The use of Trauma Focused Cognitive Behavioral Therapy with Children who have Experienced Trauma to Improve Social Functioning

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The use of Trauma Focused Cognitive Behavioral Therapy with Children who have Experienced Trauma to Improve Social Functioning

By

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MSW Clinical Research Paper

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in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize and research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master’s thesis nor a dissertation.
Abstract

Children who have experienced trauma are often affected socially, relationally and personally. Some children will require therapeutic interventions to improve these symptoms and functioning, while others will recover with no therapeutic intervention at all. One evidence based intervention to treat trauma in children is Trauma Focused Cognitive Behavioral Therapy (TFCBT), however current research on TFCBT primarily focuses on how it improves PTSD symptoms, not necessarily its effect on improving a child’s social or relational functioning. Therefore, the present study focuses on the clinician’s perspective of how the use of TFCBT improves social functioning. The findings indicate that the use of TFCBT helps to reduce trauma symptoms that affect a child socially, relationally and personally. However, the findings also indicated reasons why participants chose not to use TFCBT even when the child was experiencing trauma symptoms. Further research is needed to better address the benefits of a broader use of TFCBT.
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The use of Trauma Focused Cognitive Behavioral Therapy with Children who have Experienced Trauma to Improve Social Functioning

The purpose of this study is to understand clinicians’ perspectives on the use of Trauma Focused Cognitive Behavioral Therapy’s (TFCBT) and the treatment protocol’s effect on social functioning when used with children who have experienced trauma. In today’s society children are expected to participate in a number of social activities. They are expected to attend school, engage in sports or other community events; however, if a child has experienced a trauma these social activities may become very difficult for them (La Greca, Lai, Llabre, Silverman, Vernberg & Prinstein, 2013). Therefore, it is important to understand how the use of TFCBT affects social functioning in order to tailor interventions to best meet the needs of the child.

According to the American Psychiatric Association DSM-IV-TR (2000), trauma is defined as any deeply disturbing experience a person either directly or indirectly has outside usual life experiences. Children can experience trauma through a variety of experiences such as: car accidents, sexual abuse, witnessing community violence and more. In 2011, child protective services received 3.4 million referrals and 19% of those cases were referred because the child had suffered neglect, physical abuse or sexual abuse (Hamblen & Barnett, 2013). Furthermore, the National Survey of Children’s Exposure to Violence found that more than half of the representative sample of 4549 children aged 0-17.2 had experienced physical assault, child maltreatment, sexual victimization or had witnessed domestic or community violence within the past year (Hamblen & Barnett, 2013).
Children who have experienced trauma may experience symptoms of: “fear, anxiety, depression, anger and hostility, aggression, sexually inappropriate behavior, self-destructive behavior, feelings of isolation and stigma, poor self-esteem, difficulty trusting others, substance abuse and sexual maladjustment” (Hamblen & Barnett, 2013). Children who have experienced trauma also show difficulty with peer and family relationships, acting out and school performance (Hamblen & Barnett, 2013). Children who experience trauma may also develop Post Traumatic Stress Disorder (PTSD) that does not resolve without treatment (Sheering, Zeanah & Cohen, 2011). According to the American Psychiatric Association DSM-IV-TR a PTSD diagnosis is defined as “the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury…” (p 463). However, not all children who experience trauma develop PTSD; therefore, it is important to assess a child’s symptoms and functioning rather than whether they have a diagnosis when determining the trajectory of treatment.

One evidenced based practice intervention that is used to treat children who have experienced trauma is Trauma Focused Cognitive Behavioral Therapy (TFCBT) developed by Cohen, Mannarino and Deblinger (Cohen, Mannarino & Deblinger, 2006). TFCBT has ten core components, or stages, that the client works through with the clinician. The components are: psychoeducation, parenting skills, relaxation, affective modulation, the narrative, cognitive coping and processing, in vivo mastery of trauma reminders, conjoint child parent interaction, and enhancing future safety (Cohen et al., 2006). Each stage is designed to help the child work up to and then through talking about the trauma. Therefore, by the time a child has worked through all the stages of TFCBT
they should be able to put all the pieces together to regulate their emotions and symptoms. Cohen and Mannarino (2008) found emotion and symptom regulation to be more effective when all the TFCBT components were used.

Socially, children relate to peers and caregivers through play and communication. With peers, children will engage in reciprocal play moving from one activity to another. With caregivers, children will also play or communicate their needs and wants. Social functioning is important in order for children to make friends and to have their needs and wants met. It is crucial for development in children because it helps develop positive social skills at home, school and in the community. However, social functioning may be negatively impacted by trauma. According to Ceballo, Aretakis and Ramirez, (2001) one way a child’s play might be negatively impacted is by restricted play due to the child repeating the same activity over and over. Sheeringa et al. (2011) report that the child may also become socially withdrawn. Therefore, social functioning is crucial for development in children because it improves environmental interactions at home, school and in the community. Therefore, understanding how social functioning is improved through the use of TFCBT would give clinicians a better understanding of how to support clients in meeting their social skills goals.

For purposes of this research social functioning is defined as a child’s ability to be at school, home and in the community with reduced internal and external symptoms. Internal symptoms are defined as the child’s intrusive thoughts and negative thinking when interacting with peers, family and community members (Kassam-Adams Garcia-Espana, Miller & Winston, 2006; Stover, Hahn, Im & Berkowitz, 2010; Oransky, Hahn & Stover, 2013). A reduction of symptoms will show that the child will be able to
interpret social cues from peers and change negative thoughts about peers to more positive thoughts. For example, a child will be able to sit with peers in the lunchroom and not feel as if the other children are talking about or making fun of them. Furthermore, external symptoms are defined as the child’s restricted play and social withdrawal, and outbursts and aggression when interacting with peers, family and community members. A reduction of symptoms will show that a child will be able to participate in developmentally appropriate play with reduced aggression and outbursts and they will at times join in on play.

The literature review addresses the current research on the effect trauma has on children and social functioning, trauma and development of trauma symptoms, TFCBT, TFCBT’s effect on trauma symptoms, and social functioning of adults who have experienced trauma. This study also addresses the limitations in the current research and implications for future research. Furthermore, this study evaluates the conceptual framework that will guide this research through the theoretical lenses of Cognitive Behavioral Therapy Theory and Developmental Theory. Lastly, this study will use qualitative analysis with grounded theory methodology to address the clinician’s perspective of how the use of TFCBT with children who have experienced trauma affects social functioning.

**Literature Review**

Current research was reviewed to identify how trauma affects children and social functioning. Research was also reviewed to understand the effectiveness of TFCBT with children who have experienced trauma. However, since there is limited research focused directly on the use of TFCBT and social functioning, current research was reviewed to
understand TFCBT’s effect on trauma symptoms related to a PTSD diagnosis. Lastly, since it is difficult to conduct research on children, research was reviewed to understand social functioning in adult survivors of trauma to forecast the outcome for children who have been traumatized.

**Trauma’s Affect on Children and Social Functioning**

Research shows that children who experience trauma often experience multiple traumas in one year. Every year, a total of 71% of children are exposed to traumatic events, 70% of those children are exposed to more than one traumatic event, and 18% are exposed to more than four traumatic events (Finkelhor Ormrod & Turner, 2007; Finkelhor, Ormrod, & Turner, 2005). The research showed that the more traumas a child experienced the more likely they were to develop significant symptoms, and children who experienced multiple types of trauma were more symptomatic than children who were exposed to the same trauma multiple times (Finkelhor et al, 2005). It has also been reported that children often report that the most frightening part of trauma is not the trauma itself, but the fallout after the traumatic event such as disclosing it, seeing a parent cry, or removal from a violent parent (Sheeringa et al, 2011). In addition, children who experienced multiple traumas had difficulty initially forming relationships with caregivers (Sarlin, 1995); therefore, children may have trouble developing helpful social supports that could result in better recovery (La Greca et al, 2013).

It is important to understand the symptoms a child may experience due to trauma to better understand how symptoms relate to a child’s social functioning. Research was reviewed to assess children’s symptoms from primary and secondary trauma exposure. Research shows that some children show fear and helplessness or develop agitated
behaviors while others show sadness, anger, confusion, surprise, crying, numbing or become very quiet (Sheeringa et al 2011; Blom & Oberink, 2011). Children may also experience trauma symptoms such as frightening dreams and they may not be able to identify where they are coming from or what they are about (Sheeringa et al, 2011; Blom & Oberink, 2011). Furthermore, children express symptoms of detachment and estrangement through restricted play and social withdrawal (Sheeringa et al, 2011).

Children who have experienced trauma often re-enact traumatic events in their play (Blom & Oberink, 2011); however a child’s interpretation of trauma can be different because of their age at the time of the event; therefore play can look different (Scheeringa et al, 2011). Therefore children who have experienced trauma often re-enact traumatic events in their play. This play can be aggressive and alienating to other children.

Additionally, when play becomes restricted, a child may be stuck in one type of play, have a difficult time doing what other peers want to do, or have a difficult time including peers in their play. This too can be alienating to others.

Children respond to trauma differently depending on biology, physiology and environment. Females are more likely to internalize their symptoms by expressing feelings of sadness while males are more likely to externalize symptoms by expressing more behavioral trouble (Stover et al, 2010; Boney-McCoy & Finkelhor, 1995). However, that being said, girls can also externalize their behavior and boys can also internalize their behavior. Boys and older children are also more likely to experience multiple traumas in one year (Finkelhor, Ormrod & Turner, 2005). Children who show higher levels of anxiety and stressors immediately following the trauma are more likely to have chronic symptoms later on (La Greca et al, 2013); however, when social supports
such as teachers and family are present, the likelihood of chronic symptoms declines (La Greca et al, 2013).

The way in which children interact in relationships after experiencing trauma is important in assessing social functioning, therefore, existing research was reviewed to determine how children who have experienced trauma form relationships and supports. Research shows that traumatized children have a difficult time forming alliances with parents around the traumatic event; therefore, communication and agreement about the trauma is often lacking, which can lead to conflict with caregivers (Stover et al, 2010; Ceballo et al, 2001). Research also shows that avoidance of trauma-related reminders and feeling distant or cut off from others leads to a decline in social functioning (McLean, Rosebach, Capaldi & Foa, 2013). Furthermore, if there is low to moderate agreement between child and caregiver on posttraumatic and depressive symptoms and functional impairment (Kassam-Adams et al, 2006; Stover et al, 2010; Oransky, Hahn & Stover, 2013); caregivers will often minimize the emotional suffering of the child (Oransky et al, 2013). Children often report more traumatic events than caregivers (Oransky et al, 2013; Stover et al, 2010), caregivers and children assess traumatic events very differently (Kassam-Adams et al, 2006), and caregivers often assess traumatic events through their own view of the traumatic event rather than assessing the traumatic event through the child’s experience (Kassam-Adam et al, 2006; Oransky et al, 2013; Shemesh, Newcorn, Rockmore, Shneider, Emre & Gelb, 2005). As a result, children who have difficulty forming alliances and agreement with their caregiver are more often reluctant to seek help (Eltz Shirk & Sarlin, 1995; Lawson, 2009); therefore, having a higher risk of reduced social functioning.
Not all children present with the same types of symptoms, thus it can be difficult for caregivers and professionals to assess for clinical need. Even if a child needs therapeutic intervention they may be feeling shame and negative emotions that could lead to avoidance of trauma related therapy (DePrince, Chu & Pineda, 2011; Kearney, Wechsler, Kauer & Lemos-Miller, 2010). Caregivers can also be essential in providing social and emotional supports, guidance, coping and protection as well as access to help (Kliwer, Parrish, Taylor, Jackson, Walker & Shivy, 2006); therefore, it is important for caregivers to play an important role in trauma recovery. If a child is having difficulty forming alliances they may struggle to let social supports play an active role in their recovery. Understanding the importance of alliances, social supports and the impact that trauma has on children is helpful to better understand how trauma can affect a child’s social functioning.

**Trauma and Trauma Symptoms**

Clinicians often use a diagnosis of PTSD to assess whether TFCBT is an appropriate intervention with children who have been traumatized, therefore, there is a limited amount of research that looks at which specific symptoms associated with trauma are impacted by TFCBT. Therefore, current research was evaluated to address how symptoms associated with trauma affect social functioning. Trauma can have short term and long-term effects on children (Boney-McCoy & Finkelhor, 1995; Finkelhor et al, 2007) that can interfere with functioning (La Greca et al, 2013). Current research shows that one third of adults exposed to trauma will develop trauma symptoms related to a PTSD diagnosis and 50% of those adults’ symptoms will resolve within one year without any treatment (Forneris, Garlehner, Brownley, Gaynes, Sonis & Coker-Schwimmer,
2013; Cary and McMillen, 2012); however, with children, trauma symptoms are less likely to have a reduction in symptoms without intervention (Sheering et al, 2011). When a child is exposed to trauma, trauma symptoms develop and change over time (Salloum & Overstreet, 2012). Children who develop trauma symptoms and do not seek clinical intervention within one year of the traumatic event are at higher risk for distress to continue into 21-, 24- and 30 months (La Greca et al, 2013), however, it should be noted that this research only evaluated children with a diagnosis of PTSD and did not include children who had trauma symptoms without the PTSD diagnosis. Despite these findings, research has also shown that 40% of children who have experienced trauma show resilience in functioning and 20% show chronic distress or slow recovery one year after the trauma event (La Greca et al, 2013).

PTSD diagnoses in children have been associated with traumatic events including exposure to death, disaster, violence and other loss or illness (Goenjian, Molina, Steinberg, Fairbanks, Alvarez & Goenjian, 2001; Raussos, Goenjian, Steinberg, Sotiropoulou, Kokaki & Kabakos, 2005; Salloum & Overstreet, 2012). Posttraumatic stress levels are predicted by life threat, loss and disruption, more stressful life events, less social supports and more negative coping skills (La Greca et al, 1996). In addition, people diagnosed with PTSD report placing lower values on life circumstances including health, social relationships, occupation, home and family, and report a lower quality of life overall (Olatunji, Cisler & Tolin, 2007). PTSD symptoms have also been associated with relationship distress and problems (Riggs, Byrne, Weathers & Litz, 1998) resulting in worse social functioning overall (McLean, Rosebach, Capaldi & Foa, 2013).
Despite the negative impact that trauma symptoms can have on quality of life, children have been found to recover from trauma at a faster rate when actively using coping skills verses adaptive skills such as avoidance and dissociation (Salloum & Overstreet, 2012). In addition, the longer a child remained in treatment the greater the decrease in avoidance and re-experiencing symptoms (Deblinger, Mannarino, Cohen, Runyon & Steer, 2011), which also led to improved social functioning (Mclean et al., 2013). Studies have also shown that children recover faster when the caregiver and child are in agreement about the child’s exposure to the trauma; however, as mentioned previously, there is often very little agreement between caregiver and child on trauma exposure, with the caregiver often underestimating the child’s experience (Ceballo et al, 2001; Kassam-Adams et al, 2006; Shemesh et al, 2005; Oransky et al, 2013). As a result, discrepancies in caregiver and youth views on traumatic events may lead to a higher risk of trauma and depressive symptoms and increased functional impairment, including impaired social functioning (Oransky et al, 2013; McLean et al, 2013). Although research shows that there is often dissonance between parents and children after trauma, one study found that mothers and daughters as well as mothers with younger children were more likely to agree about the trauma than mothers and sons or fathers and daughters (Ceballo et al, 2001).

**Social Functioning of Adult Survivors**

Research was analyzed to understand the social functioning of adult survivors of trauma to forecast the impact that trauma might have on the social functioning of children. Research shows that a history of trauma does not necessarily lead to difficulty later in life with trauma reminders unless the trauma resulted in a diagnosis of PTSD.
(North, Pfefferbaum, Kawasaki, Lee & Spitznagel, 2011; Martinson, Sigmon, Craner, Rothstein & McGillicuddy, 2013). In addition, adults who experienced trauma earlier in life and exhibited PTSD symptoms were more likely to report attachment-related anxiety to peers and family (Martinson et al, 2011); however, this study focused solely on sexual abuse victims and trauma reminders; therefore, it is a small representation of trauma victims. Another study evaluated the overall functioning in adult survivors 6- and 7-years post-trauma which showed symptoms improving because the individuals were able to adapt to their symptoms (North et al, 2011), but this study was conducted on individuals who had experienced trauma when they were adults; therefore, their perception of the trauma and coping skills may have been different then a child’s.

As a result, analysis of research shows that adult survivors of trauma report more difficulty later in life, and anxiety with relationships when they have a history of PTSD symptoms; therefore, if children do not receive help after developing PTSD symptoms it may result in a higher risk of difficulties in adulthood.

**Trauma Focused Cognitive Behavioral Therapy**

Research on the use of TFCBT was examined to assess its efficacy and the impact it has when used with children who have been exposed to trauma. However, the majority of research on TFCBT focuses on how PTSD symptoms as a whole are improved verses individual trauma symptoms in children. Research shows that the use of TFCBT is effective across age, gender, ethnicity and the number of treatment sessions (Cohen, Mannarino & Knudsen, 2004). The use of TFCBT was effective in improving behavioral functioning in children ages 4-11 who had experienced trauma (Deblinger et al, 2011). Furthermore, current research shows that the use of TFCBT is effective with the child
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alone or with caregiver involvement (Lang, Ford & Fitzgerald, 2010); however, stronger outcomes have been found when the child’s caregiver is involved (Salloum & Overstreet, 2012; Cohen & Mannarino, 1998). More specifically, when the caregiver was involved the trauma narrative improved the caregiver child agreement (Deblinger et al, 2011) and reduced PTSD symptoms (Jaycox et al, 2010; La Greca et al, 2010). Caregivers and children who continued to discuss the trauma found it helpful and reported significantly reduced trauma symptoms (Grasso, Joselow, Marquez & Webb, 2011; Deblinger et al, 2011). Despite mostly positive outcomes with TFCBT, one study showed that the process of completing and sharing the trauma narrative may have a negative affect on the caregiver’s mood and it may lead to an increase in the child’s behaviors (Grasso et al, 2011). This study also showed that negative mood in parents and the increase in behavioral issues in children significantly declined in the sharing phase of treatment (Grasso et al, 2011).

Research has also found that the use of TFCBT is able to accommodate caregiver, individual and family needs and circumstances by teaching helpful skills (Grasso et al., 2011). The use of TFCBT also contributes to forming an alliance between the therapist and client, thus improving symptom reduction (Ormhaug, Jensen, Wentzel-Larsen & Shirk, 2013) and possibly improving social functioning. Therefore, TFCBT is appropriate to use with a variety of clients regardless of age, gender, ethnicity or caregiver involvement.
**Trauma Focused Cognitive Behavioral Therapy and Post Dramatic Stress Disorder**

As mentioned earlier, clinicians often use a diagnosis of PTSD to assess whether TFCBT is an appropriate intervention with children who have been traumatized, therefore, there is a limited amount of research that looks at which specific symptoms associated with trauma are impacted by TFCBT. Furthermore, because PTSD symptoms are often related to trauma symptoms it is important to understand how the use of TFCBT reduces these symptoms. Research found that when therapists used TFCBT with children, their PTSD symptoms resolved faster than children who were treated with other interventions (Cary & McMillen, 2012; Cohen & Mannarino, 2008; Forneris et al., 2013). The use of TFCBT was also found to significantly reduce anxiety, depression and behavioral problems in children (Forneris et al., 2013; Cary & McMillen, 2012). PTSD symptoms were also found to continue to reduce at 6, 9 and 12-month evaluations (Grasso et al., 2011). Furthermore, one of the components of TFCBT, the trauma narrative, has been found to be effective in significantly reducing trauma symptoms in children (Salloum & Overstreet, 2012; Grasso et al., 2011; Deblinger et al, 2011). Use of the trauma narrative also helped children improve faster, move out of clinical symptom ranges and results were more reliable (Salloum & Overstreet, 2012); however, over a period of 12 months other interventions and time were also found to reduce PTSD symptoms, depression and internalizing symptoms (Cary & McMillen, 2012 and Salloum & Overstreet, 2012). It should be noted that the other interventions evaluated incorporated many of the same techniques as TFCBT such as the trauma narrative (Cary & McMillen, 2012 and Salloum & Overstreet, 2012).
Conceptual Framework

Everyone experiences the world through a variety of lenses. Each person’s lens can offer a variety of interpretations or understanding of the world. In research, the lenses that a person uses can influence how they perceive the research. Therefore, it is important to understand a person’s conceptual framework to better understand which lenses they see the world through to better understand the impact it has on their research. In this research Cognitive Behavioral Therapy and Developmental Theory influenced this researcher.

Theoretical Lenses

Cognitive Behavioral Therapy relates to the idea of structured psychotherapy that focuses on helping a person become aware of inaccurate or negative thinking so they are more able to respond clearly and effectively. Thinking impacts feeling which also impacts behavior and results in a multi-directional link. People respond differently to different situations; therefore, it is important to understand how an individual experienced a situation in order to best help that specific individual. Life’s events may lead a person to have inaccurate or negative thoughts about future situations; often this shapes how people respond not only to situations and experiences, but how people respond in social interactions and relate to others. Therefore, a person’s relationships may be impacted or harmed by previous experiences. As a result, cognitive behavioral therapy theorists believe it is important to help a person address negative cognitions and restructure them so that they are more accurate and less negatively impactful to the person’s future.

This research was also influenced by Piaget’s stages of cognitive development. Piaget suggests that children think differently than adults, and are constantly striving to
gain knowledge about the world (Papalia, Wendkos Olds & Duskin Feldman, 1999).

According to Piaget, children process through a series of four stages: sensorimotor stage, preoperational stage, concrete operational stage and the formal operational stage (Papalia et al, 1999). As the child moves through each stage they have a new understanding and interpretation of the world around them. Furthermore, Piaget’s stage theory involves changes in a child’s cognitive process and abilities early in development. In later stages, as the child develops, the child shows changes in cognitive operations as the child becomes more logical, organized and flexible (Papalia et al, 1999).

TFCBT uses cognitive behavioral therapy concepts to help children cope with trauma; therefore, Cognitive Behavioral Therapy concepts guided this research in focusing on how TFCBT helps a person address and change their negative thoughts, feelings, and behaviors. Piaget’s cognitive development theory is best used as a lens for the researcher because it helps the researcher understand and define a child’s interpretation of trauma in relation to age. It also helps evaluate the effectiveness TFCBT has on children throughout each developmental stage. It also helped the researcher understand how social functioning can be impacted differently throughout the stages of a child’s development.

Child Developmental Theory takes into consideration the age and developmental level a child is at when an event occurs and how these factors influences their perception of stimuli (Bijou & Bauer, 1961). For example, if a child experiences trauma and is nonverbal, they might have a more difficult time verbally expressing thoughts and feelings about a trauma, so it comes out in behaviors. If a child is older they might be able to talk about the trauma and have a better understanding of it, however they may be
more likely to internalize. Furthermore, developmental theory looks at the history of experiences a child has and how that history influences the child today (Bijou & Baer, 1961). For example, if two children have the same genetic makeup and experience the same event their reactions may be different based on their own previous experiences.

This research was also guided using John Bowlby’s Social Child Development Theory. Bowlby believed that early relationships with caregivers would influence a child’s social relationships later in life (Papalia, Wendkos Olds & Duskin Feldman, 1999). Bowlby focused on attachment with caregivers in early life and the effect that early experiences in childhood have on children later in life (Papalia, Wendkos Olds & Duskin Feldman, 1999). According to Bowlby there are four main characteristics of attachment: proximity maintenance, safe haven, secure base, and separation distress (Papalia et al, 1999). Proximity maintenance is a person’s desire to be near the people they are attached to and safe haven is being able to return to an attachment figure for comfort when there is a threat (Papalia et al, 1999). In addition, Bowlby believed that there were three key elements that result from attachment. First, children raised to know that their caregiver will meet their needs are less likely to experience anxiety (Papalia et al, 1999). Second, how a child experiences attachment is grounded in infancy, early childhood and adolescence, and cannot be changed in later adult life (Papalia et al, 1999). Finally, attachment is formed through a child’s experiences of the caregiver responding to their needs (Papalia et al, 1999). Therefore, Bowlby believed that attachment was continually happening and evolving throughout childhood as a way of survival and that it is part of human nature (Papalia et al, 1999).
Developmental Theory guided this research because the focus is on children at different developmental stages and their experiences. This theory guided the researcher in understanding that children experience events in different ways depending on their stage of development; therefore, the impact of trauma on social functioning will likely vary from individual to individual. Developmental theory also guided this research in understanding that genetic makeup also impacts a child’s ability to cope with different experiences. In summary, developmental theory helped this researcher take into account age, genetics and previous experiences when interpreting results.

**Methods**

**Research Design**

This research design was based on a grounded theory methodology. Grounded theory methodology is used to analyze in-depth interviews or observations to allow a theory to emerge rather than to support a theory (Patton, 2002). Grounded theory strives for complete objectivity in research through in-depth interviews and observations (Patton, 2002). Grounded theory also “emphasizes systematic rigor and thoroughness from initial design, through data collection and analysis, culminating in theory generation” (Patton, 2002, p. 489). Through the use of grounded theory the researcher is able develop the theory through the presentation of the research rather than to test theory (Patton, 2002). According to Patton (2002), “It emphasizes being systematic and creative simultaneously” (p. 489). Therefore, the researcher is able to critically analyze the data while still being creative in the analysis process (Patton, 2002). The process of grounded theory starts with “basic description,” then “conceptual ordering, and then finally theorizing (Patton, 2002).
A qualitative design using grounded theory methodology was the best approach for this research because it allowed the researcher to gather the clinicians’ perspectives of how TFCBT impacted social functioning and allowed the researcher to objectively analyze the data. Furthermore, through the interview design there was a possibility of learning additional information that could lead to ideas for future research. The interview design also allowed the researcher to ask additional questions as appropriate in the interview. It also allowed the clinicians the opportunity to add additional information or explanation. Furthermore, since there is limited research on TFCBT and social functioning a grounded methodology was the best approach for this research because it allowed a theory to emerge through the interviews and coding process rather than the researcher attempting to support a theory. The grounded theory methodology also allowed the researcher to enter the interview process with an open mind to changing views and interpretations; therefore, providing a better representation of the data and allowing room for a theory to emerge from the data. Grounded theory methodology gave the researcher the opportunity to continually intertwine and work with the data through collection, analysis, open coding, thematic coding and theory emerging rather than entering into the research with the intention to prove a theory. Open coding is the process of reviewing the participants’ responses and pulling out relevant responses line by line. Next, thematic codes were found by reviewing each open code and grouping them into common themes. Finally, axial codes were found by identifying the related themes to address a larger picture. In addition, grounded theory methodology incorporated all three elements: collection, analysis, and theory development. This
allowed data collection to be a back and forth process rather than a linear process; therefore allowing the opportunity for theories to emerge throughout the entire process.

Sample

Theoretical sampling was used in determining participants for this study because participants needed to have knowledge and direct experience with TFCBT and children who have experienced trauma. The sample consisted of clinicians who had done therapeutic work with children. Participants were also selected based on the number of children they had worked with who had experienced trauma. Furthermore, participants were selected based on their training in and use of TFCBT and the number of children they had completed the TFCBT protocol with.

Recruitment Strategy

The administrator from the participating agency emailed clinicians informing them that there was a researcher looking to interview clinicians about the use of TFCBT and its effect on social functioning. Through the email the administrator communicated that any clinician had the opportunity to opt out and be removed from the final list that was released to the researcher. The administrator then provided a final list of clinicians who had been trained in TFCBT and had not chosen to opt out. From that list the researcher contacted clinicians by email for recruitment and participation (Appendix A). From the list of respondents willing to participate a total of three clinicians were randomly selected for interviews. All participants selected had an independent license: Licensed Independent Clinical Social Worker (LICSW), Doctor of Psychology (L.P.), or Licensed Marriage and Family Therapist (LMFT) and were trained in TFCBT and had used the TFCBT model with at least two children. The clinicians practiced in the
Minneapolis community working with children who had experienced trauma. An agency approval letter was obtained and agency consent was signed (Appendix B). The sample of clinicians was also randomly selected based on age, gender and ethnicity.

**Protection of Human Subjects**

All participants were informed of confidentiality and consent. Participants were provided with a consent letter to sign to participate (Appendix C). Participants were informed that the interview would be recorded and transcribed for coding purposes and that once the transcription had been completed and the project submitted all recordings would be destroyed. The participants were also informed that no identifying information would be released to anyone. Data was kept on the researcher’s computer hard drive, which was locked, and password protected. The researcher was the only one with the password. Interviews took place in the clinicians’ offices unless they indicated a preference for a different location and then a checked out office where the conversation could not be overheard was used. However, quotes were used to support themes; therefore, there is a minimal risk that others may identify them; participants were informed of all risks. Participants were informed that there are no direct benefits for participating in this study. An application was also submitted for IRB approval to the University of St Thomas.

**Data Collection Instrument and Process**

The data was collected through interviews. The interviews were conducted using a semi-structured format with a set of questions that came from the conceptual framework and past research for reliability and validity purposes (Appendix D). The questions were developed to be non-leading and open ended to encourage honest
feedback, upholding the integrity of the research. Each interview was scheduled for 45 minutes and the entire interview was recorded and transcribed.

The first two questions, “What do you see as being the primary impact of trauma on children?” and “How have you seen children respond to trauma socially?” were designed to obtain a baseline of how the participants understand the impact of trauma on children and their perspective on how children respond to trauma socially. Research addresses how trauma impacts children, however, the question was designed to get a better understanding of how the clinician may see the impact on children directly in their work. The first two questions also gave the researcher a clearer understanding of any differences that may arise in how different clinicians see the impact of trauma and its effects on social functioning.

The question, “How do you determine when to use TFCBT with a child?” is important because it assesses how the clinician uses TFCBT and how they feel it may be the most helpful with children. The question also helped to address if the clinician is using TFCBT based on trauma symptoms or current research of its effectiveness, which relies on the actual diagnosis of PTSD. The analysis of this question helped the researcher understand what guides a clinician in their decision to use TFCBT.

Research shows the effectiveness of TFCBT in reducing PTSD symptoms, however, due to the current criteria for PTSD it can be difficult for children to meet the necessary requirements for the diagnosis. Therefore, by asking the question, “How does the presence or absence of PTSD symptoms in a child influence your decision to use TFCBT?” this research addressed how often clinicians are using a PTSD diagnosis or symptoms when deciding whether to use TFCBT.
Studies have shown that TFCBT is helpful in forming alliances. Therefore, this researcher asked the question, “In your experience, how is the use of TFCBT helpful to the child?” to address the clinicians’ experience with the effectiveness of TFCBT. This question also helped to identify, from the clinician’s perspective, how the effectiveness of TFCBT relates to research and what TFCBT may be helpful with that research does not currently address. Furthermore, this question allowed the clinician to speak freely of their experience without leading them to specific answers.

This research addressed the question of the clinician’s perspective of how TFCBT affects social functioning. Therefore, the question, “In your experience, how does TFCBT as an intervention impact social functioning in children with trauma?” was important because it directly asked the question that this research is designed to identify. Furthermore, this question identified the clinicians’ experience rather than what they have read or heard. The question was designed to identify the clinician’s perspective through their client’s experiences.

Lastly, to identify any misunderstandings during the interview this researcher asked the question, “Do you have any questions for me?” This helped to clarify any questions the clinician may have had. It also allowed the clinician to ask for clarification on any questions he or she may not have understood clearly. This question also allowed for additional questions and feedback to present.

Although the questions were used as a guide, there was plenty of room for the researcher to add additional questions if needed therefore allowing the participants to elaborate on understandings and experiences. Following the interview, the researcher transcribed the entire interview. The researcher then coded each interview.
the researcher maintained a research journal to address any biases that arose while coding.

**Data Analysis Plan**

Using grounded theory, interviews were conducted, recorded and transcribed for analysis purposes. The researcher attended each interview with a list of questions; however, as the interviewee began to answer each question the researcher informally analyzed their answers to assess the direction of the interview and guided any additional questions. Following the interview the researcher transcribed the entire interview for coding purposes. First the researcher analyzed the data and identified all open codes that were relevant to the research questions. Open coding is a process where the researcher identifies all statements through the transcripts that are relevant to the research statement (Patton, 2002). Then the researcher put the open codes into thematic codes by grouping similar statements together. Thematic codes are developed by identifying similarities within the open codes and grouping them together (Patton, 2002). Finally, the researcher then indexed each group.

**Findings**

This research originally set out to understand clinicians’ perspectives on the use of TFCBT and its effect on social functioning when used with children who have experienced trauma. The interviews were conducted using clinicians; therefore they will be referred to as participants throughout the remainder of this paper. Throughout the interviews participants were able to identify how trauma affects children and how TFCBT can be effective with children who have experienced trauma. This research found that participants perceive TFCBT to be helpful with social functioning through
increasing the child’s functioning personally, socially and relationally. This research also identified that there are times when participants do not use TFCBT because it’s not appropriate; therefore, this research also addressed how participants made the decision when to use TFCBT.

The researcher identified a number of open codes that were relevant to the research question. The researcher then identified three thematic codes and indexed them with the labels: trauma’s effect, TFCBT’s appropriateness, and TFCBT’s helpfulness. Axial codes were then identified for each thematic code.

**Trauma’s Effect**

There was significant agreement on the impact that trauma has on children and the use and effectiveness of TFCBT with children who have experienced trauma. Participants agreed that depending on the child, trauma could often have a very different impact. Some children may not experience any long-term symptoms, while others will need professional help to work through their symptoms. Furthermore, depending on the child, symptoms can also present very differently.

Trauma’s effect was one of the thematic codes that the researcher found throughout the interviews. When participants were asked what they saw as the primary impact of trauma on children, many of the participants had a difficult time identifying one primary impact. One participant stated:

“Primary impact of trauma on children. Mmmm, if it were just one general thing.”
Throughout the interviews the participants identified the impact that trauma has on children as being pivotal to understanding the importance of treatment. One participant shared:

“You can have a child who I feel experienced trauma when I hear their story and it’s shocking to me and I think, wow, that would be traumatic for me, but they might not have that experience, and so part of the model foundation is really to let the child define their own trauma.”

The participants also explained that there are multiple impacts that trauma can have on children and that many children become hypervigilant, clingy, and/or worried. One participant shared:

“Kids get hypervigilant or clingy when they are worried about what might happen next that is out of their control.”

However, the participants also explained that trauma impacts children differently and that children can go through the same event and have different outcomes. One participant shared:

“That’s something that’s really fascinating to me about trauma is that you can have group of kids who go through very similar situations and their outcomes are completely different.”

Therefore, it is important to allow the child to define the traumatic event and how it impacted them.

The researcher also identified three axial codes throughout the interviews related to the effects of trauma. Throughout the interviews the participants identified the effect trauma has on children personally, socially and relationally. The participants identified
how trauma affects children personally because they lose their sense of self and the trauma defines who they are and what they can do. One participant shared:

“I think one of the things that I notice a lot is that when a child goes through a traumatic experience, they just completely lose their own sense of self and it’s very easy for them to become defined by what occurred to them.”

The trauma can also make the child’s world smaller, which can impact normal developmental growth emotionally, socially and intellectually. Participants shared:

“Our worlds get smaller, and because their trauma can influence their sense of safety in the world.”

“When trauma happens to a child, it stunts their growth emotionally, socially, intellectually, it makes their world smaller. It closed off parts of their world that they need to enjoy life and to learn from life.”

“I see trauma as impacting their normal trajectory.”

Trauma can also make it difficult for the child to concentrate, which makes it difficult to succeed in school or community activities. One participant shared:

“When kids are preoccupied with safety, their own well-being, the well-being of family members it’s hard to concentrate on things like school work.”

Diagram 1 shows how trauma affects children on a personal level.
Throughout the interviews participants also identified the social effects of trauma. Trauma affects children socially by impacting their trust of other people and situations, which can make it hard to make connections, or can lead children to seek out negative social interactions. Participants also agreed that TFCBT helped the caregivers know how to respond to the child; which helped bridge the relationship between the child and caregiver. Participants agreed that by building support between the child and caregiver, children were able to feel more comfortable to go to their caregiver for help (which is essential in a child’s social development). Participants shared:

“When kids are preoccupied with health and safety it impacts trust. Especially when the trauma comes from a primary caregiver, their ability to trust gets way off.”
“I see a lot of isolation or kids who are seeking out a lot of negative social interaction just because that’s the only way that they can [interact] at that point in time.”

Children also lose trust in themselves and their own judgment of others; therefore, making it difficult to know who to trust. One participant shared:

“If you don’t know who you are and you have all of the sudden this mistrust for people around you and you’re not sure who’s safe and who isn’t and you don’t really trust your own judgment around things it’s really hard to make connections.”

Children also begin to view social situations as scary; therefore, they lose the opportunity to socialize and feel alienated from others. Participants shared:

“The withdrawal and hypervigilence that comes with experiencing trauma as a child makes social situations scary rather than fun.”

“Places that they used to go that supported social interaction, it could be public places like parks, teen sports, just being out in public seem very unsafe to them and so they lose the opportunities to socialize. So that’s one level, and then the other level is missing the potential to socialize, but then the other level is literally feeling alienated from other people.”

Diagram 2 shows the effects that trauma has on children socially.
Throughout the interviews participants identified how trauma impacts children’s relationships. In children, trauma creates strained relationships with caregivers because of feelings that others don’t understand them; therefore kids stop seeking relationships with others. Participants shared:

“Feeling like other people don’t understand me and then the kids stop seeking connection with individuals on an individual level.”

“I’ve seen them have strained relationships with their caregivers and their siblings and friends.”

Children who have experienced trauma also have a difficult time in relationships with other people; therefore, they struggle in community, family and other activities. One participant shared:
“It throws all of their relationships with other people into question and so I think that comes out at school, I think it comes out in extracurricular activities, I think it comes out at church or in the family.”

Trauma also makes it difficult for children to make and keep friends. One participant shared:

“‘It’s hard to make and keep friends when a child isn’t sure if that friend is going to hurt them or not.’

Diagram 3 shows the effects that trauma has on children’s relationships.

Diagram 3:

*The effects of trauma on children’s relationships*
TFCBT’s Appropriateness in Use

When it came to how the participants in this study decided whether or not to use TFCBT with a particular child, all agreed that the model was designed to be used with children who met criteria for PTSD; however, many of the participants found it difficult at times for children to meet these rigorous standards and often chose to use the model even if the child did not meet full criteria. Participants did agree that children had to be showing symptoms related to PTSD or trauma symptoms and the symptoms needed to be significantly impacting functioning and/or typical development in order to consider using the model.

Whether TFCBT was appropriate for a client was a second thematic code that the researcher found throughout the interviews. TFCBT defines what type of symptoms the model is appropriate for, however, participants also make further determinations on whether to use it based on the individual client. One participant shared:

“The interventions are really tailored to help a child improve their, bring relief for their symptoms.”

The researcher identified three axial codes throughout the interviews related to the appropriateness of whether to use TFCBT. One axial code identified throughout the interviews was what the TFCBT model requires for use. The TFCBT model requires an extensive assessment process that focuses heavily on PTSD symptoms. One participant stated:

“There’s a really extensive assessment process in TFCBT that helps us.”
The model requires that children show heightened level of PTSD symptoms and that the participants make the distinction between the child experiencing discomfort versus trauma symptoms. Participants shared:

“I think if you’re a purist and you’re using the model the way you’re trained, they have to meet a certain heightened level of criteria. So when we were going through the training, they talked a lot about just the importance of not like creating more out of a situation than there is, so they really wanted to make sure that we were making a distinction between discomfort and anxiety versus trauma. So they really wanted us to make sure that these kids were like full-blown PTSD symptoms.”

“Fairly (PTSD) symptomatic in order to use the model”

“The model would say that kids need to be (PTSD) symptomatic.”

Diagram 4 shows what the TFCBT model defines as appropriate criteria for use.
Throughout the interviews participants identified when they would choose to use TFCBT. Participants identified that they would often choose to use TFCBT when clients showed trauma symptoms, even when they did not necessarily meet all of the criteria for PTSD, or they found that the child’s symptoms were getting in the way of normal development. Participants shared:

“There has been a lot of times where I’ve made the decision to move forward with TFCBT even if kids weren’t at like the really critical level showing that they had made, how do I wanna say it, so their trauma indicators weren’t as high. Maybe they were kind of in the borderline range and I’ve decided to use it anyway because I think it’s a really good protocol for kids.”
“[If] there is a significant trauma history that’s affecting their symptoms and their functioning and it doesn’t have to be that they meet full criteria for PTSD, they often don’t, but I think the important thing is that they’re having symptoms that are related to the trauma.”

“Many of the PTSD symptoms which are getting in the way of normal development indicate TFCBT would be really helpful.”

A determinate of using TFCBT was also child and family involvement and the child’s verbal ability. Participants shared:

“If there’s a single event trauma, or even multiple traumas but a safe, supportive caring environment, TFCBT could be really helpful.”

“The verbal ability of the child can increase success as well.”

“Client involvement is really big.”

Participants also identified throughout the interviews that they would choose to use TFCBT if the child’s symptoms followed a traumatic event and the child’s symptoms were affecting the child socially, emotionally, and academically and their functioning.

One participant shared:

“If those symptoms started after a traumatic event... and there was no history of them before the traumatic event, then I kind of presume that that makes a good TFCBT case because they’re trauma symptoms. And then the second part is just the functioning and how those symptoms affect their social, emotional, academic, functioning.”
Participants also identified that they often determined to use TFCBT when the child was experiencing specific symptoms such as arousal, avoidance, recurrent memories, and intrusive memories. Participants shared:

“To directly address the things like arousal and avoidance and recurrent memories.”

“The way that I as a clinician … look for the ones who do need treatment are the [children] that have those prolonged effects of trauma and I mean, there has to be some arousal that’s, that’s happening. There has to be some avoidance. Avoidance, to me, is like, when I’m doing a diagnostic assessment; it’s like dogs getting onto the scent of something. And then the recurrent memories and intrusive memories; there has to be some, some of those.”

Diagram 5 shows when participants found it appropriate to use TFCBT.

Diagram 5:

*The participant’s findings of appropriateness of use*
Throughout the interviews participants also identified a number of situations when they had decided not use TFCBT because they felt that it would not be successful, even though the child was experiencing trauma symptoms. Participants did not find the use of TFCBT to be appropriate if the child did not have a supportive caregiver or environment. Participants shared:

“If their environment is not stable, for example if they were placed out of the home and that placement is very recent or that placement is not stable... [or] if they’re not going to have a consistent caregiver for the length that TFCBT is gonna last, that can be a rule out.”

“When a lot of the family systems were really disrupted or... caregivers were not available ‘because kids were in foster care or...[when caregivers] were out of state.”

Participants also decided not to use TFCBT if the child was currently experiencing a lot of trauma or if there was serious dissociation. One participant shared:

“If there’s serious dissociation or if the child is currently experiencing a lot of trauma, they may need more supportive resources to decrease stress before starting TFCBT.”

Participants also decided not to use TFCBT if the child had other things going on that would take the focus away from the treatment of the traumatic event. Participants felt that they needed to resolve the other crisis before they could move forward with the trauma treatment.

“If there’s other stuff going on that really becomes a focus of treatment and takes trauma out of the spotlight, you know, so suicidal behavior, very frequent
behavioral dysregulation that really just needs to be addressed, you know, getting kicked out of school, things like that.”

Participants also identified that the use of TFCBT was not appropriate if the child could not manage the different components of the model. One participant shared:

“There’s only a couple of times where I’ve decided against it even though kids definitely were showing symptoms and had experienced trauma. I’ve had a couple of kids that were low functioning that [I] didn’t think would be able to manage... the CBT aspect of it. They just didn’t have the insight or the capability to follow through on skills. I also had one child who was 16, almost 17, who just adamantly was not going to do it.”

Diagram 6 shows when participant found it inappropriate to use TFCBT.

Diagram 6:

The participants’ determination when it is not appropriate to use TFCBT
TFCBT’s Effectiveness

The helpfulness of TFCBT was another thematic code that the researcher found throughout the interviews. Throughout the interviews the subjects identified how the use of TFCBT was helpful to the child in working through their traumatic experience and moving forward developmentally. One participant stated:

“Sharing one’s pain with another person I think, is one of the most important parts of trauma healing in, at least through this model.”

Participants found that the use of TFCBT was helpful because clients were able to share their story in a safe environment with safe people. Participants stated:

“I think from my personal use with the narrative, though, I think that process can be helpful for kids who maybe even aren’t that severe. This idea of like creating their own story around it, helping to explain to other people what happened to them, I feel like that’s therapeutic anyway.”

“When a kid can address their trauma and confront it in a safe and structured way, all those doors that got shut on them get reopened and they can go on and be, you know, to be a normal kid again.”

Participants also identified that the use of specific components of TFCBT was helpful in reducing specific symptoms; therefore giving the child helpful skills to deal with their symptoms. Participants stated:

“It’s very helpful, very helpful. I think that they really stressed this when I went through training, but I found it to be very true that even if you don’t complete the entire model with the child, even just making it through the first half with the
practice skills is really beneficial for a lot of kids who have any sort of anxiety. So that’s really helpful.”

“This model allows kids to gain coping skills, gain confidence, externalize the trauma through the narrative and use a caregiver to make sense of and then heal from what happened.”

The researcher also identified three axial codes throughout the interviews related to the helpfulness of TFCBT. Throughout the interviews the participants identified how the use of TFCBT is helpful to the children personally, socially and relationally. Throughout the interviews participants identified that the use of TFCBT was effective in helping children feel empowered and able to manage their symptoms. One participant stated:

“I feel like kids feel really empowered, they have more control over their own symptoms and their ability to regulate.”

Participants also identified that using TFCBT helped children regain their sense of self and who they are to find confidence. One participant stated:

“The biggest thing is giving, like kind of repairing that loss of sense of self, so when a trauma happens, it kind of steals that identity piece away from a child, and so by going through this process, I found it to be really helpful with children being able to say this is what happened to me, but here’s who I am, and, there’s so much stigma around talking about traumatic events and kids often will protect the people around them.”
Participants also identified that the sharing portion of TFCBT was very healing for children because they were able to share their story with someone who was safe in a safe environment. One participant stated:

“Kids get to practice sharing these very private, hidden memories with someone who’s a safe person and usually that is a very healing process.”

Diagram 7 shows where the use of TFCBT is helpful to children personally.

Diagram 7:

The use of TFCBT and how it helps children personally

Throughout the interviews participants also identified how TFCBT is helpful to children socially. Participants identified that TFCBT helped children feel safe to explore the world and trust others. Participants stated:

“Increasing the amount that they explore the world and their social world.”
“There’s a huge sense of trust that can happen afterward and just like that, that stigma goes away.”

“I think that once their confidence is up and they’re feeling more empowered and they have this good sense of who they are, those pieces just kind of naturally come after that.”

Participants also identified that TFCBT gives children the skills to be confident in themselves and to have mastery over how they view themselves; therefore, increasing their ability to socialize and participate in their community. Participants stated:

“TFCBT can help a child’s sense of self and mastery develop which increases their ability to socialize with peers.”

“I’ve seen the coping skills used in groups and there is a huge impact on learning and practicing self-soothing together.”

Diagram 8 shows where the use of TFCBT is helpful to children socially.
The use of TFCBT and how it helps children socially

Throughout the interviews participants also identified how TFCBT is helpful to children relationally. Participants identified how TFCBT helped caregivers by giving them resources and teaching them how to respond to the child who had experienced trauma. Participants stated:

“I think for caregivers or teachers or other helpers in the family it gives them some resources to go to rather than just feeling like my child’s out of control and I have no idea how to be helpful.”

“Helping to prepare the caregivers, whoever’s gonna listen to the story at the end, help prepare them to know exactly how to respond, and so you do all this groundwork before it actually would happen, and in that moment I’ve just seen like just melt because there is a sense of relief, this, oh, my gosh, it’s out there. It wasn’t scary for the people who I need to know.”
Participants also identified that TFCBT was helpful in bridging the relationship between caregiver and child; therefore, building supports so that the child could feel comfortable going to the caregiver for help. Participants stated:

“With TFCBT, there’s specific components that help kids connect to their primary support people, so the conjoint sessions and the parenting components and the presentation of narrative, those things are to can be really powerful because often kids lived their lives with this story inside or this thing that happened, and it, it hasn’t been shared with others, and it, with this story inside or this thing that happened, and it, it hasn’t been shared with others, and it, or understood by others or witnessed by others, and kids often haven’t necessarily shared or processed it themselves and so it gives kids an opportunity to process it on their own or with a therapist, definitely in the therapy relationship is extremely powerful and central to TFCBT.”

“There’s the caregiver relationship that you kind of add on to that after they’ve shared it with you, and then you establish that caregiver as the person who the child can to for help.”

Diagram 9 shows where TFCBT is helpful to children relationally.
Diagram 9:

*The use of TFCBT and how it helps children relationally*

Diagram 10:

*Thematic Codes/ Axial Codes*
Table 1:

**Thematic Codes/ Axial Codes and Sample Responses**

<table>
<thead>
<tr>
<th>Category</th>
<th>Axial category</th>
<th>Sample Responses</th>
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<tbody>
<tr>
<td><strong>Theme 1: Participants views on the effects of trauma on children</strong></td>
<td></td>
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<tr>
<td>T1</td>
<td>Personal effects</td>
<td>their worlds get smaller, because trauma can influence their sense of safety in the world.</td>
</tr>
<tr>
<td>T2</td>
<td>Social effects</td>
<td>The withdrawal and hypervigilance that comes with experiencing trauma as a child makes social situations scary rather than fun.</td>
</tr>
<tr>
<td>T3</td>
<td>Relational effects</td>
<td>It’s hard to make and keep friends when a child isn’t sure if that friend is going to hurt them or not.</td>
</tr>
<tr>
<td><strong>Theme 2: Participants determination in the appropriateness of using TFCBT with a client</strong></td>
<td></td>
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<tr>
<td>A1</td>
<td>Model Guidelines</td>
<td>The model would say that kids need to be (PTSD) symptomatic</td>
</tr>
<tr>
<td>A2</td>
<td>When to use</td>
<td>If those symptoms started after a traumatic event, then I’m presuming you know, and there was no history of them before the traumatic event, then I kind of presume that that makes a good TFCBT case because they’re trauma symptoms</td>
</tr>
<tr>
<td>A3</td>
<td>When not to use</td>
<td>If there’s other stuff going on that really becomes a focus of treatment and takes trauma out of the spotlight, you know, so suicidal behavior, very frequent behavioral dysregulation that really just needs to be addressed, you know, getting kicked out of school, things like that</td>
</tr>
<tr>
<td><strong>Theme 3: Participants experience of how the use of TFCBT is helpful</strong></td>
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<tr>
<td>H1</td>
<td>Personally helpful</td>
<td>I feel like kids feel really empowered, they have more control over their own symptoms and their ability to regulate</td>
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<tr>
<td>H2</td>
<td>Socially Helpful</td>
<td>TFCBT can help a child’s sense of self and mastery develop which increases their ability to socialize with peers</td>
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<tr>
<td>H3</td>
<td>Relationally Helpful</td>
<td>There’s the caregiver relationship that you kind of add on to that after they’ve shared it with you, and then you establish that caregiver as the person who the child can go to for help</td>
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Note. T=Trauma’s effect, 3 subthemes, A=Appropriateness of use, 3 subthemes, H=Helpful, 3 subthemes
Discussion

The findings of this research indicate that trauma can have a negative impact on children and their relationships. However, throughout the interviews participants identified that children respond to trauma differently; therefore, it is difficult to follow the models criteria exactly. This supports current research in that some children show fear and helplessness or develop agitated behaviors while others show sadness, anger, confusion, surprise, crying, numbing or become very quiet (Sheeringa et al 2011; Blom & Oberink, 2011). Therefore, it is important to understand how this research can be helpful in assessing the need for changes within the intervention, while keeping its fidelity, to adapt to the needs of the child.

All participants found trauma to impact the child in three major categories: personally, socially and relationally. Participants agreed that when a child experiences trauma it affects how they see themselves and their world. Children lose their sense of self and often can become defined by the trauma, making their worlds much smaller. Participants agreed that this impacts a child’s development and emotional, intellectual and social growth. This is in alignment with current research’s findings that children who experience trauma show signs of fear and helplessness and focus their play and social interactions around the traumatic event (Sheeringa et al, 2011; Blom & Oberink, 2011). Participants found that TFCBT helped children feel more empowered and able to manage their symptoms; therefore children were able to define who they are rather than having the trauma define them. Participants also found the sharing portion of TFCBT to be helpful in making the child’s world larger by finding confidence in themselves and identifying people they can feel safe with. These findings are important in understanding
how TFCBT can be effective to a child in managing their symptoms and helping the child interact socially.

Participants also agreed that trauma affects children socially through the child’s ability to trust others and situations; social interactions are often scary rather than pleasurable. Participants agreed that following a traumatic experience, children may find it difficult to make connections with others and likely feel alienated from peers. They may use negative interactions as a way to connect to people, without getting too close. This was also evident in current research. Several studies have shown that children have trouble finding social supports and can become socially withdrawn following a traumatic experience (Sheeringa et al 2011; La Greca et al, 2013). In addition, participants identified that the use of TFCBT helped children to feel safe, giving them the ability to explore the outside world. Participants also agreed that the use of TFCBT gave children specific skills that helped them feel more confident socially, allowing them to participate in their community without fear or anxiety.

Participants indicated that trauma has an impact on a child’s relationships; mainly that they feel that nobody (including their caregiver) understands them. This is similar to findings of current research, which indicates that there is often a disagreement between the caregiver and child’s assessment of the traumatic events (Kassam-Adams et al, 2006) resulting in a discrepancy of reported symptoms (with caregivers often underreporting the impact of the trauma) (Stover et al, 2010; Ceballo et al, 2001). Current research has also found that because children avoid trauma reminders; they often feel distant or cutoff from others (McLean, Rosebach, Capaldi & Foa, 2013). Therefore, the findings of this study indicate that the use of TFCBT could be effective in improving the child’s relationships
by helping them feel as if others can understand them. This study also shows the
effectiveness that TFCBT has in forming alliances between the caregiver and the child;
therefore helping the child feel more empowered in their relationships.

The TFCBT protocol requires that children have a diagnosis of PTSD to use it. However, participants reported a variety of reasons outside of a PTSD diagnosis when they chose to use it with a child. All participants agreed that their determination to use TFCBT depended on the child having trauma symptoms and those symptoms interfering with the child’s functioning, even though they may not meet criteria for a PTSD diagnosis. These results are in agreement with the current research that focuses on the use of TFCBT in reducing PTSD symptoms (Jaycox et al, 2010; La Greca et al, 2010) and the use of TFCBT to reduce trauma symptoms (Grasso et al., 2011; Deblinger et al, 2011). Other factors that were crucial to a participants choosing to use TFCBT included making sure the client was verbal (and/or cognitively able) and that they had involved parents/caregivers.

There were times that participants did not feel that using TFCBT would benefit the child even though they were experiencing trauma symptoms. Participants agreed that if there was not a supportive caregiver or environment then they would choose not to use the intervention. Although current research finds that the use of TFCBT can still be effective without an involved caregiver or stable environment (Lang et al., 2010), other research shows that when the caregiver is involved it improves the agreement between caregiver and child and as a result there is a greater reduction in trauma symptoms .(Deblinger et al, 2011; Grasso et al., 2011). Participants also agreed that the use of TFCBT was not appropriate if the child was currently experiencing trauma and/or if the
child was experiencing serious dissociation; clinicians noted that in these cases the child would not be able to manage the different components of the model. This is in alignment with current research that demonstrates that TFCBT helps to form an alliance between caregiver and child (Ormhaug et al., 2013); however, if the child is not able to participate in the model due to current experiences of trauma or an uninvolved parent then that alliance will not be formed. Participants also agreed that it was not appropriate to use the model if the child was experiencing a crisis that would take away from the focus of the trauma work.

These findings indicate that the use of TFCBT could be effective in helping a child relationally and socially. However, the current protocol for TFCBT requires that a child meet the criteria for a PTSD diagnosis, which can be difficult with the current criteria. Children may be experiencing trauma symptoms that impact their functioning and could greatly benefit from the use of TFCBT; therefore, it is important to understand that the intervention could be adapted to help those children. It is also important to understand how additional research would better assess the need for changes in the current protocols’ requirements, to be helpful for more children while still keeping its fidelity.

Limitations

There were a number of strengths and weaknesses in this research methodology that may have had an effect on the findings. A strength of this research question is that it addresses the clinicians’ perspective of the use of TFCBT on social functioning, which helps to understand what type of impact TFCBT has on social functioning; therefore assessing the need for further research. Furthermore, this research addresses gaps in
existing research as to the benefits of using TFCBT with clients who are not diagnosed with PTSD. This research also helps to better understand the impact trauma has on social functioning and how TFCBT could be useful in improving social functioning; therefore, addressing the need for further evidence based research to expand the use of TFCBT with children.

There are a number of limitations in this research. A limitation in this research is that the research was to be conducted and completed within 9 months, which resulted in a small sample size. Furthermore, limited resources and participants’ time availability may have resulted in a smaller sample size. For these reasons the research did not result in saturation. Saturation occurs when the number of participants is high enough that no new data is obtained; therefore, information is repeated. In this research there were not enough participants for this to occur, resulting in possibly missing data. Furthermore, this research will only focus on the clinicians’ perspectives on a client’s social functioning, which may result in biased data. Participation was low with only four participants total; therefore, there was limited information for coding purposes. The limited number of participants also reduced the chances of varied responses, which did not result in saturation. Furthermore, all participants were from the same children’s mental health agency; therefore, peer support may have influenced them to use the model. Participants were also primarily female, with only one participant being male; therefore gender may have influenced participants’ perspective on the outcome of TFCBT.

Limitations also exist in this research due to the sensitive nature of the material. Participants were asked to answer questions addressing the effects of trauma on their
clients; therefore, participant avoidance may have limited the data they reported. Furthermore, the sensitive nature of the material may have also limited the number of participants willing to be interviewed.

**Future Directions**

Due to the limited number of participants, this research should be conducted using a larger sample size from a variety of agencies to better identify the effectiveness of TFCBT on social functioning. This research identified a variety of reasons that participants felt the use of TFCBT was appropriate or not; therefore further research to assess clinicians’ decision to use TFCBT would be important to better address the possible need for adaptations in the protocol. Furthermore, due to the limited number of participants who reported using the full protocol it would be helpful to understand what barriers the clinician may have in using the full model with more children. Another area of interest might be to investigate whether clinician’s are choosing to use the full model or only specific parts of the model and why they are making that determination. This may better assist clinical social workers in choosing the right protocol to use with their clients based on the broader idea of symptoms rather than selective to a diagnosis. This would also assist clinical social workers in understanding how specific components of TFCBT may be beneficial to their clients, even if the entire protocol is not used.

The majority of research focuses on the effectiveness of TFCBT on PTSD symptoms; however, with the current requirements for a PTSD diagnosis in the DSM IV-TR it is difficult for a child to meet necessary criteria for the diagnosis even when TFCBT may be clinically appropriate (Scheeringa et al, 2011). Scheeringa et al (2011) found that there was a lower rate of PTSD diagnoses in young children than older children exposed to
trauma. On the other hand, current revisions were made to the PTSD diagnosis in the DSM-5 which were designed to address the need for the diagnosis to fit children as well. The DSM-5 criteria are developmentally sensitive, lowering the threshold for children and adolescents and including separate criteria for children 6 and younger (American Psychiatric Association, 2013). However, even with the changes and improvements to the DSM-5 there is still questionable agreement about a PTSD diagnosis in children (Freedman et al, 2013); therefore, since the majority of current research shows the effectiveness of TFCBT on PTSD symptoms it is important to understand the effectiveness of TFCBT on trauma symptoms without a PTSD diagnosis. Expanding the research to include clients would help clinical social workers understand the effects of a broader use of the protocol; therefore, possibly feeling more comfortable using it to address trauma symptoms even if the child does not meet the criteria for PTSD.

A child’s trauma symptoms can impact their functioning socially and relationally; therefore, it is important to understand how the use of TFCBT can help reduce these symptoms and improve social functioning. This research found that participants agreed that the use of TFCBT improves trauma symptoms that impact a child’s social and relational skills. Therefore, further research should be conducted on a larger population of clinicians to determine broader agreement. Additional research should also be conducted with children to assess direct improvement in social and relational functioning following the use of TFCBT.
References


Dear Potential Participant,

My name is Danielle Hernandez and I am a Master’s student in the School of Social work at the University of St Thomas and St Catherine University of St Paul, MN. I am currently conducting research under the supervision of Dr. Felicia Sy. As part of my research I am conducting interviews with licensed mental health professionals who have been trained and used Trauma Focused Cognitive Behavioral Therapy with at least 2 children who have experienced trauma. My research will assess clinician’s perspectives on the use of TFCBT and it’s effect on social functioning with children.

I received your name and credentials from XXXXXX as a potential participant for this study. I understand that you are a licensed mental health professional who has been trained in TFCBT and used it with children who have experienced trauma. I would like to speak with you about your perspective of how the use of TFCBT effects social functioning in children.

Interview Information:

- The interview will last approximately 1 hour and will be scheduled at your convenience. With your permission the interview will be recorded and transcribed verbatim for analysis purposes.
- Involvement in this interview is completely voluntary and there are no known risks associated with participation.
- All information you provide will be kept confidential and in a secure location until July 31st, 2013 when it will be destroyed.

If you wish to participate in this study please email me at XXXXXX by March 1, 2013. If you have any questions or concerns please call me on my confidential cell at XXXXXX or call my supervising chair, Dr. Felicia Sy at XXXXXX.

Thank you for your consideration,

Danielle Hernandez, BA
Graduate Student at the School of Social Work
University of St. Thomas and St Catherine University
**Agency CONSENT FORM**

Researcher: Please provide your agency with the information about your project and have your agency contact complete this form.

Agency: Please read this form and ask any questions you may have before agreeing to allow this study to take place at your agency. Please keep a copy of this form for your records.

<table>
<thead>
<tr>
<th>Project Name</th>
<th>The use of Trauma Focused Cognitive Behavioral Therapy to improve social functioning: A clinician's perspective.</th>
<th>IRB Tracking Number</th>
</tr>
</thead>
</table>

**General Information Statement about the study:**

I am conducting a study about clinician's perspectives of the use of Trauma Focused Cognitive Behavioral Therapy (TFCBT) and its effect on social functioning.

Your agency is invited to participate in this research. The agency was selected as a host for this study because:

A number of clinician's have been trained in the use of TFCBT and the agency has seen a number of children who have experienced trauma.

**Study is being conducted by:** Danielle Hernandez

**Research Advisor (if applicable):**

**Department Affiliation:** Social Work

**Background Information**

The purpose of the study is:

The purpose of this study is to determine clinician's perspectives on the use of Trauma Focused Cognitive Behavioral Therapy (TFCBT) and its effect on social functioning to determine if the use of TFCBT is helpful in improving social functioning for children who have experienced trauma.

**Procedures**

Study participants will be asked to do the following:

*State specifically what the subjects will be doing, including if they will be performing any tasks. Include any information about assignment to study groups, length of time for participation, frequency of procedures, audio taping, etc.*

Participate in an interview that will last approximately 1 hour, where the researcher will ask a series of questions about the use of TFCBT and social functioning. At any time you may choose not to answer a question or stop the interview for any reason.

**Risks and Benefits of being in the study**

The risks involved for subjects participating in the study are:
The risk and benefits associated to participants is minimal, however there is the possibility of re-experiencing the work they did with the child, which might cause some mild disturbance. However, the likelihood of such distress is minimal due to the fact that those interviewed are trained and experienced professionals. There prepared to deal with such emotional risks due to the nature of their daily work. All participants will go through the informed consent process where informed consent will be explained, confidentiality and the voluntary nature of the study. There is a minimal risk of inconvenience for the participant to schedule are participate in the interview; therefore, the researcher will accommodate their needs by meeting at an on or off site location of their choice. If significant emotional or psychological distress occurs during the interview, the interview will be immediately terminated to debrief.

The direct benefits the agency will receive for allowing the study are:

There are no direct benefits to participants in this study.

### Compensation
Details of compensation (if and when disbursement will occur and conditions of compensation) include:

'No compensation' in this study

### Confidentiality
The records of this study will be kept confidential. The types of records, who will have access to records and when they will be destroyed as a result of this study include:

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. The types of records I will create include audio transcriptions and typed transcriptions of the interviews. To maintain confidentiality the interviews will take place in an office or outside location of the clinician's choice where content cannot be overheard. All identifying information will be removed and replaced with an id number. All typed transcripts will use id numbers and the final research paper will use quotes to support themes, but will not use any identifying information. The transcription devise will be kept in a locked case when not in use and the typed transcriptions will be kept on a password protected computer that will be accessible only by the researcher. All recordings and typed transcriptions will be destroyed on May 31, 2014.

### Voluntary Nature
Allowing the study to be conducted at your agency is entirely voluntary. By agreeing to allow the study, you confirm that you understand the nature of the study and who the participants will be and their roles. You understand the study methods and that the researcher will not proceed with the study until receiving approval from the UST Institutional Review Board. If this study is intended to be published, you agree to that. You understand the risks and benefits to your organization.

If you decide to participate, you are free to withdraw at any time up to and until March 1, 2014. Should you decide to withdraw data collected about you will be destroyed immediately. You are also free to skip any questions I may ask or end the interview at any time for any reason.

Should you decide to withdraw, data collected about you will be used in the study
### Contacts and Questions
You may contact any of the resources listed below with questions or concerns about the study.

<table>
<thead>
<tr>
<th>Contact Type</th>
<th>Information</th>
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<tbody>
<tr>
<td>Researcher name</td>
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<td>Researcher email</td>
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<td>Researcher phone</td>
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<td>Research Advisor name</td>
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<td>Research Advisor email</td>
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<td>Research Advisor phone</td>
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<tr>
<td>UST IRB Office</td>
<td>651.962.5341</td>
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</tbody>
</table>

### Statement of Consent
I have read the above information. My questions have been answered to my satisfaction and I consent to allow the study to be conducted at the agency I represent. By checking the electronic signature box, I am stating that I understand what is being asked of me and I give my full consent.

<table>
<thead>
<tr>
<th>Signature of Agency Representative</th>
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<td>Electronic signature</td>
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Print Name of Agency Representative

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<tr>
<th>Signature of Researcher</th>
<th>Date</th>
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<tbody>
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<td>Electronic signature*</td>
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Print Name of Researcher

*Electronic signatures certify that:
- The signatory agrees that he or she is aware of the policies on research involving participants of the University of St. Thomas and will safeguard the rights, dignity and privacy of all participants.
- The information provided in this form is true and accurate.
- The principal investigator will seek and obtain prior approval from the UST IRB office for any substantive modification in the proposal, including but not limited to changes in cooperating investigators/agencies as well as changes in procedures.
- Unexpected or otherwise significant adverse events in the course of this study which may affect the risks and benefits to participation will be reported in writing to the UST IRB office and to the subjects.

The research will not be initiated and subjects cannot be recruited until final approval is granted.
Appendix C

CONSENT FORM
UNIVERSITY OF ST. THOMAS

The use of Trauma Focused Cognitive Behavioral Therapy to improve social functioning: A clinician’s perspective

I am conducting a study about clinicians” perspectives of the use of Trauma Focused Cognitive Behavioral Therapy (TFCBT) and it’s effect on social functioning. I invite you to participate in this research. You were selected as a possible participant because you have completed the TFCBT training and used it with at least 2 children. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Danielle Hernandez, Researcher and Dr. Felicia Sy, Advisor

Background Information:
The purpose of this study is to determine clinician’s perspectives on the use of Trauma Focused Cognitive Behavioral Therapy (TFCBT) and its effect on social functioning. Ultimately, this investigation will be used to determine if the use of TFCBT is helpful in improving social functioning for children who have experienced trauma.

Procedures:
If you agree to be in this study, I will ask you to do the following: Participate in a 1 hour interview that will be audio recorded, where the researcher will ask a series of questions about the use of TFCBT and social functioning. At any time you may choose not to answer a question or stop the interview for any reason.

Risks and Benefits of Being in the Study:
There are no direct risks or benefits to participants in this study.

Confidentiality:
The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way, consent. The types of records I will create include audio transcriptions, typed transcriptions of the interviews, consent forms and written research notes. To maintain confidentiality the interviews will take place in an office or outside location of the clinician’s choice where content cannot be overheard. All typed transcripts and written research notes will use initials rather than full names and the final research paper will use quotes to support themes, but will not use any identifying information. The transcription devise will be kept in a locked case when not in use and the typed transcriptions will be kept on a password-protected computer that will be accessible only by the researcher. All consent forms and written research notes will be kept in locked filing cabinet when not in use. All recordings, typed transcriptions, consent forms and written research notes will be destroyed on May 31, 2014.
Voluntary Nature of the Study:
Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with Washburn Center for Children or the University of St. Thomas/ St. Catherine University. If you decide to participate, you are free to withdraw at any time up to and until March 1, 2014. Should you decide to withdraw data collected about you will be destroyed immediately. You are also free to skip any questions I may ask or end the interview at any time for any reason.

Contacts and Questions
My name is Danielle Hernandez. You may ask any questions you have now. If you have questions later, you may contact me at 214-558-8144. Or you may contact my advisor Dr. Felicia Sy at XXXXXXX. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:
I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age.

________________________________________  __________________________
Signature of Study Participant             Date

________________________________________
Print Name of Study Participant

________________________________________  __________________________
Signature of Researcher                   Date
Appendix D

1. What do you see as being the primary impact of trauma on children?

2. How have you seen children respond to trauma socially?

3. How do you determine when to use TFCBT with a child?

4. How does the presence or absence of PTSD symptoms in a child influence your decision to use TFCBT?

5. In your experience, how is the use of TFCBT helpful to the child?

6. In your experience, how does the use of TFCBT impact social functioning?

7. Do you have any questions for me?