

Building Resiliency after Trauma

Results of Focus Groups and Interviews with Providers

The Building Resiliency after Trauma study is intended to explore the role of infrastructure in the dissemination of an evidence-based therapy in community settings. The study includes the collection of a variety of quantitative data on organizational readiness, therapist perceptions of manualized treatments, and youth and family outcomes. However, there is much to be learned from the personal experiences of therapists and agency leaders as they attempt to change their treatment practices, modify agency policies, and learn new ways of doing business. To capture this valuable information, focus groups and interviews with participating agencies were conducted.

Procedure

Participating therapists and agency leaders were invited to participate in a debriefing meeting following completion of the training and coaching portion of the study. The meetings were facilitated by a community leader (Fort Worth) or the investigator (Austin) and followed a semi-structured discussion format. Participants were provided a summary of the study outcomes available at the time, a description of the future research activities, and encouraged to provide feedback on research questions of value to the agency. An agenda for the meeting is included in Appendix A. Participant responses were recorded to facilitate documentation of the feedback. Individuals who were not able to attend debriefing meetings were contacted and interviewed by telephone by a research staff member. A summary of the feedback is provided below. It is important to acknowledge that the experiences of an individual participant or agency may be unique, and the feedback should not be assumed to reflect the opinion of all participants.

Planning and Readiness

Participants highlighted the importance of support and buy-in for the project by agency leadership. In many agencies, individuals had been participating in efforts to learn about evidence-based practices, including TF-CBT, for several years and had support for these efforts throughout the agency. Efforts to incorporate trauma-informed care, beyond this specific intervention, were occurring at some agencies and this enhanced the readiness for implementation. Agencies indicated that selecting appropriate therapists for participation in the initial implementation was important. They indicated that the therapist's willingness to participate and their enthusiasm were critical for success. The therapists indicated that it was important for them to fully understand the time commitment involved before agreeing to participate. Some agency leaders indicated that finding therapists who are comfortable with trying new things and the disorganization that frequently accompanies change projects was important. In a few cases, leaders found that it was helpful to ensure that the new treatment fit comfortably with the therapist's theoretical orientation.

Many participants indicated that changes needed to be made within their organization to allow therapists the time required to implement TF-CBT. Training required a significant time commitment, including the 10 hours of online training and two days of live workshop. In addition, therapists noted

that they needed additional time to prepare for sessions, especially early in the implementation process. They needed time to locate psychoeducational resources and develop games and activities appropriate for the child's age. Therapists indicated that having flexibility within their schedules to attend to these extra duties was critical for success. In some agencies, implementation occurred at a time when pressures to increase productivity were increased, which made implementation more complex.

Some agencies had to make policy and process changes if current practice did not support the treatment model. The majority of participants highlighted the importance of examining their processes for identifying children with trauma-related symptoms. Some agencies reported that their current intake processes did not always identify children with traumatic experiences, unless that was the presenting problem. They indicated that there was not a clear place that trauma was documented in the intake report. Few used standardized screening assessments. Several agencies reported that it was helpful for them to educate providers across the organization regarding whom to refer for the treatment and to repeat these informational efforts over time. In addition, some agencies needed to make changes to allow for individual treatment (versus group format). Another agency made policy changes to support outpatient treatment, including finding physical space to hold treatment sessions. Across the participating organizations, strategies for referring clients to other agencies offering TF-CBT needed to be outlined. Each agency utilized different intake processes and the flow of referrals needed to be well-documented to ensure families could easily access services after a referral was made.

Training in TF-CBT

Training within the project included completing the online training program, attendance at a 2-day workshop, and the provision of a written manual. Most therapists felt that the online training was very helpful for providing an overview of the treatment model. Some therapists indicated that it was helpful to require completion of the web-based training, because it would have been difficult to find time if this was not made a priority. Many therapists reported that they continued to use the online training throughout the project to refresh their memory about particular treatment techniques or to show caregivers skills they were teaching to their child. A few therapists reported the online training did not add much to the live training.

Participants enjoyed the live workshop on TF-CBT and appreciated the expert trainer's enthusiasm and knowledge. They indicated that the experiential components of the training were the most helpful, and appreciated opportunities to watch the skills in role plays or practice them with partners. Participants indicated that the workshop overlapped significantly with the online training, covering much of the same material, and that some additional time during the workshop could be devoted to more role plays and practicing of skills. Some therapists also indicated that the training assumed that practitioners were skilled in providing CBT techniques (e.g. Socratic questioning, in vivo desensitization) before the training. They indicated that providers with less experience with this treatment modality could have benefitted from more opportunities to see and practice these techniques in depth. They particularly noted that it would have been helpful to have more practice with in vivo desensitization and safety planning. One unique suggestion was to have therapists complete the activities (e.g., workbook) during training as a client would to enhance their understanding.

Participants also reported that having access to the manual was helpful and gave them a place to review information if they were “stuck”. They appreciated having multiple ways of learning the information. Many therapists also found the binder of resources provided at the training, containing worksheets and the TF-CBT workbook, were very helpful. They indicated it would be helpful to further expand on these resources. The therapists at one clinic created their own binder of activities and resources to make implementation easier. Several therapists indicated that it would have been very helpful to have all of the resource materials intended for youth or caregivers be available in Spanish.

Providers expressed an interest in one or more advanced workshops, particularly with opportunities to practice less familiar skills. Suggestions for topics for advanced workshops included secondary trauma and self-care, case presentation and discussion, or particular techniques. Some individuals also reported that it might be helpful to have a refresher course following the original workshop to allow participants to advance their skills after treating a few initial clients and to focus on skills they were less familiar with. They indicated this could help re-energize therapists as they are working with more difficult clients.

Coaching or Technical Assistance

Participants attended one-hour telephone supervision calls either every other week or monthly, depending on their group assignment. Therapists reported that the telephone calls were very helpful. They appreciated having a regular, scheduled time to ask questions of the expert and get immediate answers. Participants appreciated the positive, supportive manner of the expert. Most therapists indicated that listening to audiotapes of sessions was one of the most helpful components of the coaching. They appreciated hearing their colleagues implementing the techniques and valued receiving feedback from their peers. Individuals reported that it was difficult to share audiotapes and that it made them nervous to have others hear their attempts to use the techniques, but indicated that it became easier over time. Several participants acknowledged that there were technical difficulties hearing the audiotapes at times, and improving the audio quality would improve the experience. The availability of the expert supervisor by e-mail outside of scheduled calls was also identified as very helpful.

Some participants suggested that coaching sessions might be less frequent right after training, as therapists were enrolling youth. They indicated that the frequency could increase at the point that participants had more cases to share on the calls. Participants had mixed feelings about meeting via teleconference. Some individuals felt that it was a convenient method of consultation and liked that they did not need to leave their office. Others felt that face-to-face coaching would have been preferable. Several suggestions were offered, including meeting face-to-face initially to build cohesion as a group and then moving to teleconference as well as alternating teleconferences with the expert and face-to-face peer coaching. Videoconferencing was another suggested format.

When participants were asked about potential changes to the coaching model, a number of suggestions were made. One individual suggested having each call focused on a specific topic (e.g., assessment, psychoeducation) and tailoring the case presentations to that treatment component. Another suggestion was to have only one case presented on a call so that a more in-depth discussion could occur. Several individuals commented that they would have liked more direct supervision on implementing TF-CBT with young children, and did not feel fully prepared to treat this sub-population.

Screening and Assessment

Most therapists indicated that trauma experiences were not routinely screened for and would frequently come up after several initial sessions. This led to a delay in initiating TF-CBT. Some therapists indicated that it would have been helpful to have the information at the initial phone screening so that the family could be directed to the appropriate provider. Participants had varying degrees of comfort and familiarity with assessment tools. Although some providers already used one or more of the trauma-related measures, most reported they do not routinely use any of these scales. Some individuals found the scales to be helpful in treatment planning and measuring response to treatment. However, the majority reported that they really did not use the scales clinically. Although a few individuals were open to more training regarding the use of trauma-related assessments, most report they would not regularly use them within their clinic and had minimal interest in training.

TF-CBT Treatment Model

All participants who were interviewed reported that they felt the treatment model was helpful with some families. Many of the responses regarding the most appropriate youth and families to receive TF-CBT varied by provider and agency. Some individuals felt that TF-CBT was most appropriate for children with good verbal skills, especially those over 5 years of age. Others reported that the model was particularly useful for younger children because of the use of activities to engage children in the therapeutic process. Some therapists indicated that the model was best for children who had experienced a trauma in the past, but were not actively experiencing the trauma at the time. Some suggested that children need to be experiencing lots of symptoms related to the trauma to benefit from the model. Others indicated it was most helpful when the family or youth indicated that the traumatic experience was the presenting problem, rather than families seeking counseling for other purposes. Some therapists indicated it was helpful for the child to be stable on medication (if necessary) and for safety issues, such as suicidality or substance abuse, to be addressed prior to starting TF-CBT. Responses were mixed about whether the model was helpful for youth with minimal symptoms, with some therapists indicating that the components did not seem relevant to some children with mild symptoms and other therapists feeling these children benefited too.

The stability of the home environment was felt to be an important consideration in selecting a child for TF-CBT. Therapists found that parent support and engagement was a key factor in successful treatment. They indicated that it was important for the youth and families to be patient in the beginning of therapy, when improvements may be minimal or symptoms may even worsen. They highlighted the importance of families keeping regular appointments and working through assignments. Therapists reported that

they had difficulty using the model when youth had little family support or stability at the home. In fact, some providers found it easier to provide treatment while the child was in a structured group setting and more difficult when they returned to their home. It was noted that it was sometimes difficult to keep the youth within the community for enough time to see progress in the treatment. In addition, families who were experiencing significant crises, including severe behavioral problems, were identified as less successful in the treatment. Therapists noted that it was difficult to balance addressing the immediate crisis and progressing through the treatment components.

Therapists reported that relaxation and identifying feelings components were generally very helpful. Some individuals reported that younger children had difficulty with cognitive coping components and may be less able to grasp the relationship between thoughts, feelings, and behaviors. Several individuals indicated that the psychoeducation component was sometimes a struggle. For some, they felt that presenting psychoeducation early in the treatment was counterproductive for some families and noted that they had difficulty hearing/accepting this information. Others noted that psychoeducation did not fit well with families' expectations of their services. Individuals also noted that more emphasis could have been given to changing maladaptive thoughts, as this was difficult for youth across the age span.

Although they generally appreciated the flexibility of the TF-CBT model, therapists reported the need to make some modifications. Some therapists reported that they needed to progress very slowly through the model or revisit previous components with some youth and families. It was noted that this was particularly true in the school setting, where the child must manage their emotions before returning to class. Some therapists reported including more experiential activities, such as art activities, within the treatment process. In some cases, participants reported they needed to meet more frequently than once per week or to spend time enhancing the child's support system. They indicated that this was important in order for the child to begin to address the trauma experiences. Some participants noted that they had little access to caregivers, especially if the child was seen in a non-clinic setting, and that they needed to conduct caregiver sessions by telephone. Providers also indicated a need for the workbook materials to be made available in Spanish.

Organizational or Policy Barriers

Several agencies struggled with making changes to the organization that would support TF-CBT implementation. Most notably, several agencies did not traditionally provide services in an individual format. Providers indicated it would be more practical to provide the treatment in a group format, including modifying the trauma narrative component to allow for sharing of the trauma story within a group. Finding the resources and time to provide individual treatment was noted as a difficulty. As indicated previously, most agencies had difficulty identifying youth appropriate for TF-CBT and having them directed to a trained therapist. In some agencies maintaining wait lists, there was no mechanism to ensure that a child needing TF-CBT would match to a trained therapist at the right time. In other agencies, the trained therapists worked within specific programs, and children in other programs may have little or no access to the treatment. Referrals between agencies also posed a barrier to ensuring families could receive on-going treatment with TF-CBT.

Therapists noted the importance of additional time for preparing for sessions to their ability to implement TF-CBT. They indicated when the agency was unable to allow therapists more flexibility in the schedule, implementation was problematic. Some participants noted that organizational policies that required families to be discharged from treatment after missed appointments could be problematic. They indicated that youth or families sometimes missed more appointments when addressing the trauma, and discharging them from care was a concern. In general, agencies did not report significant financial barriers to providing TF-CBT, other than those involved in individual sessions. However, it was noted that insurance companies generally did not allow for billing 1.5 hour sessions, so modifications to the length of sessions was necessary. Several agencies reported that they met as a team to address organizational barriers and provide support; others noted that this would have been helpful.

Sustainability

Most participants indicated that they or their agency planned to continue to provide TF-CBT. Several noted that they would continue to utilize components of TF-CBT, but may not continue to utilize with the same degree of fidelity that they did during the pilot program. Participants acknowledged that continued training efforts would be helpful in sustaining the program, and suggested reviewing the online training, annual refresher courses, and brief workshops on specific techniques (e.g. safety planning). In addition, participants suggested that opportunities to network with peers would be useful, with ideas including peer supervision groups, online community or message board, and groups to discuss cases and readings. Lastly, continued access to supervision and ongoing support from the expert were suggested.

Appendix A

Building Resiliency after Trauma Debriefing Meeting

- I. Welcome and Introductions
 - a. Meeting Goals

- II. Review of Preliminary Evaluation Data
 - a. Data Highlights
 - b. Next Steps
 - c. Discussion

- III. Project Feedback
 - a. Planning and Readiness
 - b. Therapist Training (Website, Workshop, Manual)
 - c. Therapist Technical Assistance
 - d. Assessments and Research Activities
 - e. Treatment Model Appropriateness
 - f. Organizational or Policy Barriers
 - g. Support Needs for Sustainability

- IV. Wrap-up
 - a. Next Steps
 - b. Recognition