10.3%) | 10 (14.7%) | 5 (7.4%) | 0.692 | .405 | 0.500 | .479 | 1.923 | .166 |
| TFT | 20 (29.4%) | 16 (23.5%) | 8 (11.8%) | 0.889 | .346 | 9.000 | .002* | 3.556 | .059* |

Table 7

Comparing Use of MPs for Adults and Children

| Therapy | Identify use w/Adults (N = 45) | Identify use w/ Children (N = 58) |
|-----------------------------|-----------------------------------|---|
| Mindfulness Meditation | 37 (82.2%) | 46 (79.3%) |
| Breathing Practices | 43 (96.0%) | 58 (100%) |
| Walking Exercise | 14 (31.1%) | 19 (33.0%) |
| Raisin Exercise | 3 (7.0%) | 3 (5.2%) |
| Meditative Affirmations | 19 (42.2%) | 29 (50%) |
| Acceptance Practices | 25 (56.0%) | 24 (43.1%) |
| Guided Imagery | 39 (87.0%) | 48 (83.0%) |
| Body Scan Meditation | 29 (64.4%) | 35 (60.3%) |
| Yoga/Qi Gong | 5 (11.1%) | 12 (21.0%) |
| Self-Soothing with 5 Senses | 37 (82.2%) | 46 (79.3%) |

Table 8

Comparing Use of MBIs for Adults and Children

| Therapy | Almost Always or Often Use w/Adults N = 45 | Almost Always or Often Use w/ Children N = 58 |
|--|---|--|
| Any Mindfulness Based Intervention | 27 (60%) | 29 (50%) |
| Mindfulness Cognitive Behavior Therapy | 20 (44.5%) | 22 (37.9%) |
| Mindfulness Based Stress Reduction | 30 (66.7%) | 34 (58.6%) |
| Acceptance and Commitment Therapy | 12 (26.7%) | 8 (13.8%) |
| Dialectical Behavior Therapy | 6 (13.3%) | 7 (10.3%) |

Table 9

Comparing Use of TFTs for Adults and Children

| Therapy | Almost Always or Often Use w/Adults N = 45 | Almost Always or Often Use w/ Children N = 58 |
|--|---|--|
| Any Trauma-Focused Therapy | 24 (53.4%) | 24 (41.4%) |
| Prolonged Exposure | 3 (6.7%) | 1 (1.7%) |
| Cognitive Processing Therapy | 15 (33.3%) | 10 (17.2%) |
| Trauma-Focused Cognitive Behavior Therapy | 18 (40%) | 18 (31.0%) |
| Eye Movement | 8 (17.7%) | 3 (5.2%) |
| Desensitization and Reprocessing | | |

APPENDIX A

Online Survey

Demographic Information

1. Informed consent, attached as Appendix 2
2. How many years have you been providing psychotherapy after receiving your degree *(can include time spent practicing with a provisional license and/or under supervision post-graduating with your graduate degree)*?
 - a. <1 year
 - b. 1-5 years
 - c. 6-10 years
 - d. 11-15 years
 - e. 15+ years
3. How many years have you been practicing *independently (without supervision/provisional license)*?
 - a. <1 year
 - b. 1-5 years
 - c. 6-10 years
 - d. 11-15 years
 - e. 15+ years
 - f. N/A
4. What is your degree/title? *(There is an optional answer to allow for commentary regarding a more specific response.)*

- a. PhD in clinical psychology
- b. PhD in counseling psychology
- c. Psy.D in clinical psychology
- d. Licensed Marriage and Family Therapist (LMFT)
- e. Licensed Professional Counselor (LPC)
- f. Licensed Chemical Dependency Counselor (LCDC)
- g. Licensed Clinical Social Worker (LCSW)
- h. Licensed Psychological Associate (LPA)
- i. Master of Social Work (MSW)
- j. Master of Education (MEd)
- k. Masters of Clinical Mental Health Counseling (CMHC)
- l. other: _____

5. What is your professional setting? *(There is an optional answer to allow for commentary regarding a more specific response.)*

- a. medical center
- b. primary care
- c. university
- d. private practice
- e. non-profit
- f. criminal justice/prison system
- g. school
- h. other _____

6. What age ranges do you work with in a typical week? Select all that apply.
- a. 0-11
 - b. 12-17
 - c. 18-29
 - d. 30-59
 - e. 60+
7. What are the theoretical orientations with which you identify? Please list all that apply. *(There is an optional answer to allow for commentary regarding a more specific response. Please list the paradigm/theory.)*
- a. Cognitive behavior therapy
 - b. Cognitive
 - c. Psychodynamic
 - d. Humanistic
 - e. Eclectic
 - f. Third-wave (ACT, DBT)
 - g. Adlerian
 - h. Existential
 - i. Humanistic
 - j. Feminist
 - k. Biopsychosocial
 - l. Person centered
 - m. Narrative

- n. Relational
- o. Family centered
- p. Jungian
- q. Sandtray
- r. Play
- s. Mindfulness
- t. Other_____

8. Please rank the theoretical orientations with which you identify, starting with 1 as your primary theoretical orientation, and so on. (*Drag and drop.*)

- 1. Cognitive behavior therapy
- 2. Cognitive
- 3. Psychodynamic
- 4. Humanistic
- 5. Eclectic
- 6. Third-wave (ACT, DBT)
- 7. Adlerian
- 8. Existential
- 9. Humanistic
- 10. Feminist
- 11. Biopsychosocial
- 12. Person centered
- 13. Narrative

- 14. Relational
- 15. Family centered
- 16. Jungian
- 17. Sandtray
- 18. Play
- 19. Mindfulness
- 20. Other_____

9. How many hours of therapy do you provide, on average, per week?

- a. Less than 5 hours
- b. 5-10
- c. 10-20
- d. More than 20 hours

10. In your practice, do you routinely ask clients about whether they have

experienced any of the following during their childhood: emotional, physical, or sexual abuse; physical or emotional neglect; parental separation or divorce; witnessing domestic violence; witnessing substance abuse; living with a mentally ill family member; having an incarcerated household member (i.e., Adverse Childhood Experiences)?

- a. Always
- b. Sometimes
- c. Never

11. Do you self-identify as a therapist who works with clients who have experienced any of the following during their childhood: emotional, physical, or sexual abuse, physical or emotional neglect, parental separation or divorce, witnessing domestic violence, witnessing substance abuse, living with a mentally ill family member, and/or having an incarcerated household member (i.e., Adverse Childhood Experiences as defined by the Center for Disease Control and Prevention)?
- a. Yes
 - b. No; selected condition ends the survey.
12. How many adult (*aged 18 or older*) survivors of Adverse Childhood Experiences (defined as emotional, physical, or sexual abuse; physical or emotional neglect; parental separation or divorce; witnessing domestic violence; witnessing substance abuse; living with a mentally ill family member; having an incarcerated household member) have you treated?
- a. Less than 5 adult survivors
 - b. 5-14 adult survivors
 - c. 15-24 adult survivors
 - d. More than 25 adult survivors
13. How many child (*aged 17 or younger*) survivors of Adverse Experiences (defined as emotional, physical, or sexual abuse; physical or emotional neglect; parental separation or divorce; witnessing domestic violence; witnessing substance abuse; living with a mentally ill family member; having an incarcerated household member) have you treated?
- a. Less than 5 child survivors

- b. 5-14 child survivors
- c. 15-24 child survivors
- d. More than 25 adult survivors

14. What are the aspects you consider in choosing a therapeutic method for a client?

Please select all that apply.

- a. Conducive with practitioner schedule
- b. Conducive with client schedule
- c. Client interest {in said method}
- d. Confidence/training in implementing {said method}
- e. The level of supervision you have received {said method}
- f. Evidence/perceived efficaciousness {of said method}
- g. Preferred method at your group practice
- h. Supervisor opinion
- i. Personal experience of success as the client with a treatment
- j. Perceived client risk {of said treatment}
- k. Perceived client benefits {of said treatment}

15. Please rank order the aspects you chose previously, starting with 1 as your greatest concern, and so on. (*Drag and drop.*)

- 1. Conducive with practitioner schedule
- 2. Conducive with client schedule
- 3. Client interest {in said method}
- 4. Confidence/training in implementing {said method}
- 5. The level of supervision you have received {said method}

6. Evidence/perceived efficaciousness {of said method}
7. Preferred method at your group practice
8. Supervisor opinion
9. Personal experience of success as the client with a treatment
10. Perceived client risk {of said treatment}
11. Perceived client benefits {of said treatment}

Frequency of MP and MBI Use with ACEs

16. Please check which of the following mindfulness-based practices (MPs) you incorporate into treatment of survivors of Adverse Childhood Experiences.

- a. MP: Mindfulness Meditation
- b. MP: Breathing Practices
- c. MP: Walking exercise
- d. MP: Raisin exercise
- e. MP: Meditative Affirmations
- f. MP: Acceptance Practices
- g. MP: Guided Imagery
- h. MP: Body Scan Meditation
- i. MP: Yoga/Qi Gong
- j. MP: Self-Soothing with 5 Senses

17. How regularly do you use *mindfulness practices* (such as those listed above) with adults who are seeking treatment related their adverse childhood experiences?

(There is an optional answer to allow for commentary regarding a more specific response.)

- a. Almost always (every session)
- b. Often (at least every other session)
- c. Occasionally (once or twice with each client)
- d. Rarely (only with certain clients under specific circumstances)
- e. Never
- f. Commentary: _____

18. How regularly do you use *mindfulness practices* (such as those previously listed) with children who are seeking treatment related their adverse experiences? (*There is an optional answer to allow for commentary regarding a more specific response.*)

- a. Almost always (every session)
- b. Often (at least every other session)
- c. Occasionally (once or twice with each client)
- d. Rarely (only with certain clients under specific circumstances)
- e. Never
- f. Commentary: _____

19. What therapeutic approaches and techniques have you used when working with *adults* who are seeking treatment related their adverse childhood experiences? (check all that apply, and answer using the following Likert scale for each approach used)

Almost always (every session); Often (at least every other session);
Occasionally (once or twice with each client); Rarely (only with certain clients
under specific circumstances); Never; Commentary section provided for each
approach

- a. Prolonged Exposure
- b. Imaginal Exposure
- c. In Vivo Exposure
- d. Cognitive Processing Therapy
- e. Trauma-Focused Cognitive Behavior Therapy
- f. Eye Movement Desensitization Reprocessing therapy (EMDR)
- g. Cognitive Restructuring
- h. Behavioral Activation
- i. Cognitive Behavior Therapy
- j. Mindfulness Based Stress Reduction
- k. Mindfulness Based Cognitive Behavior Therapy
- l. Acceptance and Commitment Therapy
- m. Dialectical Behavior Therapy
- n. Psychodynamic Therapy
- o. Psychoanalytic Therapy
- p. Humanistic Therapy
- q. Existential Therapy
- r. Sandtray Therapy
- s. Other: _____

20. What therapeutic approaches have you used when working with *children* who are seeking treatment related to their adverse experiences? (check all that apply, and answer using the following Likert scale for each approach used)

Almost always (every session); Often (at least every other session); Occasionally (once or twice with each client); Rarely (only with certain clients under specific circumstances); Never; Commentary section provided for each approach

- a. Prolonged Exposure
- b. Cognitive Processing Therapy
- c. Trauma-Focused Cognitive Behavior Therapy
- d. Eye Movement Desensitization Reprocessing therapy (EMDR)
- e. Cognitive Restructuring
- f. Behavioral Activation
- g. Cognitive Behavior Therapy
- h. Mindfulness Based Stress Reduction
- i. Mindfulness Based Cognitive Behavior Therapy
- j. Acceptance and Commitment Therapy
- k. Dialectical Behavior Therapy
- l. Psychodynamic Therapy
- m. Psychoanalytic Therapy
- n. Humanistic Therapy
- o. Existential Therapy
- p. Sandtray Therapy

- q. Play Therapy
- r. Other: _____

Familiarity with MPs and MBIs versus Trauma-Focused Interventions

21. What kind of training have you received in **mindfulness-based interventions**

(such as Mindfulness Based Stress Reduction, Mindfulness Based Cognitive

Therapy, Acceptance and Commitment Therapy, or Dialectical Behavioral

Therapy)? **Please select all that apply.** *(There is an optional answer to allow for*

commentary regarding a more specific response.)

- Continuing Education workshop
- graduate school course
- supervised clinical training in graduate school
- supervised clinical training on internship
- formal postdoctoral fellowship
- informal postdoctoral fellowship
- attended a professional conference (with multiple presentations) on the subject
- attended a professional presentation on the subject
- Independent study (e.g., read book(s), watched online demonstrations)
- Please describe:

22. What kind of training have you received in **mindfulness practices** (such as

Mindfulness Meditation, Breathing Practices, Mindful Walking exercises, Raisin

(or mindful eating) exercises, Meditative Affirmations/Self-Compassion exercises, Acceptance Practices, Guided Imagery, Body Scan Meditation, Yoga/Qi Gong, Self-Soothing with 5 Senses)? **Please select all that apply.**

(There is an optional answer to allow for commentary regarding a more specific response.)

- Continuing Education workshop
- graduate school course
- supervised clinical training in graduate school
- supervised clinical training on internship
- formal postdoctoral fellowship
- informal postdoctoral fellowship
- attended a professional conference (with multiple presentations) on the subject
- attended a professional presentation on the subject
- Independent study (e.g., read book(s), watched online demonstrations)
- Please describe:

23. What kind of training have you received in **trauma-focused interventions** (i.e., interventions that use imaginal and/or in vivo exposure, such as Cognitive Processing Therapy, Prolonged Exposure, Trauma Focused Cognitive Behavioral Therapy, or Eye Movement Desensitization/Reprocessing Therapy)? **Please select all that apply.** *(There is an optional answer to allow for commentary regarding a more specific response.)*

- Continuing Education workshop
- graduate school course
- supervised clinical training in graduate school
- supervised clinical training on internship
- formal postdoctoral fellowship
- informal postdoctoral fellowship
- attended a professional conference (with multiple presentations) on the subject
- attended a professional presentation on the subject
- Independent study (e.g., read book(s), watched online demonstrations)
- Please describe:

Barriers/Facilitators to using MBIs and MPs in Practice

24. Which are the most prominent barriers to you using **trauma focused therapies** (i.e., interventions that use imaginal and/or in vivo exposure, such as Cognitive Processing Therapy, Prolonged Exposure, Trauma Focused Cognitive Behavioral Therapy, or Eye Movement Desensitization/Reprocessing Therapy) with a client who experienced adverse childhood events and is seeking treatment for those adverse childhood experience(s)? **Please check all that apply, and answer using the Likert scale for each approach used.** *(There is an optional answer to allow for commentary regarding a more specific response.)*
- a. I am not familiar with trauma focused therapies (facilitation)

- i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- b. I do not have sufficient training in trauma focused therapies (facilitation)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- c. I have been trained, but applying trauma focused therapies in practice isn't easy (facilitation)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- d. I need (but don't have) continued support, such as supervision and/or someone listening to my sessions and giving me feedback, in order to use trauma focused therapies with clients (facilitation)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- e. Trauma focused therapies are not reimbursed by insurance (context)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use

- f. Trauma focused therapies do not fit the clinical orientation/expectations of my work environment (context)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- g. My patients' schedules are not regular/stable enough to use trauma focused therapies (context)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- h. Trauma focused therapies are not conducive with my work schedule (context)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- i. Trauma focused therapies are not the best approach for clients who have experienced childhood adverse events (evidence)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- j. My clients would stop showing up if I used trauma focused therapies (evidence)

- i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- k. My clients would have adverse reactions/decompensate to trauma focused therapies due to their cognitive state (evidence)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- l. Trauma focused therapies do not work well with ethnic minority clients and/or create a potential value imposition (evidence)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- m. Some of my clients will not like it because it is reminiscent of an interrogation (evidence)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- n. My clients do not have the cognitive ability to receive benefit from trauma focused therapies (evidence)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use

- o. Trauma focused therapies make *me* uncomfortable because they do not fit with my personality or therapeutic style (context)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use

25. Which is the most prominent barrier to you using mindfulness-based therapy (i.e. Mindfulness based interventions and the extended use of mindfulness practices) with a client who experienced adverse childhood events and is seeking treatment for those adverse childhood experience(s)? **Please check all that apply, and answer using the Likert scale for each approach used.** *(There is an optional answer to allow for commentary regarding a more specific response.)*

- a. I am not familiar with mindfulness-based interventions/mindfulness practices (facilitation)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- b. I do not have sufficient training in mindfulness-based interventions/mindfulness practices (facilitation)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use

- c. I have been trained, but applying mindfulness-based interventions/mindfulness practices in practice isn't easy (facilitation)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- d. I need (but don't have) continued support, such as supervision and/or someone listening to my sessions and giving me feedback, in order to use mindfulness-based interventions/mindfulness practices with clients (facilitation)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- e. Mindfulness-based interventions/mindfulness practices are not reimbursed by insurance (context)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- f. It does not fit the clinical orientation/expectations of my work environment (context)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use

- g. My patients' schedules are not regular/stable enough to use a mindfulness-based intervention (context)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- h. Mindfulness-based interventions are not conducive with my work schedule (context)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- i. Mindfulness-based interventions/mindfulness practices are not the best approach for clients who have experienced childhood adverse events (evidence)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- j. My clients would stop showing up if I used mindfulness-based interventions/mindfulness practices (evidence)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use

- k. My clients would have adverse reactions/decompensate to mindfulness-based interventions/mindfulness practices due to their cognitive state (evidence)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- l. Mindfulness-based interventions/mindfulness practices do not work well with ethnic minority clients and/or create a potential value imposition (evidence)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- m. Some of my clients will not like it because it is reminiscent of an eastern religion (evidence)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use
- n. My clients do not have the cognitive ability to receive benefit from mindfulness-based interventions/mindfulness (evidence)
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use

- o. Mindfulness-based interventions/mindfulness practices make *me* uncomfortable because they do not fit with my personality or therapeutic style (context).
 - i. Likert scale: 1: is not a barrier, 2: potentially a barrier, 3: slight barrier, 4: not a barrier in specific circumstances, 5: strong barrier that prevents use

Gift Card/Raffle:

If you would like to enter to win a \$25 Amazon gift certificate, please click the link below and enter your email address. You will only be contacted to be provided your gift certificate if your email address is randomly selected as the winner of the raffle at the end of data collection.

Separate Qualtrics Survey link.

Your responses to this survey can in no way be linked to your email address.

- a. Yes, I clicked the link and entered my email address
- b. No, I would not like to enter the raffle

APPENDIX B

Informed Consent



MINDFULNESS THERAPY FOR SURVIVORS OF CHILDHOOD ADVERSITY:

WHAT'S THE USE?

Informed Consent

My name is Addie Goodson, and I am a Graduate student in the Psychology department at Sam Houston State University. I would like to invite you to participate in a research study titled “Mindfulness Therapy for Survivors of Childhood Adversity: What’s the Use?” I am conducting this research under the direction of Chelsea Ratcliff, Ph. D. We hope that data from this research will help us understand what therapeutic approaches clinicians use with clients seeking treatment related to adverse childhood experiences. You have been asked to participate in this survey because you are a clinician that potentially works with clients seeking treatment related to adverse childhood experiences.

This research survey is relatively straightforward, and we do not expect the research to pose any risk to any of the volunteer participants. If you consent to participate in this research, you will be asked to spend 15 minutes answering a 25-question online survey about your background and the therapeutic techniques you use when working with clients seeking treatment related to adverse childhood experiences. The survey will not record your name or any other identifying information, including your IP address. Your survey responses will be kept confidential to the extent of the technology being used. The security and privacy policy for Qualtrics can be viewed at <https://www.qualtrics.com/security-statement/>.

After you complete the 25-question survey, you will have the opportunity to provide your email address in order to be entered into a drawing for a \$25 Amazon gift

card. This is only to be entered into a drawing for a \$25 Amazon gift card. If you choose to enter your email address, you will do so in a second, separate survey to ensure your email address is not connected with your survey responses. You will only be contacted via email if you win the \$25 Amazon gift card, after data collection is complete, otherwise you will not be contacted. Participants will not be paid or otherwise compensated for their participation in this project. We anticipate including 60 participants in this study.

Participation is voluntary. If you decide to not participate in this research, your decision will involve no penalty or loss of benefits to which you are otherwise entitled, and you may discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled. If you have any questions, please feel free to ask me using the contact information below. If you are interested, the results of this study will be available at the conclusion of the project.

If you have any questions about this research, please feel free to contact me, Addie Goodson or Chelsea Ratcliff, Ph. D., using our contact information below. If you have questions about your rights as research participants, please contact Sharla Miles:

☐

I wish to participate in this survey

☐

I do not wish to participate in this survey.

APPENDIX C

IRB APPROVAL FORM

Date: 3-1-2019

IRB #: IRB-2018-179

Title: Mindfulness Based Interventions, Mindfulness Practices, and Other Therapeutic Practices and Use Rates with Survivors of Adverse Childhood Experiences

Creation Date: 11-11-2018

End Date:

Status: Approved

Principal Investigator: Addie Goodson

Review Board: SHSU IRB

Sponsor:

Study History

| | | | | | |
|------------------------|---------|--------------------|--------|-----------------|---|
| Submission Type | Initial | Review Type | Exempt | Decision | Exempt |
|------------------------|---------|--------------------|--------|-----------------|---|

Key Study Contacts

| | | | | | |
|---------------|------------------|-------------|---------------------------|----------------|---------------------------|
| Member | Addie Goodson | Role | Principal Investigator | Contact | alg063@shsu.edu |
| Member | Chelsea Ratcliff | Role | Co-Principal Investigator | Contact | chelsea.ratcliff@shsu.edu |
| Member | Addie Goodson | Role | Primary Contact | Contact | alg063@shsu.edu |

VITA

EDUCATION

| | |
|--|------------|
| Sam Houston State University | Aug. |
| 2017-Present | |
| M.A. in Clinical Psychology; <i>Expected 2019</i> | |
| Thesis: “ <i>Mindfulness Therapy for Survivors of Adverse Childhood Experiences: What’s the Use?</i> ” | |
| Sam Houston State University | Aug. 2014- |
| Dec. 2016 | |
| B.S. in Psychology with Honors; graduated magna cum laude | |

RESEARCH EXPERIENCE

| | |
|---|------------|
| University of Houston | June 2018- |
| Present | |
| Masculinity & Gender Issues in Culture Lab | |
| <i>Graduate Research Assistant (supervisor: Jonathan Schwartz, Ph.D.)</i> | |
| <ul style="list-style-type: none"> • Assisted in development of a male sexual entitlement scale • Investigated the correlation between male sexual narcissism and involvement in collegic athletics and fraternities • Submit poster presentation for the American Psychological Association annual convention • Collaborated on manuscript to be submitted for publication • Coordinating the merge of a large-scale survey study in an inter-institutional agreement between the University of Houston and Sam Houston State University | |
| Sam Houston State University | June 2018- |
| Present | |
| Investigative School Procedure & Environment Lab | |
| <i>Graduate Research Assistant & Lab Coordinator (supervisor: Justin Allen, Ph.D.)</i> | |
| <ul style="list-style-type: none"> • Coordinate all members and organize both the location, time, and structure of the meeting • Write and conduct a survey study to be administered to over 100 school districts in the state of Texas over the topic of Manifestation Determination Reviews • Build a database to use for the contact of all schools • Coordinate undergraduate researcher trainings to conduct these interviews • Support undergraduate students while applying to graduate school by reviewing paperwork • Prepare documents for journal submission | |
| Sam Houston State University | July 2018- |
| Present | |
| Integrative Health Laboratory | |
| <i>Graduate Research Assistant (supervisor: Chelsea Ratcliff, Ph.D.)</i> | |
| <ul style="list-style-type: none"> • Literature reviews for various research projects • Provide resources for undergraduate research assistants | |

- Amend and write questions for research studies to be proposed

Sam Houston State University

Aug.

2017-Present

Family and Collaboration Tiered School Supports Laboratory

Graduate Research Assistant (supervisor: Courtney Banks, Ph.D.)

- Create poster presentations to be submitted to national state conferences
- Prepare presentations to be publishable manuscripts for submission
- Provide resources and support for undergraduate research assistants

Sam Houston State University

Jan 2014-

Dec. 2016

Diversity and Health Research Laboratory

Undergraduate Research Assistant (supervisor: Craig Henderson, Ph.D.)

- Contributed to data collection used for doctoral dissertation
- Aided in conducting experimentation by directly working with participants and administering the experimental variables (i.e. questionnaire administration and 'deception' of participants)
- Collaborated on master's thesis experimentation
- Contributed to data collection used for master's theses
- Writing and editing manuscripts for publication submission
- Prepared poster presentation for local and state conferences and symposiums

CLINICAL EXPERIENCE

Sam Houston State University, Jack Staggs Counseling Clinic

Jan. 2018-

May 2018

Pre-Practicum Student (supervisor: Jeffrey Sullivan, Ph.D., LPC-S, RPT)

- Trainee working with Sam Houston State University students

Sexual Assault and Abuse Free Environment (S.A.A.F.E.) House

Aug. 2016 – Dec. 2018

Practicum Student (supervisor: Jakira Lewis)

Practicum Student (supervisor: Theresa Fusaro, LPC-S)

- Responded to hotline calls to survivors of domestic violence and sexual assault
- Attended S.A.N.E. screening trainings
- Provided direct therapy to survivors of sexual assault and domestic violence in individual therapy sessions of all ages
- Provided direct play and sandtray therapy to both primary and secondary child victims of domestic violence and sexual assault
- Earned a total of 120 indirect client contact and 40 direct therapy hours

Sam Houston State University, PeRP Mock Therapy

Jan. 2018-

May 2018

Practicum Student (supervisor: Marsha Harman, Ph.D.)

- Individual therapy sessions conducted with undergraduate Sam Houston State University students
- Earned a total of 40 direct therapy hours

The Good Shepard Mission

Jan. 2018-

May 2018

Counselor Education Program Intern (supervisor: Evelyne Fitzgerald, Ph.D., LPC-S)

- Provided group therapy to homeless individuals in the Huntsville, TX population
- Earned a total of 12 direct therapy hours

Sam Houston State University Counseling Center

Aug. 2018-

Dec. 2018

Practicum Student (supervisor: Diane Stoebner-May, Ph.D., LP)

- Provided individual therapy to students at Sam Houston State University
- Co-lead the Self-Compassion Mindfulness Group
- Earned 200 indirect client contact and 100 direct therapy hours
- Attended HAVEN training to advocate and promote equality for students of the LGBTQIA+ community on campus
- Attended weekly didactics to cover important population/subject specific training for clients

CONFERENCE PRESENTATIONS

- **Goodson, A.**, Falgout, R., Mena, C., Manning, J., A. Yenne, E.M., Schiafo, M., Sledd, M., Figureoa, M.M., Missimo, C., Langemeire, D. A., Henderson, C. (2016). *Don't Drink and Exercise*. Poster presented at the Annual Convention of the Texas Psychological Association
- **Goodson, A.**, Falgout, R., Mena, C., Manning, J., A. Yenne, E.M., Schiafo, M., Sledd, M., Figureoa, M.M., Missimo, C., Langemeire, D. A., Henderson, C. (2016). *Drinking and Physical Exercise*. Poster presented at the Undergraduate Research Symposium at Sam Houston State University.
- **Goodson, A.**, Melofsky, T., Banks, C. S. *Parental Involvement and Child Behavior in Academic Settings*. Poster presented at the Annual Convention of the Texas Psychological Association.
- Tullos, E., Ratcliff, C., **Goodson, A.**, Chaoul, A., Hall, M., Cohen, L. (March, 2019). *The association between sleep quality and anxiety in women with breast cancer undergoing chemotherapy: the moderating role of coping*. Poster accepted for presentation at the 2019 annual meeting of the American Psychosomatic Society, Vancouver, B.C.
- Broyles, A., Schwartz, J., **Goodson, A.** (2019). *Acceptance of Rape Myths and Sexual Narcissism in Athletic Team and Fraternity Members*. Poster submitted to the American Psychological Association.

SCHOLARSHIPS & AWARDS

- | | |
|--|-----------|
| • Graduate Bearkat Grant (\$1,750) | 2019 |
| • College of Humanities & Social Sciences Graduate Scholarship (\$1,000) | 2019 |
| • Graduate Bearkat Grant (\$3,500) | 2018 |
| • Graduate Studies Scholarship (\$1,000) | 2018 |
| • College of Humanities & Social Sciences Graduate Scholarship (\$2,000) | 2018 |
| • Summer Graduate Bearkat Grant (\$2,000) | 2018 |
| • College of Humanities & Social Sciences Graduate Scholarship (\$1,065) | 2018 |
| • Graduate Bearkat Grant (\$3,500) | 2017 |
| • College of Humanities & Social Sciences Graduate Scholarship (\$3,500) | 2017 |
| • Perfect Presentation, SHSU Undergraduate Research Symposium | 2016 |
| • Honors College Ambassador | 2015-2016 |

MEMBERSHIPS

- | | |
|--|--------------|
| • Texas Psychological Association Student Member | 2018-Present |
| • Texas Counselors Association Student Member | 2018-Present |
| • American Psychological Student Member | 2018-Present |