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Shamora Michelson
Treating Complex Trauma:
Therapists' perspectives on the
effectiveness of the Trauma
Focused-Cognitive Behavioral
Therapy clinical approach to treat
traumatized children

ABSTRACT

This study was undertaken to determine therapists' perspectives on the effectiveness of the TF-CBT model to treat complex trauma in children. This qualitative study aims to enhance and expand knowledge in the field about complex trauma and the usefulness of the TF-CBT clinical approach.

Therapists with a master's level degree or higher in social work, psychology or a related field and who practice the TF-CBT model with children were recruited for this study. Twelve therapists were interviewed regarding their training in the TF-CBT model; use of the model with children, including those who have experienced complex trauma; perspectives on valuable aspects of TF-CBT, perspectives on challenging aspects of TF-CBT; comparison of TF-CBT to other treatment models and outcomes from the use of the TF-CBT model.

The findings of the research showed the respondents to be in accordance in their responses with one another as a group. Participants commonly found the TF-CBT model to be a highly effective and beneficial treatment approach for traumatized children. Suggestions for further research were made on complex trauma and ways to enhance the efficacy of the TF-CBT model.

**TREATING COMPLEX TRAUMA: THERAPISTS' PERSPECTIVES ON THE
EFFECTIVENESS OF THE TRAUMA FOCUSED – COGNITIVE BEHAVIORAL
THERAPY CLINICAL APPROACH TO TREAT TRAUMATIZED CHILDREN**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements for the
degree of Master of Social Work.

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2010

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CHAPTER I

INTRODUCTION

The late 1970's marked the return of hundreds of thousands of Vietnam veterans who presented with serious psychiatric symptoms including anxiety, dysphoria, intrusive reexperiencing, hyperarousal and hypervigilance (Ford, 2009). The emergence of so many affected veterans sparked the development of a formal diagnosis to identify individuals who had encountered extreme stressors, especially in combat (Ford, 2009). The diagnosis of posttraumatic stress disorder (PTSD) attempted to capture the symptom picture of those who had experienced trauma. PTSD was included as an official diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition (DSM-III) (van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005).

The current Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR) (American Psychiatric Association (APA), 2000) states that a diagnosis of PTSD applies when an individual is “confronted with an event or events that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others” (p.467) and “the person’s response involved intense fear, helplessness or horror” (p. 467). Further, the diagnostic criteria state that the person must reexperience the event in one or more intrusive ways, must display three or more avoidant behaviors related to the traumatic stimuli, must show two or more symptoms of increased arousal not present before the trauma and must have clinically significant distress or impairment in social, occupational, or other areas of functioning. Combined, these symptoms must be present for the duration of at least one month.

Research has found, however, that, “the symptoms required for the diagnosis of PTSD, as it is currently defined, do not cover the full range of posttraumatic impairments (Ford, 2009, p. 19). Studies of abused and neglected children, as well as studies of women exposed to prolonged interpersonal violence, suggest that these populations display a range of symptoms not captured in the diagnostic criteria of PTSD (van der Kolk et al., 2005). Specifically, PTSD fails to adequately describe the affects trauma can have on attachment and biology, as well as the emotional dysregulation, dissociation, physical reactions, behavioral functioning, information processing and self concept that can be skewed as a result of exposure to extreme stress, especially in children (Aideuis, 2007; Ford, 2009).

Complex trauma, or complex PTSD, is the term proposed to address the multifaceted nature of trauma experienced by children and adolescents when abuse, neglect, violence and fear provide the framework of their early being (Aideuis, 2007; Resick, Nishith & Griffin, 2003). Ford (2009) defines complex psychological trauma as;

resulting from exposure to severe stressors that (1) are repetitive or prolonged (2) involve harm or abandonment by caregivers or other ostensibly responsible adults, and (3) occur at developmentally vulnerable times in the victim’s life, such as early childhood or adolescence (p. 13).

The emergence of complex trauma and its unique symptom manifestations as separate from PTSD will require that therapists be able to accurately and effectively treat complexly traumatized children. While various models have been empirically studied to assess their effectiveness in treating symptoms of complex trauma, one model in particular has been favorably reviewed. This model, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is designed to treat children who have experienced

extreme stressors and are subsequently displaying symptoms of psychiatric trauma. According to Cohen, Mannarino, Perel and Staron (2007) in six randomized, controlled trials for sexually abused and multiply traumatized children, TF-CBT was superior to control conditions in decreasing PTSD, anxiety, depression and externalizing behavioral problems.

While TF-CBT is burgeoning in the field as a premiere treatment model for treating trauma, most empirical research has focused on whether or not it is successful in treating children diagnosed with PTSD. The central focus of the present research study is to examine the effectiveness of TF-CBT in treating complex trauma reactions in children. This research study examines the question: What are therapists' perspectives on the effectiveness of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) in treating children with a history of complex trauma experiences? This qualitative study will interview twelve trained experts in the field of social work and psychology on their opinions and observations of the TF-CBT model. The following review of literature will review the current state of understanding of complex trauma disorders in children and the potential of TF-CBT to ameliorate the associated symptoms. The methodology chapter will describe how participants were selected and how data were collected and analyzed. The findings chapter will give an overall description of the participants and present the findings of the research by theme. Finally, the discussion chapter that will summarize the findings and application to clinical practice, present the researcher's perception regarding the findings and limitations of the study, and give suggestions for further research on the topic.

CHAPTER II

LITERATURE REVIEW

The following review of the literature will address general issues and challenges that therapists in the mental health field encounter when treating children in clinical settings. The literature review that follows will examine and define complex trauma and its origins in the mental health field and will review specific issues and challenges that therapists encounter when treating children with complex trauma in outpatient settings. The review will then provide an analysis of treatment approaches that address post-traumatic stress disorder (PTSD) and complex trauma symptoms in children. Ways in which Cognitive Behavioral Therapy (CBT) has emerged as an effective treatment method for PTSD and complex trauma symptoms will be discussed. The review will end with definition and appraisal of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) as a new treatment model, including evidence of empirically successful outcomes from TF-CBT literature related to treating children with PTSD and complex trauma symptoms. This writer will review current perspectives of this treatment model in the mental health field.

Treating Children in Clinical Settings

Erdman and Lampe (1996) state that there is nothing magical or mystical about working with children. While therapists may agree or disagree with that statement, the mental health field consent that to work in clinical settings with children requires a different set of skills and knowledge than treatment with adults. Therapists working in clinical settings typically see children between the ages of 5 and 12 years old, however

children younger than this also receive therapy. For the purposes of this literature review, the focus will be on the latency-aged child. This is the period when the child develops the knowledge and skills that will serve as the foundation for subsequent cognitive, emotional and social growth (Cincotta, 2002). Before looking at how traumatic experiences, and especially how ongoing, repetitive types of trauma affect a child's inner workings, this review will concentrate first on the tasks and skills learned during this developmental phase of the child's life, and then how complex trauma experiences may impact this development.

This time period between 5 and 12 years of age is known as middle childhood and/or the latency stage in child development. It is during this life phase that the child shifts away from an egocentric way of thinking and begins to realize the world is a more complex place. The latency-aged child is faced with overall tasks in the areas of physical, social, cognitive and moral development, as well as making gains in attachment, communication, play, self-regulation and sense of self. This stage of development, however, is not linear. Children aged 5-7 or 8 are often thought of as in a transitional phase during which the abilities of the middle years are developing rapidly, but may not be consistently present. The child will go through periods when he/she is at times advancing and at times regressing to earlier developmental ways of being (Davies, 2004). By the end of middle childhood the tasks and skills acquired during this phase will be built upon and modified as the child moves to adolescence and beyond.

Physical Development

During the middle childhood years, a child's rate of growth is gradual and steady. Biological changes enable a greater sense of capacity, strength, endurance and ability

(Cincotta, 2002). Gross motor skills are well developed during the beginning of middle childhood and continue to improve throughout this period and fine motor skills continue to be perfected. As new levels of cognitive functioning arise, a child's brain development undergoes significant changes during the early part of this period. Some areas of the brain grow more nerve pathways, while unused pathways are eliminated. The frontal lobe of the cerebral cortex, associated with language development, thinking processes and consciousness, develop rapidly between 5 and 8 years of age. As middle childhood continues, higher cognitive functions develop in the prefrontal cortex, such as working memory, planning and inhibitory control (Davies, 2004).

Attachment

Attachment affects a child's internalized working model of the self, how s/he perceives others and how s/he views relationships. The type of attachment formed in a child's earlier years is carried forward as the child grows and affect the child's ability to form appropriate attachment behaviors as s/he continues to develop. A history of secure attachment enables a child to be more independent, less isolated and less often a passive recipient of aggression. During the middle childhood years, the child will more frequently use autonomous coping and self-soothing behaviors rather than attachment seeking behaviors in situations of mild stress. In situations of severe stress, attachment-seeking behaviors may be activated, however during this phase a child's attachment needs are increasingly expressed through friendships with peers (Davies, 2004).

Social Development

During this stage other adults, peers and friendships take on increasing importance in the child's life. This coincides with the child's transition into school. In

fact children may spend up to 40% of their time interacting with peers (Cincotta, 2002). It is during this phase that children learn appropriate social behaviors. Due to an increased peer orientation, the child's own sense of self-esteem is based on recognition and acceptance from his/her peer group. The desire to fit into a peer group is a powerful motivator for children to follow rules and adhere to peer group norms. Children in this stage also develop a capacity for social perspective taking, meaning a child can hold two opposing views in mind as well as tolerate emotional ambivalence and feeling two different feelings simultaneously. Children who are slow to develop or who display social unusualness are more often disliked, and are more prone to develop symptoms of depression later in life (Davies, 2004). Additionally, how a child interacts with his/her peers is influenced by early attachment styles and the nature of the child's relationship with primary caregivers and siblings (Cincotta, 2002). Traumatic experiences, especially those of repetitive and ongoing nature, may interrupt and hinder a child's social development in these areas and be a catalyst for a range of related problems.

Language and Communication

In middle childhood, children generally possess the ability to grasp the basic syntax and grammatical structure of his/her native language. At this age, children are capable to express what they are thinking and to relay a coherent narrative that has a beginning, middle and end. Despite these gains in language and communication, it does not mean that it becomes easy for school age children to talk about emotionally charged topics, especially distressing or conflictual feelings. Therefore play and other types of symbolic representation remain essential forms of communication for this age group (Davies, 2004).

Maturing language capacity has important implications for self-regulation. As a child is able to put feelings into words he/she can delay acting on such feelings. During this time period children are encouraged to use verbal means to solve problems, which promotes verbalization as a means of regulating affect and controlling impulses (Davies, 2004). When a child endures traumatic experience(s), they may or may not be able to use language to communicate emotions they are feeling. It is important to help a child find ways of expressing themselves so that they can use verbal rather than physical communication to relay thoughts and feelings and develop self-regulation and impulse control.

Play and Fantasy

Play continues to be an important aspect of the school-aged child's life. Play during this phase is more focused on a work orientation, such sports or activities that require physical competence and mastery, which generally take the place of fantasy play. Fantasy play is increasingly ritualized and rule-governed, and is used to displace feelings and wishes onto imaginary scenarios. The structure of games in middle childhood mirrors many of the general developmental tasks of this period. For example, children must practice emotional control, maintain a focus on planning and goals, socialize with peers within the norms, follow rules, and be able to sustain concentration, all so that the game can proceed. Other children commonly respect those children who are skillful and follow rules (Davies, 2004).

Cognitive Development

The school-age child develops a more accurate perception of reality during the latency phase. Basic reasoning processes and executive functioning skills also develop.

Children begin to understand cause and effect. The prefrontal cortex also matures during this time, allowing the child to develop a better understanding of space and spatial relationships, time orientation, thinking ahead, seriation, visual organization ability, the capacity to move between details and the big picture, thinking about problems understanding multiple perspectives, and using auditory processing and verbal cues. Children also increase their attention span, acquire the ability to selectively focus and direct their attention at will. By the end of the middle years, a child's ability to categorize memories and deliberately recall information is nearly as efficient as an adult's. A child can sort information by time, place, category and other cues and can apply rules for recall. The importance of these skills is reinforced at school (Davies, 2004). The child's increased capacity for language now allows for the sharing and relaying of memories (Cincotta, 2002).

Self-Regulation

Good self-regulation is essential to the developmental tasks of school age children. Defenses become more advanced, which allow the child to avoid distressing feelings. Reality testing improves and allows the child to think about experiences more logically. The school-aged child can also tell a narrative story of his/her experiences, including a description of how he/she felt. The capacity to think and talk about stressful experiences reduces anxiety.

In this phase the child can sort out whether or not a situation is dangerous, meaning earlier sources of anxiety such as separation, worry about losing control, fear of body damage and confusion about reality are not so pressing. Typical anxieties of this

age group include being rejected, excluded, or evaluated negatively by peers. Pride and shame often influence the school-aged child's behavior.

In middle childhood the strategies for self-regulation and coping include the use of mental strategies to inhibit expression of feelings such as self-talk. Children of this age can also differentiate among emotions and are therefore less likely to become overwhelmed by them. The school aged child can also remain focused in face of external distraction, delay gratification, think through steps and plan, control impulses and accept both the negative and positive of a situation (Davies, 2004).

Moral Development

According to Piaget, "the essential aspect of morality is the tendency to accept and follow a system of rules that regulate interpersonal behavior" (as cited in Cincotta, 2002 p. 95). In the middle childhood phase the internal conscience further develops. As a child gains a sense of right and wrong, the child approves of the self when doing something right and feels guilty when s/he is unable to resist a bad impulse. The child develops a cognitive understanding of rationales, authority, rules and norms and increasingly identifies with the values of parents and peers (Davies, 2004).

Sense of Self

In middle childhood the capacity for self-observation increases and other's observations are integrated into a child's own perceptions. A school-aged child's sense of self is largely based on how s/he compares with peers. In middle childhood the child is able to differentiate his/her abilities, compare performances to others and realistically evaluate competencies. Children begin to feel shame and pride on cognitive, emotional and social levels (Cincotta, 2002). A child's history of being accepted and supported by

parents also influences a child's self-esteem, as the child is now able to make comparisons between past and present characteristics of the self. The child identifies with parents, other adults and peers as role models. A school-aged child increases his/her awareness of identity, including personal characteristics, gender expectations and sexual, racial and ethnic identity. Children in this phase also become aware of racism and negative stereotypes and apply these to the self (Cincotta, 2002; Davies, 2004).

Practice in Clinical Settings

Most children are referred for clinical services because of problems that have shown up at school. This is when many of the problems in mastering the tasks of middle childhood become enlightened. Typical presenting symptoms include behavior and academic problems, attention/concentration problems, restlessness, hyperactivity, impulsive, aggressive, oppositional or defiant behavior, poor peer relationships, social withdrawal, social immaturity or rejection by peers and generalized or separation anxiety (Davies, 2004). At this age children are typically quite resilient. However, Shaefer (as cited in Cincotta, 2002 p. 111) notes symptoms that could indicate more serious psychological difficulties, such as prolonged anxiety, fears not proportionate to reality, signs of depression, abrupt changes in mood and disturbances in sleep, appetite and sexual functioning.

Important to note is that the same symptoms can represent different problems, requiring that therapists conduct a careful assessment of each child in biological, social and psychological arenas (Davies, 2004). Developmental interferences can arise as a result of, "exposure to violence, chronic parental fighting, divorces, the loss of family members, abuse and trauma. Very often, the child's inability to proceed with normal

development in middle childhood is tied to defenses and coping mechanisms established in response to anxiety-provoking experiences during childhood” (Davies, 2004 p.391). Emergency based coping strategies may help the child survive, but may also interfere with developmental tasks. Language disorders, learning disabilities and attention deficit hyperactivity disorder (ADHD) may also contribute to interference in developmental tasks (Davies, 2004). This literature will focus specifically on the types of disruptions, problems and symptoms that are caused when a child is exposed to trauma.

Trauma, PTSD and Complex Trauma

Trauma is defined as an, “event or events that are so extreme, severe, powerful, harmful or threatening, that they demand extraordinary coping efforts” (Lesser & Saia, 2007 p.356). Research demonstrates that responses to trauma are complex and affect many different physiologic systems in the human body. If a person’s ability to survive depends on the organism’s ability to cope with and adapt to stress, what happens when the body is overloaded with stress?

Research indicates that homeostasis can only be maintained in the face of a certain amount of stress. The development of PTSD and other trauma reactions may be an indicator that stress has overwhelmed a child’s system. Exposure to trauma appears to be connected to an overactivation of the brain area responsible for assigning emotional meaning to sensory stimuli and encoding emotional memories, as well as an underactivity of the brain area involved in eclipsing learned fear responses. There is also evidence to suggest that the stress response system of traumatized children is hyperactive, causing many of the hyperarousal symptoms (Cohen, Perel, DeBellis, Friedman & Putnam, 2002).

In the adult population, studies find a lifetime incidence of PTSD ranges from 3 to 14 %. This incidence is a total population estimate. Similar studies in adolescents find incidence figures between 2 and 5 %. These figures refer to total population estimates. However, when samples of children are examined, these figures dramatically increase. Controlled studies document that between 15 and 90 % of children exposed to traumatic events develop PTSD (Perry, 1999). These numbers may exist in such a prevalent fashion due to the notion that the presentation of PTSD in children may include a combination of problems, with the signs and symptoms looking very similar to other neuropsychiatric disorders. In most studies examining the development of PTSD following a given traumatic experience, twice as many children suffer from significant post-traumatic signs or symptoms (PTSS) but lack all of the criteria necessary for the diagnosis of PTSD. In these cases, trauma-related symptoms are often identified as being part of another neuropsychiatric syndrome (Perry, 1999).

Similar findings were established in a longitudinal study done by Copeland, Keeler, Angold and Costello (2007) who study examined the developmental epidemiology of potential trauma and PTSD in a community sample of children and found that exposure to one or more traumatic events by age 16 was apparent in two-thirds of the sample investigated. This study also found that sub-clinical PTSD, assessed by endorsing at least one symptom each of painful recall, hyperarousal, and avoidance symptoms, as well as painful recall was prevalent among children under the age of 16; however, full-blown DSM-IV PTSD was rare across all sex, age and ethnic groups of the study population. The study found that the highest rates of painful recall and subclinical PTSD were associated with violent events, sexual trauma, or a lifetime history of

multiple trauma exposures. The study found that the main impairments participants reported included disruption of important relationships, school problems, physical problems and exacerbations of emotional problems.

Although exposure to traumatic events was almost commonplace, full-blown PTSD was rare across middle childhood. The rate of PTSD after exposure to a traumatic event was lower than that reported in studies of adults (Copeland et al., 2007). These findings contradict the information above about the prevalence of posttraumatic stress in children. These researchers suggest that one explanation for these findings has to do with the DSM-IV criteria themselves. The researchers note that although this study did not evaluate current DSM criteria for PTSD, that they may not accurately reflect severe responses to trauma in children or may not be developmentally sensitive (Copeland et al., 2007).

These findings support a current theory in the field that the diagnosis of PTSD does not capture the developmental effects of what is now called complex trauma exposure. Children exposed to abuse, neglect, family violence and maltreatment often meet diagnostic criteria in the DSM-IV-TR for depression, attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder, anxiety disorders, eating disorders, sleep disorders, communication disorders, separation anxiety disorder and reactive attachment disorder (Cook et al., 2005).

Research has found that, “the symptoms required for the diagnosis of PTSD, as it is currently defined, do not cover the full range of posttraumatic impairments (Ford, 2009, p. 19). Studies of abused and neglected children, as well as studies of women exposed to prolonged interpersonal violence, suggest that these populations display a

range of symptoms not captured in the diagnostic criteria of PTSD (van der Kolk et al., 2005). Specifically, PTSD fails to adequately describe the affects trauma can have on attachment and biology, as well as the emotional dysregulation, dissociation, physical reactions, behavioral functioning, information processing and self concept that can be skewed as a result of exposure to extreme stress, especially in children and adolescents (Aideuis, 2007; Ford, 2009).

Complex trauma, or complex PTSD, is the term proposed to address the multifaceted nature of trauma experienced by children when abuse, neglect, violence and fear provide the framework of their early being (Aideuis, 2007; Resick, Nishith & Griffin, 2003). Ford (2009) defines complex psychological trauma as;

resulting from exposure to severe stressors that (1) are repetitive or prolonged (2) involve harm or abandonment by caregivers or other ostensibly responsible adults, and (3) occur at developmentally vulnerable times in the victim's life, such as early childhood or adolescence. (p. 13).

According to Aideuis (2007) and Cook et al. (2005), a comprehensive review of the literature on complex trauma identifies seven domains that address the complexity of symptoms and behaviors that make up complex trauma disorders. These domains are attachment, biology, affect regulation, dissociation, behavioral control, cognition and self-concept. These domains more adequately describe the effects of ongoing and repetitive trauma of development in children. These domains mirror many of the same developmental tasks of middle childhood.

Attachment

Early attachment has a great impact on a person's capacity to develop a sense of self-worth, to regulate emotions and affect, to self-soothe and cope in times of stress, and

to form a cohesive sense of self (Aideuis, 2007; Pearlman & Courtois, 2005; Williams, 2006). When a caregiver can accurately attune to an infant and respond to his/her needs accordingly and consistently, a secure attachment forms. A secure attachment is thought to serve as a protective factor as it allows the child to develop the aforementioned qualities and to be better equipped to deal with distress should it arise in the future (Aideuis, 2007; Pearlman & Courtois, 2005). Conversely, when a caretaker does not provide this sense of security and is actually a cause for extreme distress, the child is left with a need to attach but without an appropriate primary attachment figure and an insecure attachment develops. The child experiences an uncertainty about the reliability and predictability in the world (Aideuis, 2007). Symptoms that may develop in a child who has insecure attachment patterns are social isolation, distrust and suspiciousness, interpersonal difficulty, problems with boundaries, difficulty attuning to other people's emotional states and difficulty with interpreting social cues and perspective taking (Aideuis, 2007; Cook et al., 2005).

Biology

The amygdala, a part of the brain's limbic system, is involved with the processing of sensory information and the modulation and expression of emotions. The amygdala connects with the medial prefrontal cortex, which is integral in extinguishing the learned fear response. Dopamine is a neurotransmitter involved with several functions of the central nervous system (CNS) and is related to developing appropriate coping responses to stress (Cohen, et al., 2002). According to Cohen et al. (2002);

Under normal circumstances, human beings are able to utilize these and other fine tuned biological mechanisms to adjust in the face of stressors. However, there is a limit to the amount of stress that any organism can adapt to while maintaining

homeostasis... Thus, children who have experienced severe stressors may develop PTSD or other illnesses that indicate that the person's stress adaptation systems have been acutely or chronically overwhelmed (p.92).

Manifestations of this type of disruption can be seen as difficulty with sensory processing issues, such as hypersensitivity to physical contact and/or the absence of sensitivity to pain. Additionally, children may report upper body weakness, sensitivity to sounds, tastes and smells, somatization and increased medical problems (Aideuis, 2007; Cook et al., 2005).

Affect Regulation

Affect regulation is the ability for a child to accurately identify, label and express an emotional state safely, while simultaneously being able to modulate the concurrent internal experience. Children who have experienced complex trauma show impairment in both of these areas (Cook et al., 2005). These impairments evidence as difficulty de-escalating, chronic or pervasive depressed mood, preoccupation with suicide, difficulty labeling and expressing feelings, problems knowing and describing internal states, difficulty communicating wishes and needs and explosive and/or inhibited anger (Aideuis, 2007; Cook et al., 2005).

Dissociation

Children who have experienced complex trauma can alter their awareness of self and experience. This is done primarily in three different ways. The first is automatization of behavior, which is manifested as deficits in judgment, planning and organized, goal-directed behavior. The second is compartmentalization of painful memories and feelings, the third a detachment from awareness of self and emotions (Cook et al., 2005). These alterations may be seen as one or more distinct states of consciousness, amnesia,

depersonalization and derealization and impaired memory for state-based events (Aideuis, 2007; Cook et al., 2005).

Behavioral Control

According to Cook et al. (2005), “complex childhood trauma is associated with both undercontrolled and overcontrolled behavior patterns” (p. 394). These patterns include, poor modulation of impulses, self-destructive behavior, aggression toward others, pathological self-soothing behaviors, sleep disturbances, eating disorders, substance abuse, excessive compliance, oppositional behavior, difficulty understanding/complying with rules and reenactment of trauma in behavior or play (Aideuis, 2007; Cook et al., 2005).

Cognition

Across a variety of trauma exposures, including physical abuse, sexual abuse, neglect or witnessing domestic violence, maltreated children show significant deficits in cognitive abilities. This research found that these deficits could not be better accounted for as a result of other psychosocial stressors such as poverty (Cook et al, 2005). Cognitive deficits exhibit as difficulties in attention regulation and executive functioning, lack of sustained curiosity, problems with processing new information, problems focusing/completing tasks, problems with object constancy, difficulty planning/anticipating, problems understanding responsibility, learning difficulties, problems with language development and problems with orientation in time and space (Aideuis, 2007; Cook et al., 2005).

Self- Concept

Children can normally form a stable and integrated sense of identity with appropriate care giving. In contrast, repetitive experiences of harm, rejection or both by significant others, can lead to the failure to develop age appropriate competencies (Cook et al., 2005). Combined, these are likely to lead to a lack of continuous, predictable sense of self, poor sense of separateness, disturbances in body image, low self-esteem and shame and guilt (Aideuis, 2007; Cook et al., 2005).

Complex Trauma in Clinical Settings

According to Ford (2009), the National Child Traumatic Stress Network (NCTSN) has pioneered a new potential diagnosis, Developmental Trauma Disorder (DTD) for complexly traumatized children to be included in the fifth addition of the DSM. DTD “identifies developmentally adverse interpersonal trauma and subjective reactions that include not only fear but also self-related (e.g., shame) and defensive (e.g., rage) subjective reactions as specific trauma stressor criteria” (p. 24-25). DTD was designed to enable clinicians and researchers to identify, diagnose, treat and study this population. However, this is presently not a formal diagnosis. There are a number of clinical approaches currently used in the field to treat symptoms and reactions to trauma, PTSD and complex PTSD.

Clinical Approaches that Address PTSD and Complex Trauma

A number of clinical approaches recognize that when a child grows and develops in an environment marked by multiple and chronic stressors within a care giving system intended to be the child’s primary source of safety, a complex symptom picture arises and various deficits emerge. Knowing the psychobiology of traumatic stress in children can

guide therapist's efforts to provide the best possible treatment (Cohen et al., 2002). The data from the Cohen et al. (2002) study suggests that when treating children with traumatic experiences, it is important to include psychological interventions that target the deficits left from traumatic experiences. More specifically, this study identified the most important components as cognitive processing, which helps the child to examine and reassign meaning to the trauma as well as other experiences and exposure techniques, which can help decondition the child's learned fear reactions to thoughts and discussions about the trauma. Due to the possibility that these cognitive and exposure techniques may be very stimulating to the child's system, it is therefore important to include relaxation techniques such as progressive muscle relaxation, positive imagery and deep breathing (Cohen et al., 2002). Amaya-Jackson and DeRosa (2007) state that the mental health field appears to recognize a number of core elements essential to the treatment of childhood trauma to promote developmental progression. These elements are; psychoeducation, management of anxiety symptoms and trauma reminders, trauma narration and organization, cognitive and affective processing, problem solving regarding safety and relationships, parenting skills, behavior management, emotional regulation and addressing grief and loss. Reviewed below are various clinical approaches intended to treat trauma and related sequelae that incorporate various components mentioned above.

Relational Treatment

The relational treatment clinical approach recognizes the difficulties traumatized individuals have relating to others, and the problems others have relating to them as paramount to the treatment. Pearlman and Courtois (2005) contend that the self and attachment difficulties are the core deficits that need repairing after one faces chronic and

pervasive trauma, especially if this trauma happens during childhood. These researchers assert that the attachment and self-concepts, as well as ensuing difficulties with emotions, emotional regulation, and the ability to sustain satisfying relationships must be understood, addressed and healed in and through the context of the therapeutic relationship. This clinical approach identifies and emphasizes four core elements in the treatment relationship; respect, information, connection and hope (RICH), as well as five key needs to redevelop in the child; safety, trust, esteem, intimacy and control. In this clinical approach the therapeutic relationship provides an opportunity to rework attachment difficulties after a complex trauma experience in childhood.

Attachment, Self-Regulation and Competency (ARC)

The Attachment, Self-Regulation and Competency (ARC) clinical approach recognizes that children who have experienced complex trauma need a flexible model of intervention that is embedded in developmental and social contexts and can address a variety of trauma exposures, including ongoing exposure (Kinniburgh, Blaustein & Spinnazola, 2005). ARC highlights attachment as a primary domain of intervention and aims to build or rebuild healthy attachments between children who have experienced trauma and their caregivers by creating a safe environment for healthy recovery. The ARC model also focuses on enhancing self-regulatory capacities and on building or restoring developmental competencies. The child is helped to gain mastery over his/her environment, make positive connections with others, achieve a positive self-concept and foster a sense of self-control.

Eye Movement Desensitization and Reprocessing (EMDR)

Eye Movement Desensitization and Reprocessing (EMDR) is a therapy model that emphasizes the child's gradual imaginal exposure to the traumatic experience. In this clinical approach distressing memories related to the trauma are identified, desensitized and reprocessed, allowing for the child to develop a more coherent narrative of the traumatic event. EMDR is thought to impact the memory and information networks of the brain. Contacting both networks allows the child to access the memory, make sense of it, correct negative cognitions and strengthen positive feelings and sensations (Aideuis, 2007).

Dyadic Developmental Psychotherapy (DDP)

Dyadic Developmental Psychotherapy (DDP) is a clinical approach that works collaboratively with parents/caregivers and the child as they learn intersubjective dialogue as the central activity of treatment. In this model, the child's innermost thoughts and feelings are explored and positive attributes, successes and behaviors/misbehaviors are discussed. Parents are taught the PACE acronym, standing for Playful, Accepting, Curious and Empathetic, as a way to relate and talk to their child. While keeping "PACE" in mind, the parent is invited to explore the child's negative behaviors (Aideuis, 2007).

Child Centered Therapy (CCT)

Child Centered Therapy (CCT) is a child/parent centered clinical approach focused on establishing a trusting therapeutic relationship that is self-affirming, empowering and validating for the parent and child. This treatment model allows for the parent and/or child to choose when, how and whether to address aspects of the child's traumatic experience rather than the therapist dictating this. Therapists provide

psychoeducation, active listening and encourage the development of positive coping strategies (Cohen, Deblinger, Mannarino & Steer, 2004).

Cognitive Behavioral Therapy (CBT) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

CBT is based on the idea that one's thoughts have a direct impact on one's feelings and behaviors. CBT ascertains that people can change the way they think and, in turn, improve how they feel/act, even if a situation does not change (Pucci, 2010). Gullotta, Adams and Ramos (2005) state that Cognitive Behavioral Therapy (CBT) is the most frequently researched modality for PTSD and is "recommended as the treatment of choice when used alone or in combination with other approaches" (p. 338). CBT alone has many of the components cited above that are recognized as best treatment practices for trauma sequelae, including cognitive processing, affective and emotional regulation strategies and behavior modulation. Munoz-Solomando, Kendall and Whittington (2008) established similar findings by conducting a study that systematically reviewed databases as well as the National Institute for Health's (NICE) clinical guidelines for the use of CBT to treat children and adolescents with mental health problems. The review found that the best evidence for CBT in the treatment of children was with generalized anxiety disorder, depression, obsessive-compulsive disorder and PTSD, as well as more limited evidence for the efficacy in treating ADHD and behavioral problems.

TF-CBT is a type of cognitive behavioral therapy that focuses specifically on treating children who have experienced trauma. It has been designed to address the myriad of reactions children display after experiencing a traumatic event or series of events. The TF-CBT model is broken down into steps with the acronym PRACTICE.

PRACTICE stands for Psychoeducation and parenting skills, Relaxation, Affect modulation, Cognitive coping and processing, Trauma narrative, In vivo mastery of trauma reminders, Conjoint parent-child session and Enhancing future safety and development (Cohen, Mannarino & Deblinger, 2006). Empirical research has been focused on investigating the ability for this model to treat PTSD and complex PTSD in children.

Empirical Evidence to Support TF-CBT

Research on the TF-CBT model has found that the TF-CBT model demonstrates favorable outcomes with regards to reducing symptoms and sequelae of trauma and that it is efficacious in doing so when applied to treat a variety of trauma presentations in children. Specifically, research shows that some children show marked improvement in PTSD, depression, anxiety, cognitive perceptions, affect regulation, shame and overall functioning when treated with TF-CBT.

These findings are supported in a study conducted by Cohen et al. (2004) that examines the differential efficacy of TF-CBT and CCT for treating PTSD and related emotional and behavioral problems in children who had suffered from sexual abuse and related sequelae, such as emotional and behavioral problems, depression, anxiety, and PTSD as well as disordered psychobiological functioning. The Cohen et al. (2004) study aimed to identify treatment interventions that effectively treat PTSD and other symptoms of sexual abuse. This study found that children assigned to the TF-CBT group demonstrated significantly more improvement with regard to PTSD, depression, shame and total behavior problems, as compared with the CCT group. This study not only replicated previous findings but also demonstrated the enhanced benefits of TF-CBT with

respect to children's cognitive and affective responses as well as parental functioning. Additionally, other authors have established similar findings. A follow-up study done by Deblinger, Mannarino, Cohen and Steer (2006) found that children who had been treated with TF-CBT had significantly fewer symptoms of PTSD and described less shame than as compared with follow-up at the same intervals with the CCT group.

Further research that supports the effectiveness of the TF-CBT model to reduce symptom manifestation is shown in a study done by Resick et al. (2003) that investigated the effectiveness of brief cognitive-behavioral treatments that have been shown to effectively treat PTSD and the wider range of symptoms of complex PTSD. In this study participants with extensive histories of trauma were randomly assigned to cognitive-processing therapy, prolonged exposure therapy or delayed-treatment waitlist. Since the TF-CBT model incorporates both cognitive processing therapy and gradual exposure components in its clinical approach, it is important to note the efficacy of these aspects in the treatment of trauma. The study found that the all participants improved significantly as a result of treatment on the 3 factors and all 10 subscales of the Trauma Symptom Inventory (TSI). The TSI is a 100 item self-report measure developed to assess both short term and long-term sequelae of traumatic experiences. Factor analyses have distinguished the scale has 3 factors; the Dysphoria Factor, consisting of depression, anger-irritability and anxious arousal; the Trauma Factor, consisting of intrusive experiences, defensive avoidance, dissociation and impaired self-reference and the Self Factor, consisting of sexual concerns, dysfunctional sexual behavior and tension reduction behavior. These results indicate that both types of CBT; CPT and prolonged exposure, are effective for

treating the symptom picture associated with complex trauma in the form of child sexual abuse.

Additional support for the TF-CBT model as an appropriate and beneficial clinical approach is shown in a study done by Cohen, Mannarino, Perel and Staron (2007). Cohen et al. (2007) examined the potential benefits of adding a selective serotonin reuptake inhibitor, sertraline, versus placebo to TF-CBT to evaluate the effectiveness of improving PTSD and related psychological symptoms in children who had experienced sexual abuse. Researchers administered 11 different scales, including scales that assessed for the presence of childhood psychotic disorders, child's global impairment, a PTSD symptom scale, a mood and feelings questionnaire, a screening for anxiety related emotional disorders, an abuse-related attributions and perceptions related to self-blame, loss of trust and feeling different from peers scale and parents completed a child behavior checklist, an depression inventory scale, parent's emotional reaction questionnaire, parental support questionnaire as well as a form to report side effects from the medication. The study found that there was no significant difference between the two treatment groups with regard to clinically meaningful improvement on any instrument. Although this study's small sample size does not allow it to be generalizable, it demonstrates the effectiveness of TF-CBT without the use of medication for a small number of children. This finding supports the notion of National Institute for Health and Clinical Excellence (NICE), which recommends that, "pharmacological approaches should not be the first-line approach" to clinical impairments for such a young age group (as cited in Munoz-Solomando et al., 2008 p. 332). Additionally, one-third of the potential participants in this study refused to participate due to the potential that their

child would receive the SSRI medication, demonstrating that the addition of the potential of receiving psychotropic medication limited the generalizability of the findings. An important clinical implication from this study is that the evidence-based TF-CBT model is warranted before adding psychotropic medication when treating trauma in children.

In addition to the research supporting the TF-CBT model as an effective treatment modality to reduce symptom manifestation after exposure to trauma, research indicates that the TF-CBT model is efficacious in treating a variety of trauma presentations, including single-event traumas, multiple traumas and complex trauma presentations. Given the wide range of affects of PTSD and related symptoms in a child's development and neurobiological functioning, it is important to identify interventions, such as TF-CBT that are effective and efficient in treating complex trauma reactions in order to minimize detrimental outcomes.

A 2007 study done by Smith et al. demonstrated the efficacy of individual trauma-focused CBT for treating PTSD in children and adolescents. This study included only participants who met full criteria for a PTSD diagnosis after a single event trauma; motor vehicle accident, witnessing violence or interpersonal violence. Participants were then randomly allocated to a 10-week course of individual trauma-focused CBT (CBT group) course or to placement on a wait list (WL group). The study found that at posttreatment, the CBT group scored significantly lower on the measures of PTSD symptomatology than the waitlist group. In fact all twelve of the CBT group participants no longer met the full criteria for PTSD at posttreatment and follow-up. The study also found that the CBT group scored significantly lower on depression and anxiety scales than the WL group as

well as demonstrating a significant improvement in functioning as compared to the WL group. This study concluded that TF-CBT is an effective treatment for PTSD in children.

This study, however, had a particular limitation of note; it permitted children and adolescents with comorbid diagnoses to participate. Approximately 1/3 of the participants in this study reported previous exposure to trauma. While this study excluded participants who currently had an ongoing trauma-related threat in the environment, due to the broad inclusion criteria that permitted other diagnoses and past trauma exposure, the researchers cannot be certain that all participants' post-traumatic reactions were a result of a single traumatic event.

Furthermore, the research done by Cohen et al. (2004) did not specifically identify cases that met the criteria for complex trauma; however the study did not limit its participants to having to meet all of the DSM-IV criteria for PTSD. Additionally, although the index trauma for this study was sexual abuse, 90% of this cohort had experienced multiple traumas. Similarly, a study done by Deblinger, Mannarino, Cohen and Steer (2006) included children who met only 5 of the DSM-IV criteria for PTSD, with at least one symptom each of reexperiencing, avoidance or numbing and hyperarousal. It is therefore likely that some of these children may have had reactions more in line with the symptom picture of complex trauma, although it was not identified as such. These studies suggest that the positive treatment response to TF-CBT among multiply as well as single-event traumatized children may indicate that these treatment interventions may be effective for children traumatized by different types of events. Additionally, these findings support that two components of the TF-CBT model, gradual

exposure and cognitive processes were effective in ameliorating symptoms of complex trauma established by Resick et al. (2003).

These studies provide empirical support for TF-CBT as an effective treatment model for PTSD and related psychological symptoms in children as well as empirical support for CBT using cognitive processing and exposure therapy in treating some complex PTSD presentations. These studies, however, do not specifically address the efficacy of the TF-CBT model in treating complex trauma in children as it is currently defined in the field. Furthermore, these studies use a quantitative approach to measure the effectiveness of the TF-CBT model, which is based largely on responses to scales and measures, which do not provide the opportunity for detailed, narrative responses that could elaborate and enhance the knowledge on the efficacy of TF-CBT.

Trauma Focused-Cognitive Behavioral Therapy: A Closer Look

TF-CBT is an empirically supported treatment model designed to assist children and their parents to deal with the aftermath of traumatic experiences (Cohen et al., 2006). Cohen et al. (2006) describe in more detail the components of TF-CBT summarized by the acronym PRACTICE. While TF-CBT by intent is flexible in nature, emphasizing the importance of the therapeutic relationship to allow for warmth, empathy, insightfulness and creativity, this is done so within the components-based treatment model.

Psychoeducation

Psychoeducation begins at the onset of treatment and is continuous throughout. The initial step in psychoeducation is to provide the child and parent with generalized information about the traumatic event, which may include statistics on prevalence and cause of the trauma. In this way psychoeducation is used to dispel myths about trauma

and its consequences and to provide general information about the type of trauma.

Psychoeducation can also be used to relay common emotional and behavioral responses, and in this way normalizes and validates the client's emotional and behavioral and reactions. Further, psychoeducation provides information about common symptoms and diagnoses related to trauma. The psychoeducation portion also provides descriptions of available treatments and the strong empirical support TF-CBT has gained in its ability to reduce symptomatology. Finally, psychoeducation can be used to provide strategies to children and parents to help them manage current symptoms. This will hopefully allow some immediate, short-term symptom relief, convey to the child/parent that their concerns are being heard and to cultivate confidence in the therapist and TF-CBT model.

Relaxation

Relaxation techniques are taught to help reduce physiological manifestations of traumatic stress reactions such as increased adrenergic tone, increased startle response, hyper vigilance, agitation, difficulty sleeping, restlessness, irritability and anger/rage. Psychoeducation may be included in this step to explain the differences between typical responses to stress and traumatic stress reactions (Cohen et al., 2006). The aim of the relaxation techniques is to reverse any physiologic changes and help the child gain mastery over their subjectively stressful experiences. A number of different relaxation methods are presented, practiced and tailored so that each individual child forms a “toolkit” of relaxation exercises that they can select from. Building up a number of relaxation techniques allows for the child gain a sense of control when s/he is able to choose which technique to use (Cohen & Mannarino, 2008). Examples of relaxation techniques include deep breathing, progressive muscle relaxation, yoga, mindfulness

exercises, listening to music, sports or other enjoyable leisure activities, as well as listening to relaxation tapes. It is important to find and fine tune these relaxation skills so that they may be used through the course of treatment to help the child get through the trauma narrative and in vivo exposure components of the TF-CBT model and to be used in real life situations when trauma reminders are present (Cohen et al., 2006; Cohen & Mannarino, 2008). Detailed scripts for relaxation exercises can be found in Cohen et al. (2006).

Affect Expression and Modulation

As a result of significant trauma, some children may have a predominance of painful, difficult feelings as well as dysregulation of affect. Children may feel that they will become overwhelmed by these feelings and depending on their developmental level, may or may not have the language to express and manage these feelings effectively. Affect modulation skills help the child to express and manage feelings more effectively without becoming overwhelmed by them and also diminish the use of avoidant strategies. This is done through the use of games and tools that require the child to practice feeling identification, reinforce the idea that a person can feel more than one feeling in a given situation, support the notion that a person can feel seemingly opposite feelings at once and to normalize and validate the child's feelings. Feeling identification can progress gradually to discussing feelings directly related with the trauma experience. Other affective modulation strategies include thought stopping, positive imagery, positive self-talk and social skill building. Additionally, work in the areas of building the child's sense of safety to rebuild a real or perceived loss of safety as well as enhancing problem solving skills will augment the child's coping abilities and improve affect regulation

(Cohen et al., 2006; Cohen & Mannarino, 2008). Detailed descriptions of these techniques can be found in Cohen et al. (2006).

Cognitive Coping Skills

Cognitive coping refers to a variety of interventions intended to help the parent and child explore their thoughts, and to recognize connections and distinctions among thoughts, feelings and behaviors. Children and parents are encouraged to recognize and share internal dialogues, first unrelated to the trauma experience, and then later cognitions that are upsetting and/or relate to the trauma experience. Children and parents are encouraged to explore how a single thought can generate additional thoughts and feelings, and children and parents are encouraged to challenge and correct cognitions that are either inaccurate or unhelpful. Emphasis is placed on developing alternative, more accurate and helpful thoughts for situations. This allows for the parent or child to more accurately develop their belief system. It is also a way of demonstrating to the child/parent they are able to exert control over their own thoughts, and consequently over feelings and behaviors by thinking differently. In this way these cognitive coping skills can act as self-soothing ways to regulate cognition, affect and emotion (Cohen et al., 2006; Cohen & Mannarino, 2008). Detailed descriptions of these coping skills can be found in Cohen et al. (2006).

Trauma Narrative and Cognitive Processing of Traumatic Experiences

The creation of the trauma narrative is also known as the gradual exposure component. The aim of this component is to, “un-pair thoughts, reminders, or discussion of the traumatic event from overwhelming negative emotions such as terror, horror, extreme helplessness, shame or rage” (Cohen et al., 2006 p. 119). During this component

and over the course of several sessions the child is encouraged to describe in detail what occurred before, during and after the traumatic event(s) as well as his/her feelings during these times. The therapist should introduce to the parent and child the theoretical basis and support for creating the trauma narrative, and express the purpose behind it is to overcome avoidance of traumatic memories, identify cognitive distortions and contextualize the traumatic experience into the larger framework of the child's whole life. The trauma narrative is usually written or typed but may be expressed through other creative means such as art, dance, song or poetry, however the TF-CBT model encourages a concrete way of representing the narrative so that it can be reviewed from one session to the next. Once the trauma narrative has been created, cognitive processing utilizes techniques learned in cognitive coping to correct any cognitive distortions that may be contributing to negative affective states such as self-blame, shame, feeling damaged and low self-esteem as related to the trauma. In cases where there is more than one type of trauma or complex trauma has characterized the child's life, the child should guide the therapist as to which experiences to include in the narrative and in what order (Cohen et al., 2006; Cohen & Mannarino, 2008).

In Vivo Mastery of Trauma Reminders

In vivo mastery is used to help children who have developed generalized avoidant behaviors from innocuous trauma reminder cues to overcome these fears. When the feared trauma cues are innocuous reminders of experiences that are in the past and do not serve the purpose of maintaining safety in the present, they may cause an interference with health adaption. For example a child whose abuse took place in a bathroom may avoid all bathrooms, including the school bathroom, which could potentially lead to

school avoidance, which would interfere with the child's development. The goal of this component is to help the child gradually get used to the feared situation until the child can endure the situation without undue anxiety or fear. *In vivo* mastery plans are unique and individualized, based on the child's fears/anxieties. The most important outcome of the *in vivo* mastery is that the child regains a sense of his/her own competence and mastery (Cohen et al., 2006; Cohen & Mannarino, 2008). For examples of a detailed plan please refer to Cohen et al. (2006).

Conjoint Child-Parent Sessions

Parents receive individual parallel sessions that address each of the PRACTICE components as well as interventions to optimize parenting skills following their child's exposure to trauma. Even the most competent parents may experience difficulty parenting effectively after a traumatic event(s), which creates additional barriers to the healing process. Parents are taught the power of praise, selective attention techniques, time-out procedures and behavior reinforcement programs.

The TF-CBT model also includes conjoint sessions during which the parent and child meet with the therapist to review educational information, review the trauma narrative and engage in more open communication. Joint sessions may initially focus on psychoeducation, practicing skills, safety planning and general discussions about the trauma before reviewing the trauma narrative. Before the trauma narrative is read parents should be able to emotionally tolerate the trauma narrative and be able to provide supportive verbalizations (Cohen et al., 2006; Cohen & Mannarino, 2008).

Enhancing Future Safety and Development

Realistic safety concerns can best be addressed through education and training in safety skills. Enhancing future safety and development teaches children personal safety skills as well as practical safety skills. The timing of the teaching of these skills is important and should be done once the child has completed most of the trauma work. Many children who experience trauma do not react with optimal responses that stop the abuse or violence. If children are taught safety skills too early, they may feel guilty for not having utilized the skills previously. In fact, it is important to first acknowledge and praise responses to earlier traumatic event(s). In the case of complex trauma experiences, research has shown that parental involvement enhances a child's ability to retain and utilize personal safety skills. Important concepts to include in personal safety skills training are communicating feelings openly, paying attention to "gut" feelings, identifying people and places that provide safety, learning body ownership and "ok" versus "not ok" touches, learning the difference between secrets and surprises and the ability to keep asking for help until someone provides it (Cohen et al., 2006; Cohen & Mannarino, 2008).

Further Evidence of Efficacy of the TF-CBT Model

As the studies reviewed above indicate, TF-CBT has been tested in several randomized controlled trials (RTC), which have supported the efficacy of TF-CBT for sexually abused and multiply traumatized children, as well as children who have experienced single event traumas. TF-CBT has been shown to improve PTSD, complex trauma symptoms as well as depression, anxiety and emotional and behavioral difficulties in children. An RTC is underway for children with domestic-violence related PTSD

symptoms and children have received TF-CBT approaches after the terrorist attacks in New York City and after Hurricane Katrina. Additionally, many states are currently attempting to collect further data on the TF-CBT clinical approach. TF-CBT is also being used internationally after natural disasters and terrorist attacks, however no known data was collected (Cohen & Mannarino, 2008).

Current Perspectives on the TF-CBT Model

The present study will be qualitative in design in order to allow for therapists perspectives on the TF-CBT model to be gathered in a more open-ended and in depth fashion. This method of obtaining information was chosen to provide a less restrictive manner for therapists to express their sentiments on the effectiveness of TF-CBT. A study done by Jensen-Doss, Cusack and Arellano (2008) measured therapists perceptions of the effectiveness of TF-CBT by using a self-report measure for which the therapists rated the percentage of traumatized youths they believed are successfully treated with various types of modalities. While therapists rated cognitive behavioral approaches as significantly more effective for treating traumatized youth than all other modalities, this study did not explore more in-depth what aspects of the cognitive behavior therapy were most useful to therapists when treating traumatized youth, or how they employed these techniques.

The Jensen-Doss et al. (2008) study also assessed therapists' attitudes about their training in TF-CBT using a quantitative measure, and found that 60.9% of the therapists had a more positive attitude regarding TF-CBT post-training, but 37.5% of therapists reported no change in their attitude and 1.5% reported a negative shift in attitude about TF-CBT post-training. This study demonstrates the TF-CBT model as one regarded by

therapists to be an effective clinical approach for treating traumatized youth. This study, however, does not go into detail about what aspects of the model are most helpful, nor does it elaborate on the challenges or outcomes of TF-CBT.

Research has demonstrated that there is an array of symptom manifestations for children who have experienced complex trauma that is markedly more comprehensive than described in the DSM-IV diagnosis of PTSD. Research has also indicated that the TF-CBT model is a credible and efficacious approach to treat trauma, PTSD and related symptoms in children. The present study aims to further our understanding of the usefulness of the TF-CBT model to treat complex trauma presentations in children.

CHAPTER III

METHODOLOGY

The purpose of this study was to examine the research question: What are therapists' perspectives on the effectiveness of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) in treating children with a history of complex trauma experiences? This study used a qualitative design in order to allow for therapists' perspectives to be gathered in a more open-ended and in-depth fashion. This study employed an interview guide approach measurement to structure the interview process to ensure that the same material was covered in all interviews, while also allowing for unanticipated responses to emerge. This qualitative design permitted flexibility to hear from a sample of experts trained in the TF-CBT clinical approach and expanded our understanding of the clinical use of the model, with a special focus on its use and effectiveness with complex trauma presentations. This chapter presents the methods of research used in this study and will describe the sample selection, data collection, and data analysis procedures.

Sample

Twelve female therapists participated in this study. All participants had a degree of at least a master's level in social work, psychology or applied art theology. All participants were trained in the TF-CBT model through their agency of employment so that they satisfied the agency's requirements to practice the model in a clinical setting. All participants worked with children using this model in outpatient clinic settings in cities in the Northeast.

This study used nonprobability sampling procedures, including purposive, availability and snowball sampling techniques in order to identify and recruit participants who met inclusion criteria. These sampling procedures were used due to the small sample size and due to the fact that the study required the researcher to select therapists with specific expertise in the TF-CBT model in order to address the research questions. Due to practicality and convenience, participants were recruited from agencies in the Northeast.

Data Collection

Data collection was gathered via an interview guide approach method. Interviews were conducted on agency grounds or over the phone. Procedures to protect the rights and privacy of participants were outlined in a proposal of this study and presented to the Human Subject Review Board (HSRB) at Smith College School for Social Work before data collection began. Approval of the proposal (see Appendix A) indicated that the study was in concordance with the NASW *Code of Ethics* and the Federal regulations for the Protection of Human Research Subjects. Approval from each individual agency to conduct interviews onsite was also submitted to the HSRB at Smith College School for Social Work.

Prior to each interview participants were given an informed consent document describing their participation in the study, their rights as human subjects, as well as the potential risks or benefits of participation (see Appendix B) and were permitted to ask questions regarding the research study before the interview began. The researcher kept a signed copy of the informed consent document and encouraged participants to do the same. The researcher will keep these documents in a secured location separate from the data for three years after the conclusion of the study as mandated by Federal Regulations.

In order to assure participant confidentiality, demographic information, transcripts, and audiotapes are kept separate from informed consent documents and are identified by codes rather than names or other identifiable information. Any names or other identifiable information from participants or clients that were recorded during the interviews was removed or disguised for use in the final thesis project. Participants were first asked to read and sign the informed consent before the interview began. In the event that an interview was conducted via phone, the informed consent was emailed or faxed to the participant prior to the interview and signed and returned to the researcher prior to the onset of the interview. During the interview, participants were asked twelve interview questions intended to elicit the participants' knowledge and perspectives regarding the TF-CBT model to treat children who have experienced trauma, with a specific focus on children who have experienced complex trauma situations (see Appendix C for interview guide). Each interview was audio taped and transcribed by this researcher. The entire interview process ranged from 25 to 45 minutes in length. All interviews took place between February 26th and April 7th 2010.

Data Analysis

This researcher manually transcribed data collected from the interviews. Content of the data was then analyzed using the qualitative method of grounded theory analysis. The transcriptions were read in order to organize and identify common themes that appeared in participant responses. Content from the transcripts was first compartmentalized by question and then delineated into discrete categories based on occurrence of similar words, phrases and themes based on the responses of the study participants. The ultimate aim of the data analysis was to create a theoretical

understanding of the effectiveness of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) in treating children with a history of complex trauma experiences, based on the collective, aggregate perspectives of the experts in the study sample. The data analysis method led to this theoretical understanding.

CHAPTER IV

FINDINGS

The purpose of this study was to investigate therapists' perspectives on the evidenced based practice model; Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), with a special focus on the use of this model with children who have experienced complex trauma situations. This chapter will present the data from interviews with twelve clinicians who have been trained in, and currently practice, the TF-CBT model with children. Each interview contained thirteen questions organized around the following major themes: training in the TF-CBT model; use of the model with children, including those who have experienced complex trauma; perspectives on valuable aspects of TF-CBT, perspectives on challenging aspects of TF-CBT; comparison of TF-CBT to other treatment models and outcomes from the use of the TF-CBT model. The twelve interviews were transcribed and concepts from all of the responses were coded into themes using grounded theory analysis. Topics coded in to themes came directly from themes present in the interview questions as well as themes that emerged in the process of coding. Demographic data such as agency location and degree type were also obtained.

Findings are organized as follows: presentation of the demographic data collected; training received in the TF-CBT model; types of trauma presentations and the use of the TF-CBT model; types of diagnosis and the use of the TF-CBT model; perspectives on what is valuable about the TF-CBT model; perspectives about what is challenging about the TF-CBT model; comparison of the TF-CBT model to other approaches and outcomes

as a result of using the TF-CBT model. Additionally, this chapter presents other themes relevant to the research questions that emerged during the interviews.

Demographic Data

The sample size for this study is twelve participants. All participants are female. Participants practice the TF-CBT clinical approach in two different agencies, both located in cities in the northeast. Four participants are Licensed Clinical Social Workers (LCSW), three participants are Licensed Doctor's of Psychology (PsyD), one participant has a degree as a Doctor of Psychology (PsyD), three participants have their degree as Master's of Social Work (MSW) and one participant has a Master of Arts in Applied Theology (MAAT).

Training in the TF-CBT Clinical Approach

Participants identified similar training tactics that were used to educate and prepare therapists to learn and employ the TF-CBT model in clinical practice. The two major training tactics were delivered through an online, web-based instruction course and through a learning collaborative approach.

Online/Web-based Training

The majority of participants reported completing a ten-hour web based training on the TF-CBT model through the Medical University of South Carolina (MUSC) in partnership with the National Child Traumatic Stress Network (NCTSN) called "TF-CBT*Web*, a learning course for Trauma-Focused Cognitive-Behavioral Therapy." The TF-CBT*Web* manual includes specific, step-by-step instructions for each component of the TF-CBT model; psychoeducation, stress management, affect expression and modulation, cognitive coping, creating the trauma narrative, cognitive processing,

behavior management training and parent-child sessions. This online training manual also includes printable scripts for introducing techniques to clients, and streaming video demonstrations of the therapy procedures (MUSC, 2005). Therapists have ongoing access to the TF-CBT *Web* workshop and can proceed at their own pace through the instruction course, as well as return to modules as needed.

Some participants also mentioned the web resources available on the NCTSN website as being critical in their training:

I think the most helpful part [of training] is the experiential part with the trauma narrative. Through my access to the website, I have really been able to value the presentations by Ester Deblinger that are posted. They are about processing the narrative, and those have been very valuable to me.

Learning Collaborative

The majority of participants also reported taking part in at least a portion of, if not the full, year-long, learning collaborative designed to train therapists to use the TF-CBT model in clinical practice scenarios. The NCTSN (2010) describes the objectives of the learning collaborative as follows:

The NCTSN Learning Collaborative (LC) approach focuses on spreading, adopting, and adapting best practices across multiple settings, and on creating changes in organizations that promote the delivery of effective interventions and services. The ultimate goal of the Learning Collaboratives is to provide high-quality training in best practices of trauma-focused treatments in diverse settings—including Network sites and their local communities—and to ensure the sustained use of those practices.

Specifically, the TF-CBT learning collaborative through the NCTSN (2010) is:

a components-based psychosocial treatment model that incorporates elements of cognitive-behavioral, attachment, humanistic, empowerment, and family therapy models. Children and parents are provided knowledge and skills related to processing the trauma; managing distressing thoughts, feelings, and behaviors; and enhancing safety, parenting skills, and family communication.

Participants reported partaking in a year-long learning collaborative. The collaborative included approximately three in-person training sessions over the course of nine to twelve months facilitated by a trained professional in the model, follow-up consultation activities through phone and internet interactions with trained supervisors as well as ongoing opportunities to practice new skills and share progress through group/peer supervision at each individual agency site. Participants noted the value in having this type of ongoing, comprehensive approach:

This is a newer type of model and people are investing a lot of time in it, and using the collaborative to implement it, but the fact that we have the weekly meetings with a core group of people who are doing it is also extremely beneficial...in keeping faithful to the model and really fine tuning the skills. I know that the model does not specifically call for that type of collaborative group, but that is what we are employing here, and that has really been key. If we were doing it without that, I don't think we would have people using it as much or using it as well.

How Training in TF-CBT Has Affected Practice with Traumatized Children

All therapists stated that prior to their training in the TF-CBT model they had worked in clinical treatment settings with traumatized children. Therapists were asked to describe how their work with traumatized children has changed as a result of their training in the TF-CBT model. Therapists commonly reported that their approach to treatment of trauma is more structured and transparent and their personal style is more directive after completing training in the TF-CBT model. Additionally, therapists frequently commented on how they are better able to manage vicarious traumatization. Therapists stated that they have an increased confidence in working with traumatized children because they have seen more effective outcomes when using the TF-CBT model. A majority of therapists also remarked on being more involved with parents and using

more psychoeducation in their practice with traumatized children. Less commonly reported, but important to note is that therapists also mentioned their training in the TF-CBT model has informed and amended how they conduct supervision of trauma work.

Types of Trauma Presentations and the TF-CBT Clinical Approach

Participants were asked if they had used the model to treat children who had experienced complex trauma. This researcher provided the same definition of complex trauma to each participant. One main finding that emerged was that therapists did not seem to have a uniform grasp on the concept of complex trauma or the way that symptoms may manifest as a result of this experience separate from their understanding of how single event or multiple trauma manifest and affect children. The majority of participants had, however, heard of complex trauma, and were able to identify several clients who met the definition. All participants stated that they have worked in a clinical setting with children who have experienced complex trauma, as well as with children who had experienced single event traumas and multiple traumas. All participants have used the TF-CBT model, or a portion of the TF-CBT model, with children who have a history of experiencing one or more types of complex trauma.

Therapists reported the types of complex trauma presentations they have used the TF-CBT model to treat. Among the most common complex trauma situations are sexual abuse, physical abuse, witnessing domestic violence and disruption in attachment with primary caregiver due to unfit caregiver(s) and/or multiple foster placements. Other complex trauma situations that therapists used the TF-CBT model include neglect, verbal/emotional abuse, community violence and traumatic grief and loss.

Therapists were asked to comment on if and how they use the TF-CBT model differently depending on the type of trauma situation. In general therapists stated that they did not use the model differently with different types of trauma presentations; with the exception of the psychoeducation phase. Therapists reported that the psychoeducation phase typically covered general physiological, psychological, emotional and social reactions to trauma, as well as provided specific information directly related to the type of trauma experience. However, therapists did find that because the model can be used with creativity and flexibility, they tended to tailor the model to each client's unique needs, and based on age, developmental level, personality and special interests of the child.

Complex Trauma and the TF-CBT Model

When asked to comment on their perspectives of the TF-CBT model to treat complex trauma, therapists commonly identified these cases as taking longer to complete, having greater difficulty getting through all of the components of the model, less frequently reaching the trauma narrative component and generally seeing clients display more avoidance:

I think [when there is complex trauma] all of [the TF-CBT model] takes longer. The way the model is set up, and maybe that is a caveat when people are learning the model and trying to figure out how to apply it, they have very nice session 1,2,3 as recommendations, but unless you are in a real upper socioeconomic status...where this is the only issue that came up for the family, can you be very clear with the model...I've never used the model where it is a perfect neat package. But I can see that could be in a different setting, I could imagine it working very nicely.

The kids that I am using it with who have experienced sexual abuse are extremely avoidant. It has been really challenging getting them through and actually using the model, using the breathing exercises and relaxation strategies.

Although therapists observed the TF-CBT model as taking a longer time to complete, experienced more difficulty having the child master each individual component and observed more avoidance, the same therapists also reported that the components of the TF-CBT model were helpful in dealing with the broad symptom picture presented by clients with complex trauma. Therapists commonly reported that the model provided a comprehensive framework to address the various symptom presentations, the model is equipped to help the therapist address and deal with the various crises and avoidance that often emerges, and that the trauma narrative and cognitive restructuring components were essential to the therapy work:

I found that it has been effective, as far as it gives a little bit more of a direction. Especially with complex trauma, because it can be overwhelming [to tackle] and it gives it more of a direction. You can get really lost and caught up in it and it puts some direction to it and you can put your hands around it some more. You can contain it a little bit more, and with complex trauma it is all over the place so I find that it does help to contain it. It does get complicated as far as what trauma to go with, and do you go with multiple, do you go with one, which one is the leading one, you kind of have to go with you instincts and what you see. But I think compared to regular therapy, I think it is a little bit more effective at containing.

I think the main thing we take from the model is that we are not going to avoid. He/she may never get to the narrative, but I will bring that material in, provide them with the gradual exposure.

Therapists were asked specifically how they addressed the trauma narrative with children who have experienced complex trauma and they reported that they would go with what the client identified as affecting them the most, do more than one narrative or help the child to structure the narrative(s) by asking them to work on the first, last and worst traumatic experience:

[The trauma narrative] took a lot of preparation for her. She likes to write, so that is a strength of hers. Her narrative is five pages, single-typed; it is long. We talked

about what do we include, what do we not include. For her, letting her know exactly what to expect, how to structure it, was helpful. We first set up a structure and outline. We then talked about how she identified the sexual abuse as the main thing so we focused on that and then describing the first, last and worst time as a way not to overwhelm her with it.

I address multiple. I will give you an example. I am just starting, 3-4 sessions in. A client who had prolonged exposure to sexual abuse by her biological father. There was domestic violence, and she has been in multiple foster placements as well. The referral was based on sexual abuse and so I asked her, "Tell me about the last time you saw your mother" and the story she told me was so horrific. I said to her "If you had to tell me what was the worst experience in your life, the sexual abuse from your father or the parting scene with your mother?" and she looked at me and said "my mother." Most people would say "What?! It has to be sexual abuse."... So we will probably do the piece with her mother, the sexual abuse, and the experiences being put in to multiple foster placements. So there will be 2-3 narratives.

Diagnoses and the TF-CBT Clinical Approach

Participants were asked to relay the types of diagnoses of the children they have used the TF-CBT model to treat. All participants reported that they have used the TF-CBT model with children who have a diagnosis of Post-traumatic Stress Disorder (PTSD). Other common diagnoses in children that therapists have used, or currently use the TF-CBT model with include; anxiety disorders, major depression, adjustment disorders, attention deficit hyperactivity disorder (ADHD) and reactive attachment disorder (RAD). Less common diagnoses that therapist reported using the TF-CBT model with were learning disorders, oppositional defiant disorder (ODD), conduct disorder (CD) and a history of a psychotic disorder, not otherwise specified.

While therapist's reported that the most common diagnosis given to children with single event, multiple traumas and complex trauma was PTSD, therapists often found co-occurring mood or behavioral disorders. Additionally, therapists observed that not all

children who had histories of complex trauma and were treated using the TF-CBT clinical approach met the all of the criteria for PTSD.

Therapists were asked to comment on if and how they use the TF-CBT model differently depending on the diagnosis/diagnoses of the client. Again the most frequent response was that the therapists did not use the model differently, however used flexibility and creativity within the model to tailor the therapy to each individual client's unique needs.

Valuable Aspects of the TF-CBT Clinical Approach

The majority of therapists emphasized the perspective that the TF-CBT model was an effective, beneficial and useful tool to treat traumatized children. Themes the participants identified as valuable aspects of the TF-CBT model were, the structure of the model and ownership of the treatment, the TF-CBT model's effective components and the TF-CBT model's direct approach while also allowing for flexibility and creativity.

Structure and the Ownership of Treatment

All participants in this study reported that the structure of the TF-CBT model was one of the most valuable and effective aspects in their treatment of traumatized children. Therapists commented on the usefulness of having a "roadmap," concrete steps, direction and/or guide to refer to in the treatment of trauma:

I know that you hear in the beginning stages of becoming a therapist...people are kind of like "oh my god," I wasn't trained in this and I wasn't trained in that, you question yourself a lot in your beginning years and so it is nice to have an actual manual to look at, say, "okay this, this, this and this," and then to actually see the kids change...it helps you see that it actually works.

I really do like it, I keep saying because it is focused, you have a main focus; you have an actual way things are supposed to be done. And a lot of the times in therapy you kind of go in and address what's occurring at that moment, because

client's come in with high anxiety, there's this, there's that, you go in with something you want to do, but you never do. So having something where you explain, this is what we are going to do next time, and you stay focused on that I think is what really helpful in this model.

In addition to providing a roadmap for the clinician, therapist's commented on the usefulness of having this guide for the child. Therapist's found that with the TF-CBT model, clients were better able to anticipate and plan ahead for what was coming in treatment. Therapists noted that this structure built a sense of ownership of the treatment, eased anxiety about the therapy and fostered motivation in many clients to continue to do the work:

I find that because the model is structured, it really helps to put kids' minds at ease, they know what to expect and what is coming next. They can anticipate that, and I think that has been really helpful.

The structure is about building competence.

Providing a roadmap for the work and for the client, it creates accountability in a way. It gives a context to check and see, why we are doing this, what it is about.

It helps them kind of see there, what the focus of treatment is and what the model looks like and it really has steps where they start...they learn about trauma, go up to handling stress then identifying and expressing their feelings which would be affective expression and then doing some CBT work around changing thoughts and creating trauma narrative and working through, doing in vivo and then completion. Being able to see where they're at, I've had some kids really be invested in this and say, "OK where am I at?" "Where do we go next?" "Am I at the top?" pretty much having that visual guideline to show them were almost at the end our this is our next step helps to ease the anxiety I believe.

I think clients like it a lot because its like you can show them the [steps of the TF-CBT model in a] little picture and they know what they have to do and they can connect it... [my client] she'll color in the step as she does each one and it's an accomplishment for her and she can see where she has to go, so it makes therapy more like a goal for her to reach, which is helpful, because it kind of motivates on to doing what she needs to do... and she feels proud of it and she can look back at the steps and talk about what she's learned and she gets really excited when she can color in the next one, so it builds some confidence, some ownership of the treatment.

I think it provides a nice structure for people, and for the clients to be able to anticipate, alright, this is why we are doing this, they have an understanding, it is pretty transparent, I think it is valuable for people, especially when you are dealing with issues with trauma because there is so much anxiety that gets stirred up around ok, what are you going to be doing, why are you asking me this, that there is no mystery about why we are doing what we are doing.

Less frequently reported but significant to note are the therapists' perspectives on how the structured use of instruments is employed to measure outcomes and symptom reduction. While not all agencies using the TF-CBT model use the same instruments to measure outcomes and symptom reduction, therapists reported that the TF-CBT model does indicate the use of instruments as tracking devices. Therapists report that the measurements allow for clinician and client to track improvements and progress made, provide opportunity to be reflective and transparent about the therapy and serve to keep the therapists and clients on track and focused.

Effective Components

Therapists commonly reported the value in each component of the TF-CBT model. Therapists commend the model for including components that are applicable outside of the therapy room that target the symptoms and manifestations of the trauma experiences. Therapists commented on the usefulness of each of the components.

A majority of the therapists interview identified psychoeducation as being an extremely effective and valuable part of the model. Therapists observed that through psychoeducation children and caregivers can increase their understanding of the type of trauma and become better informed of prevalence, as well as common symptoms and

symptom manifestation and physiological responses to trauma. Additionally, it normalizes the experience and helps for the child to feel less alienated, less alone:

I think that it is normalizing for the children and one of my clients said to me, “wow, I’m not so alone.” I think that was therapeutic for her to go through and realize how many children had gone through sexual abuse that was valuable.

Participants also commonly reported that the inclusion of a caregiver was a most valuable aspect of the model. Therapists report that the inclusion of the caregivers in the therapy has allowed for increased support outside of the therapy office, helped to increase and improve communication between children and caregivers around the topic of trauma, in general, provided caregivers with effective ways to cope with the trauma and deal with the symptom manifestation in their child, and provided adequate support for both child and caregiver to continue the trauma work:

The parental support gives the parents concrete steps and things to use at home with the child to remain consistent with what they are using in therapy... having the child know that the parent is aware of what is going on with the child and that the parent is there to support them at home, not just in the therapy session.

I think the work and expectations of the caregivers has been helpful. It provides them with information on how to cope and deal with their child, and also many of them have their own trauma histories, so it can be helpful for them as well.

Providing the roadmap and structure for the parents as well as they are processing the trauma [is valuable]. Having them involved and intense parent involvement is most valuable. Otherwise a child comes to therapy and we might tell the parent yeah, they are talking about the trauma but it is confidential, but in this model it is transparent whatever we discuss. They know that the parents will be involved, which is awesome because they are going to be the ones who are there for them after all this is done, the therapy is done... having the parents feel empowered and also desensitized from the trauma.

I think that the heavy inclusion of the parents in the process has been really helpful and provides support for the child outside of therapy.

And I think for the parents as well its not this ok I’m throwing my child in this room with this person and they come out and the child says “I played UNO for 40

minutes.” So there is a lot of instruction and information disseminated to the parents on how what we are doing is therapeutic, which isn’t to say we shouldn’t be doing this with other kinds of things, but I think because of the way this is structured it really lends itself towards educating people and keeping them informed.

Participants also highlighted gradual exposure to the trauma and the trauma narrative as integral to the therapy process of the TF-CBT model. The gradual exposure especially prepares the client, caregiver and therapist to be able to tolerate the construction of the trauma narrative. This aspect of the model is also helpful to prevent vicarious traumatization:

There are multiple ways of getting at trauma and the trauma narrative and I think narrative therapy is really awesome.

Obviously, I think the narrative is the most helpful because that is what you are striving for, them telling their story and restructuring it.

The trauma narrative as well, with art therapy is phenomenal. They can get into different types and different ways of expressing themselves, what they have gone through.

I think for clinicians doing this type of work it is also really beneficial in terms of thinking about vicarious trauma, the gradual exposure piece is pretty key so that they are getting accustomed to tolerating the material the client is sharing in a gradual way, preparing themselves for the trauma narrative. And then as well for the client, the parent/caregiver, the gradual exposure piece is pretty essential. I think that is one of the biggest components of this, especially around sexual abuse.

I think that the gradual exposure piece is a key thing. Its not that I didn’t use it before, but it is much more of a conscious effort this time and I think that that kind of effort is needed and really gets at looking at some of the countertransference that clinicians have with dealing with these subjects that are tricky to get into with clients and not wanting to push people and how much of that is about us? How much of that is about wanting to respect the client and their boundaries and what they can tolerate?

In addition to the TF-CBT model providing a structured guide and applicable and effective components, the model is designed to provide a direct approach to treating trauma. Therapists reported favorably on this aspect of the model, stating it has allowed them to delve into trauma issues, deal with avoidance, and to develop a language to talk about sensitive topics with both children and caregivers.

Being Directive, Giving a Language and Tackling Avoidance

All therapists interviewed about the TF-CBT model commented on its direct approach. In general, therapists' perspectives on this aspect of the model was that although it was not necessarily innate to their personal style when working with traumatized children, this tactic has been extremely effective to help reduce symptom manifestation, has kept clients and parents engaged by being transparent with what the TF-CBT therapy entails, has allowed for a language to talk about the trauma and has encouraged the therapist to confront and integrate avoidance into the use of the TF-CBT model:

What I really love in particular is that it is a very direct model. It is no nonsense, you get right down to it...everybody would walk on eggshells as far as dealing with trauma. And now, I think nothing of going right in to it and I know that the kids can tolerate it. I really like that aspect of the model; you get right in to the work.

You know, we aren't conditioned to talk about sex openly and then you throw in a trauma around a sexual experience, so it is that much more difficult to talk about, so it really forces clinicians to kind of get over some of their own stuff when talking about this with the client, so it kinds of helps to facilitate that.

I think the true TF-CBT model...doesn't say that everything is a COW (crisis of the week), but some of the things that a parent or child might bring to the session and want to focus on might be diversions from where you're trying to go, so I think the general approach is to try and incorporate the solution to that problem or the response within the skills of TF-CBT, maybe the learned something before or you are about to teach them something that will apply to that problem, and you try to fit it in.

We are not omniscient so we can't tell exactly, but what is helpful about looking at the COW, and where the training was helpful is trying to bring that crisis back to the component you have addressed. If you look at psychoeducation, affective expression, cognitive coping, generally any sort of crisis you will be able to connect back to and say, you can use this to be able to cope with that... I think that as long you are able to effectively tie that back to what is going on and say this is a reason why we need to get to the trauma narrative, that there are ways of incorporating the COW into the work in a meaningful way and try not to let it take over the whole session and avoid the trauma work.

The TF-CBT Clinical Approach is Creative and Flexible

While therapists interviewed for this study found the structure and directiveness of the model to be highly valuable, many therapists remarked on the ability to be creative and flexible in the therapeutic delivery of the components, while still staying faithful to the model. Therapists remarked that this was especially helpful in order to tailor the TF-CBT model to each client's unique needs. Therapists reported a range of trauma presentations and a range of diagnoses of the children they work with. Additionally, these children vary in their developmental stage, cognitive ability and personality. Therapists reported that they are able to present components in creative ways in order to best meet the needs of individual clients. Therapists remarked on their ability to use different forms of instruction when teaching psychoeducation, relaxation and affect modulation and incorporating art and/or play therapy techniques as well as using various mediums to construct the trauma narrative(s):

I think that there are benefits for people to have guided treatment as opposed to manualized treatment. There is a prescribed set of components you are meant to cover, but it not so manualized that you can't then veer off a little bit, or in certain types of interventions and tailor it to your clients unique needs.

Challenges of the TF-CBT Clinical Approach

Therapists were asked to comment on the challenges and obstacles they have encountered while implementing and using the TF-CBT model. Themes the participants identified as challenging were an unrealistic time frame to complete the model, using the model with younger children or children with developmental delays, as well as the resources, materials and costs associated with the execution of the training and practice of the TF-CBT model.

Difficulty Completing the TF-CBT Model in the Given Time Frame

The majority of therapists interviewed noted that it was unrealistic to complete a case from start to finish in the time frame of the TF-CBT model. Therapists noted several reasons that necessitated a longer time frame to complete the model. The two most frequent reasons therapists noted were having to deal with and incorporate avoidance and/or crises that clients brought up during sessions and complicated family situations. Therapists often indicated the caregiver's own trauma history as a main barrier to keeping up with the pace of treatment as noted in the TF-CBT model. Another major obstacle to completing the model in the designated time frame is related to the demanding time commitment the model requires. Therapists noted it was difficult to get and keep parents engaged with the model and that missing sessions was a main disruption in treatment:

I don't know if it is about the model or the nature of the clients, but getting the parents on board. That is a challenge, I don't think it is the model, I think it is just the nature of clients.

One of the things I find difficult is to have the dedication that is needed for coming in twice a week or whatever, so that has been tailored to the parents needs.

The part that I find to be challenging is caregivers availability, either emotionally or physically, so recognizing, in assessment when it is physically not available, is

it their own trauma that is being triggered? So being mindful of the assessment when you are talking about the guardian. And that the caregiver has to get the child to the session ongoing, or it loses fidelity to the model. So that can be an interruption.

When you are working in it you may understand that the model needs to keep going and forge ahead and unfortunately families are dealing with so much chaos that it does interfere. But I have found that many clients are more engaged through the model because it does feel like we are doing something, but it doesn't stop those crises... But there are still the crises that pop up and also I find with the caretakers, because the caretakers themselves often come from their own trauma histories and so they are sometimes triggered and then it is that much easier to find an excuse not to bring the child, more so with the caretaker than the child.

Another challenge that therapists noted as hindering their initial ability to stick with the pacing of the model was being direct. Many therapists noted that when first beginning to use the model, they found it challenging to adopt such a directive style with clients.

Developmental Ability and the TF-CBT Model

One common theme that emerged from therapists' responses to the question about the TF-CBT model's challenges was that it required certain developmental and cognitive abilities from the child. Therapists noted that the cognitive elements of the model are difficult with many children who, because of their developmental level, may not fully grasp this section.

The cognitive coping is challenging, so I don't know that she uses it as much. I think that she has some concept, so if I coach her through it she can use it but I don't think outside of sessions she uses it at all, so I think for her it is less helpful, but I don't think that it was a waste to do it with her.

Cognitive restructuring is pretty challenging, depending on the kid. Keeping them engaged and finding creative ways to do it so that they get it and not feel bored. They have to be verbally based. Whereas the other components you can be more creative with. So I think that is one of the toughest for the kids to get and understand.

Therapists also note that because of varying developmental levels and working with some children who are nonverbal or less verbal, the structure of the model can be challenging. Therapists mention that being able to incorporate some more nondirective techniques, such as play therapy and art therapy, was most helpful in these cases.

Resources, Materials and Cost

Less commonly reported, but still important to note is that training therapists in the TF-CBT model requires resources and materials. Attending trainings and maintaining ongoing supervision necessitates that therapists, supervisors and individual agencies devote time and allocate finances to the implementation and continuation of the TF-CBT model.

TF-CBT Compared to Other Treatment Approaches

Participants compared the TF-CBT model most commonly to general talk therapy, play therapy, art therapy and relational therapy. Therapists also commented on the TF-CBT model as compared to other CBT approaches and solution-focused therapy. One of the most frequent comparison reported was that the TF-CBT model provided an effective way to provide information to the client, explain why the treatment approaches used were important, and overall provided a more transparent therapy process;

I think it all comes down to structure and information. What is nice about the model is being able to explain to clients this is why I am asking you to rip this Band-Aid off, not that there isn't a degree of that that I did. But being able to couch that as 'this is a model' not just my good judgment and training, this model is going to make you feel better, and that the research has shown that it will make you feel better and this is why we do all this stuff. I think that description helps the client to feel a little bit safer.

The majority of therapists also found the TF-CBT model provided an effective structure, was more directive in its approach and helped therapists and clients to stay more focused. Therapists also reported that the model challenged avoidance while giving therapists and clients a way and a language to talk about the trauma:

And more often than not, we end up holding back with that stuff a little bit more, so it really, *really* forces you to be more conscious of what is going on for you when the model calls for you to plow through stuff, whereas when it is a little bit less directive, you aren't forcing yourself or your client to go there, direct them to go there, of course you're never going to make them do something like that, but when you know that is the purpose of the activity, when you bump up against that resistance, you really can see how much of that is me and how much is where the client is at and what do I have to do to help them to do that work.

It is definitely more structured, with some flexibility in it, but definitely very structured as compared to other treatment approaches where you might let the client take the lead on what you do that day. It is very directive, it is meant to be that way. You have something to accomplish each session and you try not to get swayed in any other direction. There is a goal in mind. I think that is the biggest difference I have noticed with this model as compared with more traditional talk therapy.

I think with relational therapy it is more about meeting the client where they are at and allows for avoidance to really play into everything whereas TF-CBT really challenges them and challenges the avoidance, which has been helpful with the clients I have used it with.

Other common responses were that the TF-CBT model allows therapist the flexibility to integrate other treatment approaches, and that the model allows for the therapist and client to go more in-depth into the trauma work, engage more effectively with the client and focus on the relationship:

I have used more CBT, and I've been trained in solution focused brief therapy, and that is pretty good in engaging the client in to the narrative stage, but it didn't have the structure. CBT and solution focused didn't go in depth like the TF-CBT model does.

[With TF-CBT there is] a lot of flexibility and a lot of creativity without compromising the fidelity of the model. [Compared with other treatment models] I think [TF-CBT] is all integrated.

I think with the TF-CBT I'm more actively engaged because I know where to go and how to see it through and it increases my anxiety so I think I reach out more than I normally do with the clients I am doing TF-CBT with, especially when they are later in the model, when they are in the middle of doing the trauma narrative. I'd say the clients probably stay engaged a little bit better.

We didn't call it a model in those days. The approach was more just meet the client where they are at and build the relationship and try and be supportive...Much less directive. It was about relationship, and I think that is still the case. The kids would come in and they new they had to talk about it, but we didn't have a way to talk about it, we didn't have a way to approach what avoidance was.

Observed Outcomes From the Use of the TF-CBT Clinical Approach

Therapists were asked to comment on the outcomes they have observed as a result of therapy sessions conducted using the TF-CBT clinical approach. The majority of therapists reported that they observed a decrease in avoidance of dealing with the trauma and related stimuli, improved communication between caregiver and child, as well as an increase in parental involvement.

Another frequent observation was that the child and caregiver developed a better understanding of trauma and related sequelae and symptoms manifestations, the traumatic experience felt more normalized and there was an increased sense of self-esteem among the children after therapy with the TF-CBT model.

Additionally, a common observation was that there was a reduction in symptom manifestation in the children. Therapists noted a decrease in anxiety, arousal and acting out behaviors, decreases in intrusive thoughts, flashbacks, nightmares, enuresis and decreases in anger and impulsivity. Therapists also noted children had improved focus

and concentration, enhanced affect regulation skills and performed better academically, socially and emotionally in school. Therapists also observed both children and caregivers improve their coping skills and develop a “tool box” of ways to manage symptom manifestation:

Outcomes-wise, I’ve noticed a reduction in anxiety, a reduction in depression, a better understanding between in communication between the parent and the child, which is huge because they are here, then they go home and they spend the majority of their time either at home or at school, so working with parties involved, whether it be the parents or the school, whoever their main support is, parental understanding has increased and their ability to cope with future hurdles, they are given like a tool box of sorts, to be able to manage those.

Less commonly reported, but important to note was that some therapists observed symptoms still present or exacerbated during the therapy process. Therapists reported the presence of physiological arousal and anxiety, as well as an increase in or maintenance of acting out behaviors.

Here are examples of the themes that emerged as therapists were discussing commonly observed outcomes as a result of employing the TF-CBT model:

I was talking already about the child’s perception of progress and growth and accomplishment, which I think is a good outcome throughout the process. I certainly notice that formalized psychoeducation piece is making a big difference, like the client right now who is working on her trauma narrative included a section about learning about trauma, and wanted to talk about how “I learned about trauma and it helped me” and other people should learn about trauma because it makes you feel better, so really helping normalize that and helping the child and the parent what that means and what that does to people, I think that was a huge thing for this kid, and I didn’t realize it until she got to the narrative and started writing about it.

I mean certainly for this client, the level of arousal and anxiety around the experience is getting better, the avoidance is a lot better, she is not doing as much of it, certainly not as reactive around, certainly made a difference in some of the symptoms.

I would say anecdotally, that clinicians report a high degree of satisfaction. That clients overall when they are finishing their narrative that they have a great sense of pride and accomplishment, there has been a greater degree of communication between parent and child and greater understanding around the trauma and things that will be helpful to the client, that people are effectively using the coping skills and reporting a high degree of satisfaction of it.

It varies. Even the clients I worked with on a short-term basis, whether they dropped out or decided with me to end their treatment, I think it was clear to both me and the client that there had been gains.

I think another thing is that we are looking at the outcomes as an agency. We are asking the questions, we are doing the measures. That is not necessarily the model, but from the learning collaborative, that gets built in. It provides us with feedback and we are able to share that with the clients and I think that furthers the work as well.

I see that the avoidance goes down. We talked about the “alarm system” the arousal goes down. For different kids it is different. For some kids when they begin the narrative, those symptoms go up, there are kids who are initially pretty numb emotionally, they are not symptomatic and they are functioning pretty well, so when they are able to acknowledge and articulate their feelings, that is a big piece... And language, for the kids and the parents to talk about trauma. Emotional literacy increases. And even if they are not using the coping skills, they understand the concept of them.

Definitely the best moment I’ve had so far with a client, was her being able to say, “wow, I’m not alone, there are other children out there who have been through what I have been through. I am normal, I’m not weird or crazy for having these reactions.” That was one of the best.

This part is really interesting, at least a couple clients can identify what their triggers are, the awareness and ability to acknowledge those triggers is amazing. Not having the avoidance system, not feeling like they have to keep secrets. Not having the avoidance there, they are calmer when it is talked about, not having that fear that the parents will react if they were to bring it up, that reactive piece isn’t there.

Decrease in nightmares, enuresis, decrease in acting out behaviors, impulsivity and anger, sleep better, improved relationship with parent, improvement in school, focus and concentration improve. Some increase in self-esteem, in their knowledge and understanding it was not their fault, that their identity is not based on their trauma, that doesn’t define them. And to understand that this was an episode in their life, a piece, not their life. And to have their parental support, acceptance and non-blame. That has been really helpful.

Therapists' Additional Comments on the TF-CBT Clinical Approach

During the interview process, additional themes emerged with respect to therapists' perspectives on the TF-CBT model and improvements they would hope to see in the future. Therapists noted that the model does incorporate and account for cultural differences when training therapists on the implementation of the model, however therapists noted that there could be more research done in that looks specifically at trauma in Latino and Black families as well as the traumatic impact of community violence.

Another common perspective was that the model seems geared towards a child who is verbal and on track developmentally. Therapists would like more training in the use of the model with the non-verbal or developmentally delayed child who has experienced trauma.

Therapists also commented on the numerous caregivers who have their own trauma histories or who may be vicariously traumatized during the process of exposure to their child's trauma. While therapists' general perspectives of the model was that the caregiver inclusion was an essential aspect, therapists felt that even more support or individual therapy could be beneficial for caregivers of traumatized children going through the TF-CBT model.

Additionally, therapists commented on the importance of the collaborative approach to training clinicians in this model. Not all therapists trained in the TF-CBT model have access to a collaborative and therapists experience and perspectives note that this may cause a therapist to not fully engage in the TF-CBT model or abandon the model as an approach to treating trauma altogether.

The findings above are reflective of the aggregated responses of the participants interviewed for this study. The next chapter will discuss the relevance of these findings to the literature previously reviewed as well as their relevance to clinical social work practice.

CHAPTER V

DISCUSSION/CONCLUSION

This study sought to obtain therapists' perspectives of the TF-CBT clinical approach with the hopes of elaborating and enhancing the knowledge in the field on the efficacy of TF-CBT to treat complex trauma in children. Main findings of this study are summarized in the following categories: outcomes produced and observed as a result of implementing the TF-CBT model in clinical practice; the ways in which the TF-CBT model has been effective in incorporating components that address and treat the seven domains of development affected by complex trauma experiences; areas in which TF-CBT could be more effective in treating complex trauma; the interface between the developmental stage of latency and the TF-CBT model; and finally, clinical implications and suggestions for future research. This chapter will relate key findings of this study to prior studies and theoretical frameworks presented in the literature review.

Outcomes of the TF-CBT Model

Participants in this study reported outcomes similar to the findings presented in prior research on the efficacy of the TF-CBT model. Findings in the present study supported results by Cohen et al. (2004), Deblinger, Mannarino, Cohen and Steer (2006) and Resick et al. (2003) that the TF-CBT model is effective in decreasing overall symptoms of PTSD and anxiety as well as improving overall functioning:

Outcomes-wise, I've noticed a reduction in anxiety, a reduction in depression, a better understanding between in communication between the parent and the child, which is huge because they are here, then they go home and they spend the majority of their time either at home or at school, so working with parties involved, whether it be the parents or the school, whoever their main support is,

parental understanding has increased and their ability to cope with future hurdles, they are given like a tool box of sorts, to be able to manage those.

Specifically, this study found that the TF-CBT model reduced symptom manifestation of arousal, intrusive thoughts, flashbacks, nightmares, enuresis, anger and impulsivity. Therapists also noted children had improved focus and concentration, enhanced affect regulation skills and performed better academically, socially and emotionally in school. One participant summarized salient findings when she stated:

[I've seen a] decrease in nightmares, enuresis, decrease in acting out behaviors, impulsivity and anger, sleep gets better, improved relationship with parent, improvement in school, focus and concentration improve. Some increase in self-esteem, in their knowledge and understanding it was not their fault, that their identity is not based on their trauma, that doesn't define them. And to understand that this was an episode in their life, a piece; not their whole life. And to have the parental support, acceptance and non-blame; that has been really helpful.

The current study also supported findings from the study done by Resick et al. (2003) that the TF-CBT model, which includes and expands upon cognitive-processing and prolonged exposure therapy, as effective in treating the wider range of symptoms of complex PTSD. This present study adds an important dimension for clinical implication by asking participants to comment on the TF-CBT model's effectiveness in producing these same outcomes found in prior research, however, more specifically for children who have experienced complex trauma. This is an important demarcation that had not expressly been delineated in the studies reviewed in chapter two. Therapists frequently remarked that the TF-CBT clinical approach effectively ameliorated symptom manifestations of complex trauma reactions in children. Additionally, therapists commented on the ability of TF-CBT clinical approach to structure and contain complex

trauma presentations to allow for the trauma work to be done as laid out in the model, while also incorporating the crises from daily life that clients brought in to the therapy room. The majority of therapists found this element to be especially important, as the various components and structure of the model not only addressed and improved a wide variety of symptom manifestations, more significantly, the model provided children and caregivers with coping skills to implement in their daily lives, outside of the therapy room. Below are excerpts from participants that highlight these perspectives and provide support for the TF-CBT model as an efficacious treatment approach for complex trauma in children:

I found that [TF-CBT] has been effective [in complex trauma cases], as far as giving it a little bit more of a direction. Especially with complex trauma, because it can be overwhelming to tackle and it gives it more of a direction. You can get really lost and caught up in it and it puts some direction to it and you can put your hands around it some more... You can contain it a little bit more, and with complex trauma it is all over the place so I find that it does help to contain it. It does get complicated as far as what trauma to go with, and do you go with multiple, do you go with one, which one is the leading one, you kind of have to go with you instincts and what you see. But I think compared to regular therapy, I think it is more effective at containing.

I mean were not omniscient so we can't tell exactly, but what is helpful about looking at the crises of the week (COW), and where the training was helpful is trying to bring that crisis back to the component you have addressed. If you look at psychoeducation, affective expression, psychoeducation, cognitive coping, generally any sort of crisis you will be able to connect back to and say, you can use this to be able to cope with that... I think that as long you are able to effectively tie that back to what is going on and say this is a reason why we need to get to the trauma narrative, that there are ways of incorporating the COW into the work in a meaningful way and try not to let it take over the whole session and avoid the [trauma work].

And to talk about complex trauma, people are using the model and getting through it in 16 or 20 weeks, and I don't have that experience. I'm more meeting where the client is at, building the relationship and really working that... [The components are valuable], psychoeducation, components that deal with emotional regulation and physical arousal. Really having them understand what the

physiological impact is. The cognitive triangle is a brilliant thing. And I think the work and expectations of the caregivers has been helpful...I see that the avoidance goes down. We talked about the “alarm system” the arousal goes down...For different kids it is different. For some kids when they begin the narrative, those symptoms go up, there are kids who are initially pretty numb emotionally, they are not symptomatic and they are functioning pretty well, so when they are able to acknowledge and articulate their feelings, that is a big piece...And language, for the kids and the parents to talk about trauma. Emotional literacy increases. And even if they are not using the coping skills, they understand the concepts of them.

I’ve actually been talking with people in supervision about use of elements of TF-CBT in other types of treatment because, what I’ve really found is that the work in tandem with the parents and the scripting and structuring of all that has been really beneficial. I was talking with another therapist today that I think a lot of the stuff that we do in TF-CBT would actually work with this child with a lot of reactive attachment issues. This child is presenting with a lot of borderline traits, she is very reactive to anything anybody says and her mom is needing a lot of coaching on how to cope with her and how to work with her and so we have talked about using some of the structure of TF-CBT.

[What I find valuable about the TF-CBT model working with complex trauma cases], definitely psychoeducation, that has been huge, relaxation is key for a lot of the kids who are hyprestimulated and really all over the place and relaxation helps. Affective expression, I really found it valuable, depending on the client. Most of them are pretty good about identifying their feelings, but not at the second part modulating and regulating the feelings, so that part is more helpful. The cognitive coping and restructuring, I’ve found it helpful but I struggle with that a little bit more with the kids, depending on their age. Obviously, I think the narrative is the most helpful because that is what you are striving for, them telling their story and restructuring it.

TF-CBT and the Seven Domains Affected by Complex Trauma

Participants of the present study were presented with a common definition of complex trauma, namely: “trauma that is repetitive or prolonged, involves harm or abandonment by caregivers or other ostensibly responsible adults, and occurs at developmentally vulnerable times in the victim’s life, such as early childhood or adolescence” (Ford, 2009, p. 13).

Upon hearing this definition, all participants in this study reported using the TF-CBT clinical approach to treat children who have experienced complex trauma. The majority of therapists in the present study stated that they found the model to produce beneficial outcomes, such as a reduction in symptom manifestation of PTSD, depression and anxiety in children who had experienced trauma, which is in accord with findings in the above-mentioned studies.

Therapists in this study also supported the findings of the theoretical framework presented by Aideuis (2007) and Cook et al. (2007). Therapists in the current study reported the types of symptom presentations and diagnoses they observed in clients; PTSD, anxiety and depressive disorders, adjustment disorders, conduct disorders, attachment disorders and learning disorders. The symptom manifestations in these diagnoses mirror the domains presented by Aideuis (2007) and Cook et al. (2007) that address the complexity of symptoms and behaviors that make up complex trauma disorders and that adequately describe the effects of ongoing and repetitive trauma in the development in children. These domains, described in detail in the literature review above, are; attachment, biology, affect regulation, dissociation, behavioral control, cognition and self-concept. These findings offer support to complex trauma and its sequelae as unique from PTSD alone and suggest that the TF-CBT model can be effective to treat both symptoms presentations.

Additionally, therapists frequently observed that the components of the TF-CBT model, psychoeducation and parenting skills, relaxation, affect modulation, cognitive coping and processing, trauma narrative, in vivo mastery of trauma reminders, conjoint parent-child session and enhancing future safety and development, were able to address

and treat the array of symptom manifestations, which fell under the categories presented by Aideuis (2007) and Cook et al. (2007) observed in children who had experienced complex trauma. Furthermore, therapists commonly reported that the components of the TF-CBT model were effective and applicable for both the child and caregiver(s) in daily life, and produced an observable reduction of symptoms in children across a variety of diagnoses and types of complex trauma. Simply and directly put by one participant:

I think each of the components is very applicable, I mean it works for clients.

Areas For Improvement in the TF-CBT Model When Dealing with Complex Trauma

Despite consensus from the participants in this study that the TF-CBT model was effective with children who had experienced complex trauma, an important finding in this research study is that participants did not have a common working definition of complex trauma and for the most part, had not been specifically trained in its effects on children or trained in how to distinctly apply the model to such cases. Therapists had also not been trained explicitly to treat cases of complex trauma differently than single event trauma or multiple traumas. Therapists commonly reported that cases involving complex trauma took markedly longer to complete than suggested by the TF-CBT model and that there were greater challenges when writing the trauma narrative, such as navigating the process of writing the narrative without overwhelming the child, and/or writing longer or multiple narratives, which again required an expanded time frame. An area for future research and development would be how to better incorporate therapist training on the use of the TF-CBT model with children who have experienced complex trauma situations, as well as ways to alter or enhance the TF-CBT model to better address and serve the needs and presentations of children with complex trauma. As Ford (2009) notes, is especially

important to consider the developmental stage and capacities of the child during the period which the trauma took place, and the potential detrimental affects or delays the child may be experiencing. Due to this it is especially important to enhance knowledge in the field on the interface between developmental stage, complex trauma and clinical implications.

Developmental Level and the TF-CBT Model

Therapists reported on valuable aspects of the TF-CBT model that aided the treatment process in reducing symptom manifestation and improving overall functioning. Therapists commonly stated that each component of the TF-CBT model was purposive and necessary to obtain desired results. Findings from the current study highlight the importance of enhancing training and knowledge of the interrelatedness of the development of the latency-aged child, complex trauma and the clinical implementation of the TF-CBT.

Physical Development

TF-CBT recognizes that as a child develops physically, new levels of cognitive functioning arise, the brain grows and eliminates nerve pathways and language capacities, thinking processes, consciousness, working memory, planning and inhibitory control develop. The TF-CBT model attempts to build upon these skills by helping the child to restructure cognitive processes, master affective and emotional regulation and self soothing and construct adaptive nerve pathways to reduce symptom manifestation.

Attachment

The TF-CBT model attempts to work on making or remaking secure attachments between child and caregiver through the inclusion of the caregiver in the therapy process,

by providing extensive and transparent information on trauma and the treatment approach and through teaching affect regulation and self-soothing techniques. Participants in the current study reiterate support for the theoretical implications of developing secure attachment by acknowledging the importance of the caregiver involvement as essential for producing successful and sustainable outcomes working with traumatized children.

One participant notes:

Providing the roadmap and structure for the parents as well as they are processing the trauma [is valuable]. Having them involved and intense parent involvement is most valuable. Otherwise a child comes to therapy and we might tell the parent yeah, they are talking about the trauma but it is confidential, but in this model it is transparent whatever we discuss. They know that the parents will be involved, which is awesome because they are going to be the ones who are there for them after all this is done, the therapy is done.

Additional successes as a result of developing a more secure attachment may be seen by improved overall functioning, decreased impulsivity and improved relationships with peers.

Social Development

A majority of the participants noted that the TF-CBT model design encourages a sense of ownership and mastery of the therapy. Additionally, therapists commonly reported observing an increase in self-esteem among children treated with this model. These results are especially important when considering the social development that occurs during at this age. As this feeling of mastery and competence improves, the child is more likely to adequately attain the developmental tasks of this stage; they may experience an increase in sense of self-esteem, are better able to follow rules and adhere to peer group norms as well as tolerate emotional ambivalence. Therapists commonly

reported children's improvement in school, which may coincide with progress in social development.

Language, Communication and Cognitive Development

Literature on language, communication and cognitive development emphasizes the importance of these developmental tasks of middle childhood so that children are capable of expressing thoughts and emotions and of relaying a coherent narrative that has a beginning, middle and end. As the prefrontal cortex matures the child is better able to plan ahead, move between details and the big picture, think about problems and understand multiple perspectives. The child's increased capacity for language now allows for the sharing and relaying of memories. The current study supports the importance of the development of these tasks to facilitate efficacious outcomes with the TF-CBT model. Participants in this study especially emphasized the significance of the development of the trauma narrative as a corrective and beneficial process that helped the child to heal; and the creation of the trauma narrative requires the child to possess or cultivate during therapy the maturing developmental capacities mentioned. One participant noted:

Obviously, I think the narrative is the most helpful because that is what you are striving for, them telling their story and restructuring it.

One of the most frequent challenges mentioned by participants in this study, however, was that the TF-CBT model required a certain level of development in the child and that therapists felt less equipped to implement the model with nonverbal, preverbal or developmentally delayed children. One therapist noted:

The cognitive coping is challenging, so I don't know that she uses it as much. I think that she has some concept, so if I coach her through it she can use it but I

don't think outside of sessions she uses it at all, so I think for her it is less helpful, but I don't think that it was a waste to do it with her.

Therapists commonly reported they would like further training on ways to implement the model with traumatized children who have developmental and cognitive delays. Several participants remarked they would like to cultivate a knowledge base of how to better incorporate play into the TF-CBT model. This observation is important to highlight because literature on play and development suggests that play allows the child to practice emotional control, maintain a focus on planning and goals, socialize with peers within the norms, follow rules, and be able to sustain concentration, all skills that can be disrupted by trauma.

Self-Regulation and Sense of Self

Again, participants in the current study supported research on the development of good self-regulation as essential to the developmental tasks of school age children. In middle childhood self-regulation and coping skills include the use of mental strategies, such as self-talk to inhibit expression of feelings. The capacity to think and talk about stressful experiences reduces anxiety in general. Typical anxieties of this age group include being rejected, excluded, or evaluated negatively by peers. Children begin to feel shame and pride on cognitive, emotional and social levels (Cincotta, 2002), therefore, pride and shame often influence the school-aged child's behavior. Therapists in this study reported that the TF-CBT model had effective strategies to teach self-regulation and affect modulation skills:

Affective expression, I really found it valuable... Most [clients] are pretty good about identifying their feelings, but not at the second part; modulating and regulating the feelings, so that part is helpful.

Psychoeducation, components that deal with emotional regulation and physical arousal [are very valuable].

Additionally, therapists noted an improvement in sense of self, increasing pride as children progressed through therapy as well as a decrease in self-blame and shameful feelings and impulsivity. Generally participants noticed an overall improvement in behavior, both at school and at home:

Decrease in acting out behaviors, impulsivity and anger... improvement in school, focus and concentration improve. Some increase in self-esteem, in their knowledge and understanding it was not their fault, that their identity is not based on their trauma, that doesn't define them.

Conclusions

This qualitative study involved interviewing twelve experts on the TF-CBT model who work with children in outpatient clinical settings. The qualitative interview-guide approach allowed for this researcher to gain in-depth perspectives that expanded and enhanced her knowledge of the TF-CBT model, and the training, use, values, challenges and efficacy of this clinical approach, with a special focus on how the model interfaces with complex trauma presentations. The information gathered in the present study makes an important contribution to the clinical social work field, as it offers support to the TF-CBT model as an effective treatment option for treating trauma in children, and expands this notion to include the TF-CBT clinical approach as beneficial to treat complex trauma. Additionally, the present study supports current research in the field that defines complex trauma as a separate symptom picture from PTSD, and provides further

confirmation for the importance to integrate the impact of trauma on a child's developmental stage when considering treatment options.

Clinical Implications and Suggestions for Future Research

This study aimed to address the efficacy of the TF-CBT model for complex trauma. This study supported the notion that complex trauma, defined as trauma that is ongoing and repetitive, first occurs at an early age and is interpersonal in nature, can have significant effects on psychological functioning including problems in the areas of attachment, biology, affect regulation, dissociation, behavioral control, cognition and self-concept and that the resulting symptomatology is likely to interfere with developmental tasks. Additionally, the present study found that the TF-CBT model, which is an empirically supported clinical approach to treat trauma in children is effective in treating children who have experienced complex trauma. This study found that the TF-CBT model has comprehensive and efficacious components that target and effectively treat the seven domains of complex trauma and produced beneficial outcomes such as; decrease in avoidance of dealing with the trauma and related stimuli, improved communication between caregiver and child, increased parental involvement, better understanding of trauma, related sequelae and symptoms manifestations, increased normalization and self-esteem, reduction in symptom manifestation in the children: decrease in anxiety, arousal and acting out behaviors, decreases in intrusive thoughts, flashbacks, nightmares, enuresis and decreases in anger and impulsivity, improved focus and concentration, enhanced affect regulation skills and that overall, children performed better academically, socially and emotionally.

One main limitation of this study was the a small sample size, which limits generalizability; however the research in this study suggests that the TF-CBT model is an effective approach to treating complex trauma in children and indicates further research in this area. Future research should look to expand upon the findings in the present study to evaluate the effectiveness of the TF-CBT model in treating complex trauma in a wider range of cases. Future research may wish to expand to include a larger number of participants who practice the TF-CBT model with complex trauma cases. Future research may consider using retrospective measures that analyze outcomes, or other quantitative approaches in order to expand sample size while still protecting this client population. Future research may also consider an analysis of the training and implementation of the TF-CBT model in clinical practice in order to optimize its use and efficacy.

In ending, I would like to thank the study participant experts for their time, participation, and contribution to expanding the understanding of the complexities of the TF-CBT clinical approach.

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APPENDIX A

HUMAN SUBJECTS REVIEW BOARD APPROVAL LETTER

January 8, 2010

Shamora Michelson

Dear Shamora,

Your revised materials have been reviewed. You did an excellent job in their amendment. Your Consent is very well done, briefer and to the point and your recruitment script is very helpful in explaining exactly how you will handle this most important part of the process. We are happy to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project. If you end up doing interviews at the agencies, you will need to get and send us a copy of a letter of permission from the agency.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Elaine Kersten, Research Advisor

APPENDIX B
CONSENT FORM

Dear Potential Participant,

Thank you for your interest in this study. My name is Shamora Michelson and I am a master's level graduate student at Smith College in Northampton, Massachusetts. I am conducting a study that involves research. The purpose of this study is to examine therapists' perspectives on the effectiveness of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) in treating children with a history of complex trauma experiences. This research will be used for the MSW thesis requirement at Smith College School for Social Work and will be submitted for presentation and publication.

Participation in this research study will involve being interviewed at a place of mutual agreement. If you choose to participate you will be asked questions about your training, perceptions and experience related to TF-CBT. The interview in its entirety should take approximately 45 minutes to complete. Data will be gathered using audio and/or video tape recording. I will transcribe the data.

Your risk of participating in this study is small but does include divulging personal, professional opinion about this clinical approach. All identifying information will be kept confidential. By participating in this study you would be providing information that could elaborate and enhance the knowledge in the field on the efficacy of TF-CBT to treat complex trauma in children. There will be no tangible benefits to participants in this study.

Confidentiality of your identifiable information will be safeguarded through the use of codes in place of names on materials. The informed consent form, which includes your name, will be kept in a separate location from other materials. My research advisor will have access to the data once identifying information has been removed, but your name will not be shared with anyone. Confidentiality will be kept when reporting the data from the study. Data will be presented once it has been coded and grouped. Data will be stored in a locked cabinet in a locked office. Electronic data will be password protected. Per federal regulations, data will be kept secure for a period of 3 years, after which point all data and material will be destroyed. In the event that the data will need to be kept beyond this point, it will be destroyed once it is no longer needed.

Your participation in this research study is voluntary and you may refuse to answer any question. You may withdraw from the study should you wish to do so up to March 30, 2010. Should you choose to withdraw from the study before this date, all copies of the materials related to you used in this study will be destroyed. If during the course of the study you need to contact me for any reason, including questions or a desire

to withdraw from the study, you may do so by calling (xxx) xxx-xxx Monday-Thursday. The voice mail on this line is confidential. You may also contact me by email at any point at _____. Should you have any concerns about your rights or about any aspect of the study, you are encouraged to contact me, or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY. YOU ARE ENCOURAGED TO KEEP A COPY OF THIS FORM FOR YOUR OWN PERSONAL RECORDS.

Participant
Signature _____ Date

Researcher
Signature _____ Date

Please keep a copy for your records. Thank you for your participation in this research study!

APPENDIX C

INTERVIEW GUIDE

Interview Questions

1. What training have you received in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)?
2. How have you used TF-CBT in practice with children with complex trauma?
 - a. What types of trauma experiences have you clients reported?
 - b. What are the diagnoses of the clients you have used this clinical approach with?
 - c. Has your use of the clinical approach differed based on the client's trauma experience? On their diagnosis?
 - d. How has your use of the TF-CBT clinical approach affected your practice working with traumatized children?
3. What do you find valuable about the TF-CBT clinical approach?
4. What do you find challenging about the TF-CBT clinical approach?
5. How do you compare TF-CBT to other treatment models?
 - a. Have you used other therapy models to treat clients with complex trauma and how do you compare other models with TF-CBT to treat complex trauma?
6. What outcomes have you noticed as the result of using the TF-CBT clinical approach when treating clients with complex trauma?