CLINICIANS' PERSPECTIVES ON THE EFFECTIVENESS OF TRAUMA - FOCUSED COGNITIVE BEHAVIORAL THERAPY WITH AFRICAN AMERICAN CHILDREN: A QUALITATIVE STUDY

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CLINICIANS’ PERSPECTIVES ON THE EFFECTIVENESS OF TRAUMA - FOCUSED COGNITIVE BEHAVIORAL THERAPY WITH AFRICAN AMERICAN CHILDREN: A QUALITATIVE STUDY

A Clinical Dissertation presented to

The University of San Francisco
School of Nursing and Health Professions
Department of Health Professions
Clinical Psychology PsyD Program

In partial fulfillment of the requirements for the degree of Doctor of Psychology

By

Jada Carter
June 2022
DEDICATION

To my Mom, Grandma, family, and ancestors – Thank you for always supporting me with what seemed like an impossible journey and providing me with love, wisdom, and motivation.

To Skylar, Sean, and Story– May you forever reach towards your dreams even if they feel unattainable. Always remember that you are Black excellency.

To all my clients – Thank you for allowing me to witness your stories and vulnerabilities. You all continue to inspire me.

“‘I’ve learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.’”

-Maya Angelou
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ABSTRACT

Literature exploring clinicians’ perspectives on the effectiveness of trauma-focused cognitive behavioral therapy with African American children who suffer from trauma-related disorders is very limited. The current study examined clinicians’ perspectives on the TF-CBT model when utilized with this population, including their experiences working with African American children and families with observable types of trauma-related disorders. This research study also explored the various facets of trauma that African Americans encounter in childhood and the barriers that prevent them from receiving adequate mental health care. Thematic analysis was utilized to explore themes that emerged when treating African American children with TF-CBT. Five major themes surfaced from the data: experiences working with African American children and families; effective components of TF-CBT; hindrances to treatment unrelated to TF-CBT; addressing cultural mismatch; and tailoring the model to address client needs. The findings reveal what clinicians find to be effective in the current state of the TF-CBT model, such as the structure and method to address trauma-related symptoms, as well as ways they alter the treatment to best serve their clients’ needs. Participants also described the challenges they face when treating this population and the barriers they attempt to overcome that TF-CBT itself is not designed to address. In addition, the incorporation of the family system in treatment showed the importance of community and cultural understanding to promote healing for African Americans. The overall outcome of this study found that TF-CBT, without culturally responsive adaptations, is not effective on its own for treating African American children.
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PsyD Clinical Dissertation Signature Page

This Clinical Dissertation, written under the direction of the student’s Clinical Dissertation Chair and Committee and approved by Members of the Committee, has been presented to and accepted by the faculty of the Clinical Psychology PsyD Program in partial fulfillment of the requirements for the degree of Doctor of Psychology. The content and research methodologies presented in this work represent the work of the student alone.

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CHAPTER I
INTRODUCTION

Statement of the Problem

African Americans constitute 13.3% of the United States population and the rates of mental illnesses among this population are similar to those of the general population [APA, Mental Health Facts, 2017]. Various disparities exist in terms of their access to quality mental health care. For instance, African Americans often receive poorer quality of care, lack access to culturally competent care, and are less likely to be offered evidence-based medication therapy or psychotherapy [APA, Mental Health Facts, 2017]. African Americans face multiple risk factors that hinder their access to care, including poverty, homelessness, low education levels, inadequate health care, and high levels of imprisonment (Carter, 2007). These risk factors have resulted in intergenerational problems that negatively impact the family system and transfer down to African American children (Mullen-Gonzalez, 2012).

African American children’s exposure to interpersonal trauma, community violence, and culturally motivated injustices are correlated to both immediate and long-term mental health impairment (Gray, 2017). Over 25% of African American children exposed to violence meet criteria for posttraumatic stress disorder (PTSD), yet this population is less likely to seek treatment due to the stigma and misunderstanding of mental illness in the African American community (National Alliance on Mental Illness, 2009). Research has proven the adverse effects of childhood trauma and its long-term impact on psychological, interpersonal, and cognitive functioning (Gray, 2017). Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based practice that has been proven to treat children and families, who have significant trauma-related problems (Cohen et al., 2018). There is an overwhelming gap in the research on
TF-CBT’s effectiveness on African American children and families. To date, two studies exist that propose a framework to integrate culturally competent strategies into the TF-CBT model to promote African American healing and psychological wellness. TF-CBT certified psychologist, Metzger et al. (2021) proposes a framework to integrate racial socialization into the PRACTICE components of the TF-CBT. While professors, Phipps and Thorne (2019) proposed a community-based TF-CBT model for African American youth between the ages 12-14. As an attempt to bridge the research, this researcher will explore themes that emerge in a sample clinicians’ who use Trauma-Focused Cognitive Behavioral Therapy with African American children who have experienced trauma.

The remainder of the chapter that follows critically reviews contemporary literature regarding childhood trauma and the efficacy of TF-CBT. Initial sections discuss the disparities and barriers in mental healthcare for African Americans as a means to highlight the importance of culturally sensitive treatment for this population. In addition, various types of trauma, such as PTSD, complex trauma, and intergenerational trauma amongst African American children and families will be examined. The general effectiveness of TF-CBT and other trauma-informed modalities for treating trauma symptoms in children will be described and explored. The review concludes with a summary and critique of existing literature, followed by a discussion of the specific research question and hypotheses suggested by the review and examined in this dissertation.

**Purpose of the Study**

The present study will use a qualitative approach to examine the effectiveness of Trauma-Focused Cognitive Behavioral Therapy with African American children who have experienced trauma living in California. The specific aims of this project were:
1. To conduct qualitative research, including in-depth interviews, with clinicians to explore themes that emerge when treating African American children with TF-CBT.

2. To highlight the various facets of trauma that African Americans encounter in childhood and the barriers in place that prevent them from receiving adequate mental health care.

3. To promote awareness of issues related to implementing evidence-based practice to African American children.

4. To identify common themes in delivering evidence-based practices when culturally congruent modifications are ensued.

**Definition of Terms**

Various terms will be used and defined throughout this research study. However, the more common definitions specifically related to the research topic, clinicians’ perspectives on the effectiveness of TF-CBT with African American children will be presented in this section. Given the interchangeability of the ethnic identities of “Black and/or African American,” usage in the United States, both terms are used to represent Americans of Black African descent (Merriam-Webster, n.d.). Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based practice that has been proven to treat children and families, who have significant trauma-related problems (Cohen et al., 2018). In this study, the terms “child/children” will represent children from ages 3-18, due to the TF-CBT model proving to be effective and appropriate for children within this age range (Cohen et al., 2018). Lastly, while the DSM-5 defines PTSD as “exposure to actual or threatened death, serious injury, or sexual violence” (American Psychiatric Association, 2013, p.), this definition does not encapsulate the lived experiences of African Americans. Therefore, the use of the words trauma, trauma-related disorders, and traumatic experiences will include: racial trauma, victim or witness to community

**Research Questions**

1. What are the unique experiences of working with African American clients?

2. What components of the TF-CBT model did clinicians find effective when working with African American children?

3. Did clinicians’ cultural identities impact client care? If so, how did they address these cultural differences?

4. What strengths, improvements, or adaptations were made or observed when clinicians utilized TF-CBT with African American children?
CHAPTER II

LITERATURE REVIEW

Mental Health Barriers and Disparities

Mental health disparities are a prolonged public health concern in the United States, in particular with individuals from minority populations in comparison to culturally dominant populations. Specifically, empirically based data proves that African Americans underutilize medical and mental health services when compared to other ethnic groups due to historical misdiagnosis, healthy cultural mistrust, inadequate treatment, cost of care, and provider’s cultural bias (NAMI, 2009). These social determinants influence the delivery and treatment of mental health care to the African American community. According to Kuwaii-Bogue et al. (2017), African Americans are disproportionately vulnerable to mental illness due to their overrepresentation in socially and economically marginalized groups. As it currently stands, African Americans continuously encounter impenetrable obstacles trying to obtain effective mental health services. Burkett (2017) describes these hindrances as a maze of obstacles built of systemic oppression, institutional inequalities, and structural disparities.

The construct barriers, is made in reference to both personal and structural justifications for ethnic minorities’ reluctance to seek services and complete mental health treatment (Burkett, 2017). These personal characteristics include stigma, self-reliance, and cultural differences from the provider, while the structural attributes are transportation, location, and finances. If an African American client proceeds through the pre-existing personal and structural barriers and is able to access a provider, they are still at risk of encountering additional barriers to receiving adequate mental health care. Upon accessing care, this population can face misdiagnosis, insufficient specialty and preventative care, a loss in social support, and disempowerment during
the treatment process (Kuwaii-Bogue et al., 2017). These clinicians, Kuwaii-Bogue et al. (2017), advocate for a culture-specific integrated care framework to minimize barriers, which include cultural competency trainings, family and client psychoeducation, transportation and childcare services, and relationships between active social supports in African American communities, such as the church, and mental health facilities to provide effective and collaborative care.

**Trauma Among African American Children**

**Historical Trauma.** Trauma plays a longstanding role in the history of the developmental and collective identity of African Americans. Historical trauma can be defined as a shared collective memory of a particular cultural group (Burkett, 2017). Slavery, segregation, and systemic racism have been inculcated in the collective memories of African Americans (Burkett, 2017). Historical contexts, such as slavery, continues to negatively impact African Americans.

There is little in slavery that was not traumatic: the loss of culture, home, kin, and attendant sense of self, the destruction of families through sale of fathers, mothers, and offspring, physical abuse, or even witnessing the castration of a fellow slave. Yet subjugation was its most heinous aspect, as it sought nothing less than annihilation of that which is uniquely human – the self. (Gump, 2010, p. 48)

The end of slavery did not end the psychological detriments that still plague African Americans today. The impact of slavery on African Americans “reached far beyond the plantation, affecting the entire culture, and not just for some circumscribed period, but until the present moment” (Gump, 2010, p. 46). These events continue to impact the mental health of their descendants; substance abuse, loss of cultural identity, and significant mental health effects are noted (Goodman & West-Olatunji, 2008).
Childhood Trauma. Various childhood trauma impacts all domains of functioning, including affective, cognitive, behavioral, interpersonal, and social (Cohen et al., 2018). Childhood trauma is inherently complex and trauma responses are not limited to one diagnostic entity such as posttraumatic stress disorder (Cohen et al., 2018), therefore, the researcher will explore various traumas beyond the amplitude of PTSD. The numerous types of trauma, but not exclusive, amid this population are: racial trauma, victim or witness to community violence, system-induced trauma, intergenerational trauma, witness to domestic violence, childhood abuse, traumatic grief, and complex trauma (National Child Traumatic Stress Network, 2016). In relation to this study and the pervasive barriers and disparities that African Americans encounter in mental health care, it is paramount to highlight intergenerational and complex trauma.

Jacobs and Davis (2017) break the definition of intergenerational trauma into two different but connected experiences. The first definition is “race-based traumatic stress, societal trauma, racist incident-based trauma, emotional abusiveness, and racism” (Jacobs & Davis, 2017, p. 201). The second component is the psychodynamic notion of the intergenerational transmission of trauma – suggesting that behaviors, healthy or unhealthy, that are learned as adaptations to traumatic experiences are passed down from one generation to the next (Jacobs & Davis, 2017). Complex trauma, as defined by the National Child Traumatic Stress Network (2016, p. 2), is “children’s exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide ranging, long term impact of this exposure.” African American children are at high risk of being exposed to complex trauma. In parallel, these children and families are forced to cope with intergenerational and historical trauma (National Child Traumatic Stress Network, 2016).
For the current study, clinicians who have utilized trauma-focused cognitive behavioral therapy with African American children were interviewed. Their stories, perspectives, and observations were analyzed to explore the effectiveness of TF-CBT. The remaining sections of this literature review examine existing treatments that can presently support trauma-focused interventions. Lastly, the reviewed limitations of the following studies will illuminate the insufficient amount of research on African American childhood trauma and culturally sensitive interventions.

**Traditional Trauma Treatments**

It is recommended that evidence-based practice serve as first-line interventions when treating ethnic minority youth, especially those identified as potentially efficacious with this population (Huey & Polo, 2008). The traditional and prominent evidence-based practices will be defined as highly utilized interventions with strong empirical backing to address the psychological effects of trauma for various populations. The traditional trauma treatments include: Cognitive behavioral therapy (Mendelsohn, Herman, Schatzow, Coco, & Kallivayali, 2011; Novaco, 1996), Eye Movement Desensitization Reprocessing (EMDR; Shapiro, 2000), psychodynamic psychotherapy (Horowitz, 2001), process-oriented group psychotherapy (Makler, Sigal, Gelkopf, Kochba, & Horeb, 1990; Yalom, 1995), Dialectical Behavior Therapy (DBT; McCain & Korman, 2001), and Prolonged Exposure (Zandberg, Kaczkurkin, McLean, Rescorla, Yadin, & Foa, 2016). The unconventional evidence-based practices will be defined as interventions that are less utilized and empirically validated. These unconventional modalities that were examined with ethnic minority youth populations, include: Resilient Peer Treatment (Fantuzzo, Manz, Atkins, & Myers, 2005), the Fostering Individualized Assistant Program (FIAP; Clark et al., 1994), and Cognitive-Behavioral Intervention for Trauma in Schools
Given that there are various forms of trauma and PTSD treatment interventions, not all have been found to be equitably effective particularly with African American youth. Nor did all of the studies of these treatments include African Americans, leading to bias in the research. Ultimately, it is the clinician’s role to determine the best form of treatment for their client.

**Cognitive Behavioral Therapy (CBT).** Cognitive therapy composes exposure therapy, cognitive processing therapy, and CBT (Resick & Schnicke, 1993) with the intention to help traumatized clients develop their coping skills when confronted by internal and external cues which trigger their distress, leading to avoidance and associated negative thoughts (Mendelsohn et al., 2011; Novaco, 1996; Tucker & Trautman, 2000). This modality was originally created for women who were survivors of rape (Resick & Schnicke, 1993) and targeted five schemas by noting primary cognitive distortions: safety, power, trust, control, self-esteem, and intimacy (Resick, 2001).

Cognitive behavioral therapy, in relation to PTSD symptoms, focuses on monitoring and reducing the strong emotions that affect interpersonal relationships, such as anger (Novaco, 1996; Mullen-Gonzalez, 2012). CBT interventions assist traumatized individuals in restructuring their negative cognitions by altering their attention and focus (Mullen-Gonzalez, 2012). Relaxation techniques such as guided imagery, muscle relaxation and breathing focused relaxation are utilized as a means to monitor the frequency, intensity and triggers of anger for individuals suffering from PTSD (Mullen-Gonzalez, 2012).

**Eye Movement Desensitization Reprocessing (EMDR).** Eye Movement Desensitization Reprocessing teaches clients to focus on their traumatic memories while following the therapist’s lateral or vertical hand movements, allowing the client to access their
information processing system (Shapiro, 2000). According to Shapiro (2000), the client focuses on the most disturbing detail of the traumatic event and is then encouraged by the therapist to verbalize their cognitive or emotional connections, thus allowing the brain to heal via the metabolization of the trauma and its associated thoughts and feelings (Shapiro, 2000). During EMDR, traumatic memories are interrupted by alternating stimuli and the associations to the memories that arise in response to the stimuli, thus asserting that intermittent exposure to feared stimuli will decrease anxiety with associated stimuli opposed to exposure therapy, which asserts that intermittent exposure to feared stimuli will increase anxiety (Shapiro, 2000; Mullen-Gonzalez, 2012). Literature on EMDR supports the efficacy of the treatment in reducing PTSD symptoms however, it is not as effective as exposure-based interventions (Davidson & Parker, 2001). Various studies have been conducted comparing EMDR’s effectiveness with children to CBT and TF-CBT, with EMDR achieving better or equal results to the compared interventions (Shapiro & Brown, 2019). De Roos et al. (2011) conducted a study comparing CBT and EMDR treatments in disaster-exposed children from various ethnic backgrounds in the Netherlands. The study did not specify which specific ethnicities were included in the sample. They found that both treatments produced significant reduction in children’s symptoms with the results being maintained at the 3-months follow up (De Roos et al., 2011). Moreover, symptom reduction was attained in fewer sessions using EMDR in comparison to CBT interventions (De Roos et al., 2011).

**Psychodynamic and Psychoanalytic Psychotherapy.** Psychodynamic psychotherapy provides various perspectives on which specific psychodynamic approach is most efficacious to the treatment of PTSD and trauma related symptoms. The most common theme amongst these perspectives is examining the individual’s meaning of their traumatic experience (Mullen-
Gonzalez, 2012). A brief psychodynamic psychotherapy for PTSD was developed by Horowitz (2001), which involves bringing conflicts to the conscious mind. In this specific model, there is an exploration of maladaptive interpersonal patterns that may have resulted from the trauma (Mullen-Gonzalez, 2012). Therefore the therapist and client explore the cognitive and emotional elements that are withheld from awareness, with transference and countertransference being used as a tool to develop perception into relational patterns (Mullen-Gonzalez, 2012). Interpersonal patterns in the client’s childhood experiences, transference during sessions, and their coping skills for the trauma could be all connected via a specific link (Krupnick, 1997).

Midgley and Kennedy (2011) conducted a review that systemically reviewed the effectiveness of psychodynamic psychotherapy for children and adolescents, with no specified ethnic background. Their findings on children who have experienced maltreatments, trauma, and neglect revealed various studies that demonstrated psychodynamic interventions to be effective. One study by Heede et al. (2009) studied the effect of psychodynamic milieu therapy on a mixed group of children with histories of severe trauma. Their participants showed improved scores on projective and intelligence tests, such as the WISC, as well as improved self-confidence, self-reflection, and positive expectations of others after two years of treatment (Midgley & Kennedy, 2011; Heede et al., 2009).

**Process-Oriented Group Therapy.** Process-oriented group therapy provides clients with PTSD or trauma related symptoms the opportunity to explore interpersonal themes and dynamics within a group setting (Makler et al., 1990). A therapist can interpret the client’s relational dynamics within the group interactions to lead to possible themes transpiring in relationships in their everyday life, which in turn can assist the client to experiment with more healthy and adaptive interpersonal communicative styles (Makler et al., 1990). Foy et al. (2000) found that...
process-oriented group therapy was empirically validated in the reduction of PTSD symptoms. A review of group therapy clinical trials for adults by Foy et al. (2000) found that group psychotherapy reduced the symptoms of PTSD, distress, dissociation, depression, and fear. Foy, Eriksson, and Trice (2001) found that all groups, regardless of the theoretical orientation, reduced distress amongst individuals who have suffered from trauma related symptoms.

**Dialectical Behavioral Therapy (DBT).** Dialectical Behavioral therapy was originally created as an intervention for individuals who are diagnosed with Borderline Personality Disorder (Mullen-Gonzalez, 2012) with the intention to master conflicting dialects: (a) vulnerability versus invalidation, (b) active passivity versus apparent competence, and (c) unremitting crises versus inhibited grief (Linehan, 1993). The main objective of DBT is to create a “dialectical balance” with a concentration on change and accepting the status of what is (Mullen-Gonzalez, 2012). This balance is taught through the utilization of mindfulness, interpersonal effectiveness, distress tolerance, and emotional regulation (Linehan, 1993) via individual and group psychotherapy, skills training, and if necessary telephone consultation (McCain & Korman, 2001). DBT’s aims for patients with PTSD are to (a) reduce the individuals’ fear of trauma-associated primary emotions, (b) question their secondary emotions, and (c) accept the trauma facts (Steil et al., 2011).

Various studies have supported the efficacy of DBT as a treatment for individuals who have suffered from severe and complex trauma. Zlotnick et al. (1997) and Cloitre et al. (2002) compared the effectiveness of DBT interventions for a mixed group of women who survived childhood sexual abuse, which resulted in a significant reduction in affect-deregulation symptomatology. Steil et al. (2011) conducted a study using DBT to treat a mixed group of 29
women with chronic sexual abuse related PTSD and found that their mode of treatment reduced the PTSD related symptoms in the participants, based on pre- and posttest changes.

**Prolonged Exposure (PE).** Prolonged exposure therapy is a “trauma-focused, exposure-based treatment” originally developed for adults with PTSD who experienced various types of trauma (Rossouw et al., 2018, p.). PE has been dispersed internationally due to its empirically supported success, ease of brief training, and fruition in community settings (Rossouw et al., 2018). Prolonged Exposure for Adolescents (PE-A), which was adapted from PE, provides psychoeducation on the effects of trauma and assists youth to habitually confront trauma related memories and reminders (Zandberg et al., 2016). Zandberg et al. (2016) conducted a study to evaluate adolescents co-occurring emotional and behavioral problems after receiving PE-A or client-centered therapy (CCT) for PTSD in a randomized controlled trial. The participants consisted of 61 adolescent girls who sought treatment for sexual abuse in a community mental health clinic in Philadelphia, with 55.7% of the participants identifying as African American (Zandberg et al., 2016). The results of the study found that PE-A was more effective than CCT in reducing externalizing problems, while both treatments were similar in their ability to reduce internalizing symptoms (Zandberg et al., 2016).

**Unconventional Modalities**

**Resilient Peer Treatment (RPT).** Fantuzzo et al. (2005) found Resilient Peer Treatment (RPT) as a potentially efficacious peer based modeling intervention for maltreated, African American youth (Huey & Polo, 2008). Its aim is to “improve social competence among withdrawn, maltreated preschool children by creating routine, positive play experiences with peers, who evidence high social functioning amidst high-risk urban contexts” (Fantuzzo et al., 2005, p. 321). The study examined 82 maltreated and nonmaltreated socially withdrawn children
who were randomly assigned into both RPT and control groups. They found that RPT was superior to placebo in improving social behavior among African American youth who were considered socially withdrawn (Huey & Polo, 2008; Fantuzzo et al., 2005).

**Fostering Individualized Assistance Program (FIAP).** The Fostering Individualized Assistance Program (FIAP; Clark et al., 1994) is “an individualized case management intervention involving strength-based assessment, life domain planning, and help with linkages to family and community supports” (Huey & Polo, 2008, p. 281). The study on FIAP compared 132 children in foster care, with emotional and behavioral disorders, who were randomly assigned to the FIAP group or the standard practice control group (Clark et al., 1994). Results showed that FIAP was an effective model for neglected African American youth with behavioral or emotional problems, however, the results indicated that its effectiveness was not moderated by the youth’s ethnicity (Huey & Polo, 2008).

**Cognitive-Behavioral Intervention for Trauma in Schools (CBITS).** Cognitive-Behavioral Intervention for Trauma in Schools (CBITS; Stein et al., 2003) is a targeted weekly group intervention program for school children that have experienced a traumatic event and suffer from PTSD or trauma related symptoms. CBITS utilizes cognitive-behavioral techniques such as exposure, social problem solving and relaxation training (Huey & Polo, 2008). It aims to (a) reduce psychological reactions and decrease distress and (b) to promote resiliency factors to promote students everyday functioning (Jaycox et al., 2012). Stein et al. (2003) found this intervention to be effective among violence exposed Latinx youth with PTSD, as it was originally developed for that population, but since has been successfully implemented with inner city children from various ethnic backgrounds (Jaycox et al., 2012). CBTIS has been shown to
reduce PTSD symptoms and increase academic functioning all while maintaining flexibility to be used with minimal adaptations for various ethnic groups (Jaycox et al., 2012).

**Implications**

The analysis of the previously listed treatments was an imperative means to compare various traditional and nontraditional empirically based interventions used to reduce trauma related symptomatology. Some of these studies have been proven as effective methods in reducing the trauma symptoms amongst children; however, the more traditional treatments cumulatively fail as a whole to address the complex traumas and cultural and systemic adversities that African American children and families encounter. The nontraditional interventions specifically emphasize treating and healing this population amongst other minority communities, as evidenced above. While both traditional and nontraditional treatments are successful in treating trauma-related disorders, the nontraditional treatments that provide culturally competent care have proven to be successful in treating ethnic minority youth. Most of the research on TF-CBT acknowledges the limitations and scarcity in the literature on its effectiveness with minority children. Therefore, the focus of the remainder of this study is to address the gaps in research and literature on this treatment model and to examine themes that determine if it can serve as an effective intervention with African American children.

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

Trauma-focused cognitive behavioral therapy is a commonly used, empirically based treatment for significant trauma-related problems. The efficacy of TF-CBT has been documented in over 50 scientific studies, including 20 randomized controlled trials, proving to be a gold standard for treatment outcome research (Pollio & Deblinger, 2017). TF-CBT is a brief 12-16 session, cognitive-behavioral, resiliency-building, component and phase-based model for trauma
impacted children and their parents or caregivers (Cohen et al, 2018). According to Cohen, et al. (2018), TF-CBT is composed of nine core components that can be summarized by the acronym “PRACTICE” within three phases:

Phase 1, Stabilization Skills include the following components: Psychoeducation about trauma impact; Parenting skills to address children’s traumatic behavior responses and enhance support, understand and communication with the child; Relaxation skills to reverse physiological trauma responses; Affective skills to address emotional trauma dysregulation; and Cognitive processing skills to understand connections among thoughts, feelings and behaviors and generate more accurate and helpful thoughts. Phase 2 is Trauma Narration and Processing, which contains only one component, Trauma narration and processing, to describe and cognitively process the child’s personal trauma experiences. Phase 3, Consolidation, includes the following components: In vivo mastery to address overgeneralized fear and avoidance of innocuous trauma reminder; Conjoint child-parent sessions to enhance communication about the child’s trauma experiences and general parent-child communication; and Enhancing safety and future development to address these issues (Cohen, Deblinger & Mannarino, 2018, p. 47-48).

Due to trauma’s role in the loss of safety and sometimes, the loss of trust that the parent or caregiver can maintain their safety, the therapeutic relationship is central to TF-CBT to enable the child and parent to recover after trauma (Cohen et al., 2018). Over the course of treatment, both the child and parent or caregiver learn about the impacts of trauma, develop skills to narrate and process the trauma experience, and establish safety and healthy coping skills.

Children who experience sexual abuse, domestic violence, and/or multiple traumas are more susceptible to long-lasting negative impacts such as PTSD. The creators of TF-CBT, Cohen et al., (2018), initially focused on childhood sexual abuse, yet found that the children in their research studies experienced multiple other forms of trauma. They expanded their research to include other types of child trauma such as child traumatic grief, disasters, domestic violence and complex traumas (Cohen et al., 2018). Cohen et al.’s (2018) research demonstrates that children from various ethnic backgrounds are highly responsive to TF-CBT with several investigations documenting that 80% of children no longer met PTSD criteria at post-treatment.
Although no studies specifically examined African American children, according to Murray et al. (2013), multiple studies conducted in the United States and internationally have demonstrated TF-CBT’s broad applicability and acceptability among diverse therapists, children, and parents.

**Limitations of TF-CBT.** TF-CBT is a proven treatment that addresses the needs of children who experience child abuse and other forms of child trauma. However, cultural differences, the client-therapist relationship, and barriers to service must be addressed to reduce childhood trauma symptoms. Furthermore, researchers encourage future research on improved, culturally competent, and developmentally appropriate methods for TF-CBT (Cohen et al., 2018). While TF-CBT is empirically supported in the reduction of PTSD and trauma related symptoms, it is imperative to regard the treatments’ limitations for this study. The foremost notable element is that Cohen et al., (2018) researched treatment for children who experienced sexual abuse and not other various forms of trauma. After realizing the limitations in only treating sexual abuse, they expanded to other trauma-related disorders (Cohen et al., 2018). This in turn has led to the majority of research on TF-CBT to focus on efficacy on sexual abuse.

Michelson (2010) conducted a research study examining therapist’s perspectives on the effectiveness of TF-CBT in treating children with complex trauma. This researcher used the qualitative method of grounded theory analysis in order to create a theoretical understanding of the effectiveness of TF-CBT. Michelson (2010) interviewed twelve female graduate level therapists who were all professionally trained in TF-CBT through their specific agency of employment in the Northeast. The participants in the study noted that there needs to be more research that specifically looks at trauma in Black and Latinx families and the traumatic impact of community violence. Additionally, the challenging themes that arose were: (a) an unrealistic time frame to complete the TF-CBT model from start to finish, (b) the limitations in its use with
children with developmental delays, and (b) the resources, materials and costs to properly execute the TF-CBT model (Michelson, 2010). Within the first theme, the majority of the therapists stated that it was unrealistic to complete a case with the given TF-CBT time frame (Michelson, 2010). The two main obstacles they faced while trying to stay within the time frame were keeping the parents or caregivers engaged with the model as missed sessions were a common setback and the caregiver’s own trauma history serving as a main barrier to a timely completion of the model (Michelson, 2010). The second theme highlighted the treatments’ limitations, as it requires the child to possess certain developmental and cognitive abilities, thus making the structure of the model challenging for both the therapist and client (Michelson, 2010). Lastly, in order to allow the continuation of the model, it is required for therapists, supervisors, and agencies to attend trainings and maintain ongoing supervision, which requires time and financial resources (Michelson, 2010).

**Clinical Relevance**

Limited studies exist that specifically explore TF-CBT’s effectiveness with African American children. However, the following studies examine TF-CBT’s role as an intervention for ethnic minority children who have experienced trauma. Gibbs (2013) examined the effectiveness of an integrated trauma focused model that was evaluated by an expert evaluation panel, on African American children suffering from trauma. His integrated model included TF-CBT, trauma-focused art therapy (TF-ART), and Afrocentric psychotherapy (ACP) with the aim to (a) increase the client’s ability to differentiate between safe and dangerous situations, (b) develop coping skills, and (c) alter the client’s perception of the trauma experience and themselves. Gibbs (2013) found that the judges’ analysis supported this model to be a strength-based treatment due to its culturally specific components.
Navarro (2016) conducted a qualitative study examining clinicians’ attitudes on the effectiveness of TF-CBT amongst Latinx children suffering from PTSD and trauma related symptoms. The purpose of this study was: to gather data on clinicians’ perspectives on the qualities that make a competent therapist, to examine the meaning of cultural sensitivity, to understand the experience of working with Latinx clients, their confidence utilizing TF-CBT, and clinicians’ perspectives to how culturally sensitive TF-CBT is with the Latinx population. Navarro (2016) used thematic analysis to analyze the data collected on five clinicians who all identified as a person of color – Latina, African American, and Southeast Asian. Primary themes that were found in relation to the participants’ experience working with Latinx youth included their investment in change and a familial bond. In response to the effectiveness of TF-CBT, two participants found it effective, two found it somewhat effective, while the last participant found it effective solely if a clinician has the competency to adapt it to Latinx clients. Lastly, when asked if TF-CBT is culturally sensitive to Latinx clients, three participants agreed while the other two disagreed. Overall, Navarro’s (2016) study found that clinicians had a positive attitude towards TF-CBT’s effectiveness with this population, however they stressed the vital importance of providing culturally sensitive treatment. Moreover, the results concluded that the study had a stronger emphasis on the power of the therapist opposed to the TF-CBT model (Navarro, 2016).
CHAPTER III

METHODOLOGY

Participants

The targeted population were masters or doctorate level mental health clinicians who worked in California with African American children who have experienced trauma, who had professional training in Trauma Focused Cognitive Behavioral Therapy (TF-CBT), and who have worked with at least one child or adolescent who identifies as African American. Clinicians from diverse ethnic backgrounds and identities were recruited to generate a variety of experiences in utilizing TF-CBT. The researcher screened 8 individuals, all of whom met the project’s inclusion criteria and were interviewed for the research project. Participants in this study were six cisgender women and two cisgender men, ranging in age and ethnic backgrounds, who were all practicing clinicians working in the state of California.

Sampling Methodology

Purposive and snowball sampling was used to recruit participants based on characteristics they possessed (i.e., clinicians trained in TF-CBT) to learn about their lived experiences (i.e., utilization of TF-CBT with African American children) based on the event of interest (Etikan et al., 2016). The researcher also used snowball sampling by utilizing participants as a referral source to recruit more participants. The main goal in participant recruitment was to ensure that the sample size was small enough to manage the material and large enough to provide a rich understanding of the experience of clinicians who used TF-CBT with African American youth (Fugard & Potts, 2015).

This study utilized targeted recruitment techniques. The researcher emailed clinicians listed on the national TF-CBT certification program website who were based in California. The
email contained a brief description of the study and requirements for participants. Potential participants were encouraged to email the researcher if they met the inclusion criteria to be formally screened. Participants were incentivized with a $20 gift card for their time and contributions.

Interested participants were asked to contact the researcher via email for the initial screening to assure eligibility. The screening tool (Appendix A), which was conducted via a phone call, included questions to ensure that potential participants had a masters or doctoral level degree, were professionally trained in TF-CBT, and have used TF-CBT with African American children who have experienced trauma. The researcher informed each participant of their eligibility and scheduled each interview via Zoom due to the researcher’s location based in Puerto Rico at the time of the interview process. The researcher requested their email address to share the Zoom meeting link, a reminder notice, and the consent form (Appendix B). The consent form was reviewed, electronically signed, and returned prior to the scheduled interview date. To protect the confidentiality of each participant, the researcher randomly assigned an alpha numeric code to serve as a safeguard preventing the disclosure of any identifying information. The semi-structured interviews consisting of the demographic questionnaire (Appendix C) and interview questions (Appendix D) took 45 minutes to 70 minutes to complete. Interview questions consisted of the participants’ experiences utilizing TF-CBT with African American children. Upon completion of the interview, each participant was invited to engage in voluntary snowball sampling by contacting colleagues who also met the inclusion criteria. The one participant who was recruited via snowball sampling received an email from myself about the study, was screened via phone, and was scheduled for a Zoom interview.
Procedures

The researcher screened potential participants via phone. During the screening process, the researcher informed participants of the purpose of the study, administered the screening tool, and once the participant was deemed eligible, a Zoom interview was scheduled based on participants availability. The researcher began each interview by informing participants about the nature of the study and their participation, and then obtained their written consent to participate. The first 10-20 minutes of the interview included demographic questions about the participant’s age, gender, ethnic and racial background, level of education, years of practice with African American clients, number of clients worked with using TF-CBT, and the number of African American clients worked with using TF-CBT. The remaining time consisted of semi-structured interview questions. The questions gathered information about the participant’s experiences using TF-CBT with African American child clients and their perspectives on the effectiveness of TF-CBT as a trauma-informed modality with this population. Upon completion of the interview, participants received a $20 gift card and were debriefed. A few of the participants declined the gift card stating their joy to participate in a much-needed research study.

Data Analysis

A thematic analysis framework, with its ability to identify themes, conceptualizations, and ideologies that theoretically shape the semantic content of data, was employed (Braun & Clarke, 2006). Recurrent patterns and themes within the data set were identified (Fugard & Potts, 2015) to shed light on therapists’ experiences using TF-CBT to treat various types of trauma-related disorders in African American children. Due to the lack of research on this specific topic, the researcher believed that a qualitative study would be most effective in supplementing the literature’s limited understanding of TF-CBT effectiveness with African Americans. The
researcher took a semantic approach to analyze the themes by reporting on the assumptions underpinning the data (Braun & Clarke, 2006). This project utilized Braun and Clarke’s six-step framework to conduct a thematic analysis to pull qualitative information from the research questions.

In Braun and Clarke’s (2006) first phase of analysis, the researcher familiarizes themselves with the data by transcribing the verbal data into written form via a transcription service, re-reading the content in an active way to become immersed in the data, and noting down initial ideas. The second phase requires the generating of initial codes, in which the researcher produces codes prior to post hoc themes from the data in a systematic fashion. In the third phase, the researcher searches for themes by collating codes into potential themes and gathering all the data that will be relevant to each chosen theme. In the fourth phase, the researcher reviews and refines themes in two levels: the first level requires the review of the level of the coded data extracts and the second level involves the same process with the entire data set to generate a thematic map. In the fifth phase of analysis, the researcher generates clear definitions and names for each theme and produces the final creation of the codebook before coding begins. In the sixth and final stage, the researcher produces a report that will tell the story of the data to validate the analysis. From this process, multiple themes explaining clinician’s experiences using TF-CBT with African American children were developed.

**Phase 1.** The researcher utilized Rev, a professional audio transcription service, to transcribe the recorded Zoom interviews. Each transcribed interview was reviewed and edited thoroughly while the researcher listened to the corresponding audio recording to ensure accuracy. Lastly, the researcher read the transcriptions to become immersed in the data and note ideas that emerged (Braun & Clarke, 2006).
Phase 2. Atlas.ti, a qualitative data analysis software was used to code the thematic data. The researcher systematically produced codes prior to post hoc themes by identifying repeated patterns of meaning in each transcript (Braun & Clarke, 2006).

Phase 3. After the research generated the initial codes, they examined which codes would clearly fit together to develop a theme. The researcher then identified the relevant data that fit best into a theme and subtheme.

Phase 4. During this phase, the researcher reviewed, modified, and developed the preliminary themes that were initially identified in phase 3 (Braun & Clarke, 2006). All relevant data to each theme was gathered and the researcher explored if all collected data supported the themes. Next, the researcher developed a written thematic map to understand the relationships between the themes and subthemes (Braun & Clarke, 2006).

Phase 5. The researcher identified the essence of what each theme was about by refining the themes and generating clear definitions and names (Braun & Clarke, 2006). The relationships between the themes and subthemes were examined and the final codebook was produced with specific definitions for each theme or subtheme (Braun & Clarke, 2006).

Phase 6. In this final phase, the researcher reported the findings from the thematic analysis in their research project, which is presented in the subsequent chapter (Braun & Clarke, 2006).
CHAPTER IV

RESULTS

Participants

Participants in this study were six cisgender women and two cisgender men who were all practicing clinicians in the state of California. All participants had experience utilizing TF-CBT with African American children. At the time of the interviews, seven participants were certified in TF-CBT and one participant received professional training in the model. They ranged in age from 29 to 60 years old, with a mean age of 41 years old. The participants are briefly described below. To protect their anonymity, the names of the participants have been omitted and alpha numeric codes (P1-P8) are used for reference. All demographic information was based on their self-report at the time of the interview.

- P1 is an Armenian female, aged 38, with a doctorate in Clinical Psychology. She is certified as a TF-CBT clinician and supervisor, attaining her certification during her post-doctoral training. Her last professional training was in 2014 and she was re-certified in 2020. She has been practicing as a licensed psychologist for eight years in residential and private practice settings. She has implemented TF-CBT to over 100 African American children on and off for the past ten years.

- P2 is a Mexican female, aged 34, with a masters in Marriage and Family Therapy. She is a certified TF-CBT clinician and supervisor, and her last professional training was a few months before this interview was conducted. She has been practicing as a licensed clinician for six years in community mental health and hospital settings. She has implemented TF-CBT to no more than ten African American children over the past ten years.
P3 is a White female, aged 60, with a masters in Marriage and Family Therapy. She is certified in TF-CBT as a clinician and supervisor with her last professional training in 2014. She has been practicing as a licensed clinician for 21 years in medically funded settings. She has implemented TF-CBT to one African American child throughout her career.

P4 is a White female, aged 29, with a doctorate in Clinical Psychology. She is a certified TF-CBT clinician. She has practiced as a licensed psychologist for a year and a half in both outpatient and inpatient settings. She has implemented TF-CBT to about five African American children over the past five years.

P5 is a White male, aged 57, with a doctorate in Clinical Psychology. He is a TF-CBT certified clinician with his last professional training being five years ago. He has practiced as a licensed psychologist for 14 years in community clinics, hospitals, private practices, and correctional facilities. He has implemented TF-CBT to African American children over the past five years.

P6 is a Latina female, aged 30, with a doctorate in Clinical Psychology. She was trained in the TF-CBT model during the two-day training, three years prior. She is unlicensed and has practiced in community mental health and juvenile hall settings. She has implemented TF-CBT to no more than 20 African American children over the course of two years.

P7 is a Latino male, aged 41, with a master’s in Social Work. He is certified as a TF-CBT clinician and supervisor, and his last professional training was a month before this interview was conducted. He has practiced as a licensed clinician for 13 years in
outpatient and inpatient settings, as well as with juvenile sex offenders. He has implemented TF-CBT to about 10% of his population over the course of 16 years.

- P8 is a White female, aged 39, with a masters in Marriage and Family Therapy. She is a certified TF-CBT clinician with her last professional training being a year ago. She has been practicing as a licensed clinician for seven and a half years in county mental health and private practice settings. She has implemented TF-CBT to about five African American children over the past 16 years.

Themes

Data analysis devised five overarching themes and twelve subthemes that encompass the participants’ experiences utilizing TF-CBT with African American children. See Table 1 for the list of themes, subthemes, and number of participants with each categorized theme. The succeeding themes distinctly depict the participants’ experiences in working with African American children and their families, participants’ perspectives on what they found useful in the TF-CBT model, the hindrances to treatment for the African American community that are not addressed in the TF-CBT model, how they addressed the cultural mismatch with clients, and how they tailored TF-CBT interventions to meet the needs of their clients. A comprehensive analysis for each theme will be described via direct quotes from each of the participants interview transcripts.
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<th>Subthemes</th>
<th>Number of Participants with Theme</th>
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<td>and Families</td>
<td>▪ Various Forms of Trauma Experienced by Families</td>
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<td>B. Effective Components of TF-CBT</td>
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Table 1. Master Table of Themes for the Group

Theme A: Experiences Working with African American Children and Families

The participants described their personal accounts of working with African American children and their families. Their experiences entailed two subthemes, which included the strengths they noticed in the family system, and the multifaceted forms of trauma experienced by this population.
Subtheme: Strengths in the Family System

Three of out the eight participants noticed the significance of the role of the family system in their work with African American children. Below are three of the quotes:

“So, when I went to see that one kid, I actually saw everyone because there was nowhere to go in the house, so it was like everybody’s coming together, sitting down and we’re working together, a team.” (P1).

“It was a joy to work with the families that I had a privilege of working with. I think that strength of family and the excited family, that that role plays in the African American community, I think was more prominent than the other families I worked in.” (P4).

“It seems, to me, if I’m making a generalized statement in working with African American population, the matriarch role, the grandparent role seems to be consistent. It seems like regardless of its boys or girls that I’m working with, they seem more comfortable sharing emotion with their moms or grandparents.” (P7).

Subtheme: Various Forms of Trauma Experienced by Families

Seven out of the eight participants reported the differing forms of trauma faced by their African American clients. The participants noted community violence, various forms of abuse, poverty, and systemic trauma. Below are six of the quotes:

“But a lot of the kids that came to me specifically were the ones who had complex trauma, so a multitude of traumatic events, community violence, domestic violence, sexual abuse, all in combination throughout their life cycles.” (P1).

“And so one thing with TF-CBT that I’ve learned is what we might think is the trauma, what we feel is the worst, worst part, and I’ve read awful stories of children being raped horrifically. Right, and I think that’s the worst part. When we get to the worst part and they’re trying a narrative, they’re gonna talk about that, right. And then they won’t. And they’ll talk about how they’re separated from their step sister, they’ll talk about being separated from their family, they’ll talk about the aftermath, that’s the worst part for them, not the actual abuse, and so... Same with kiddos. I might think because of their cultural background, they’re gonna be a certain way, and they won’t be. They’ll be so different, so I’ve kind of learned to just go in with open eyes, I go in with my education, with my knowledge, don’t lose it, but also don’t put it forefront.” (P2).

“They still have some pretty significant trauma events that were vivid and impacting them till this day as far as reacting to sirens and police cars and those kinds of things
were all connected to a pretty significant traumatic event with their domestic violence exposure, neglect, poverty and substance use exposure, all that in the background.” (P4).

“But just systemically how it’s just a bunch of Latinos and African-American males in there and just hearing their traumas and then it just makes sense like, Oh my gosh, it makes sense. Some of the things that you’ve lived and done, and then for them not to have the proper resources here, it’s just like a vicious cycle. And so that’s frustrating too, because... I don’t know, I just feel like... I just feel for my people of color...” (P6).

“So that one was probably the toughest because we know the legal system does punish minorities, African-American populations harsher. So they’re more likely statistically to get higher sentencing, harsher punishment. I’m not making that up, the data is there for that. So, I think, again, having a more global validation to that kind of like... Yeah, I was the one that introduced that saying, Hey, since you bring up race and that you felt like you were treated unfairly, the data to speak that globally. That’s true.” (P7).

“I don’t think I’ve ever worked with a simple trauma. Honestly, I don’t think maybe maybe one client, but one out of how many? So many. So definitely commercial sexual exploitation of children, so human trafficking, physical abuse, displacement from the home, multiple placements of living, incarceration. Severe emotional abuse. Car accident. Near fatal car accident. Oh, I forgot about him, a near fatal car accident. I’m like that number I gave you in the beginning, it’s like climbing of me remembering clients as I’m talking. A fire, a house fire. But I would say probably the majority has been physical abuse, neglect, displacement from home and human sex trafficking.” (P8).

Generational Trauma. Three of the seven participants also reported generational trauma that was presented in the family therapy sessions of the TF-CBT model and how they encouraged parents to receive individual treatment as a means of not interfering with the child’s healing process. Below are two of the quotes:

“So, it’s like these little ways in which we include the parents, but I definitely think that parents, oftentimes, they’re dealing with their own unresolved trauma. And so through this work, they get a little bit of healing for themselves too, and so sometimes there’s a lot of collateral meetings in which I really try to be careful that it’s not there to be for parent. Our collateral meetings are about the kid, but they’ll bring up their own stuff too often, and so I’m always kind of talking about how these skills that the kiddos learning can help them and also may be gently encouraging that they also get their own services and help. But I definitely see improvement with a lot of parents with this model.” (P2).

“I actually find that the adults actually absorb it a lot more, only because I almost feel like... In thinking about the cases that I’ve had where I’ve worked with moms and grandparents, and I can’t... In my mind, think about the dads per se, but I don’t wanna
exclude them all together. It’s almost like you’re giving them a context for their experiences from a generational standpoint, because they grew up old school and they grew up in a certain format and like, ‘Hey, that’s actually called generational trauma. And what you’re talking about there are triggers and flashbacks, and those experiences, even though they weren’t part of the direct comment we’re talking about, they’ve shaped how you absorb the global part of that conversation, even though there’s an individual response to it.’” (P7).

Theme B: Effective Components of TF-CBT

This theme details what the participants found the most useful in the TF-CBT model when specifically working with African American children and families. The majority of participants are certified in TF-CBT and reported utilizing the treatment across various cultural populations, thus having a robust comprehension in the distinctions amongst different ethnicities. Subthemes for Theme C included the use of the structure as a guide, components that address trauma symptoms, the incorporation of the family system, and indicators of symptoms reduction after TF-CBT treatment.

Subtheme: Use of Structure as a Guide

Four out of the eight participants reported that the structured format of the TF-CBT model served as a useful guide when working with this population. All four shared enjoyment in the model’s structure leading to their agreement in its efficacy.

“It’s just a great structured model. I think the structure is there, it is very effective.” (P1).

“I find it very, very successful. A really, really great model. I know that there’s a lot of push back from other clinicians that it’s a little bit too structured, it’s not as multicultural, but I disagree. I think that it’s been shown and researched and validated with many populations that it is structured, but it’s also open up enough that you can make it your own.” (P2).

“You know, I really like the model itself because of how structured it is, but it does allow for autonomy when it comes to how you implement it. So, the structure is in such a way that I feel like I can track it.” (P7).
“There’s a lot of ways that TF-CBT, I love TF-CBT, it’s great. I wouldn’t use it if I didn’t like it. I do believe that I like... I am a person who likes evidence-based practices only because I like some type of structure, and I also like to see that it actually works. That’s helpful for me.” (P8).

Subtheme: Components that Address Trauma Symptoms

Six out of the eight participants directly discussed how the TF-CBT model addresses trauma symptoms through its framework, that is organized by the acronym PRACTICE, to direct clinicians to specifically focus on the various ways that trauma impacts the child. Below are quotes from three of these participants:

“I’ve trained in CPT, PE, TF-CBT, CPP, trauma systems therapy. So, all of these trauma modalities and TF-CBT is the most effective across all cultural... It addresses cultural issues in the treatment, or you can incorporate it in there as well. So, now that I work with a lot of adults, I still use the TF-CBT with adults, so that’s how effective it is, and I’ve been trained in a lot of adult treatment modalities. Trauma treatment modalities and I still go to TF-CBT. So yeah, I think it’s highly, highly effective.” (P1).

“So, I think the biggest one is affective regulation and identification. Their ability to identify feelings and express feelings, also just developing safe coping skills. How to deal with triggers. A lot of times the clients will say, ‘Okay, I have enough improvement, I’m not at 100%.’ They’ve made enough and they feel like they can cope with any triggers in the future. I feel like a lot of times, they come out with so much more psycho-education, like their eyes are opened to what therapy can be, how it can be helpful, that it doesn’t have to be you on the couch, which is a real turn-off to a lot of people, and just that sense of self-efficacy and getting that sense of empowerment back, especially depending on the trauma. Sexual abuse survivors for sure, but also physical abuse, community violence. I think those are the main things that I’ve seen.” (P3).

“So, I think TF-CBT does really good, because the first part of it is just so focused on skills building and gradual exposure, so you don’t have to directly go into anything. So, I think it allows the stream, the psycho-education piece to really kind of offer our ability, to like look, even though I’m giving you the information, it’s really giving information to get information. How do you translate accessing law enforcement? How do you translate accessing school systems? How do you translate accessing the fire department? Housing, talking to your landlord, talking to your probation? You know. Some of the cases we see are CPS cases. What’s your process for dealing with Child Protective Services? And offering that ability to be able to work on skills building, so I really like the model.” (P7).
All six of these participants also alluded to how useful the trauma narrative component is and how it invokes a sense of creativity and empowerment in their clients. Below are quotes from five of these participants:

“And then the trauma narrative, kids get to be creative. So, whether it’s someone made a rap song, so we got to play the music and he rapped his trauma narrative. Another kid made a board game and each like level was the year of their life with the traumas included, which was really creative. And each person that was a family member was each person on the board, and all of the siblings were separated, so in the board game, they were all together playing this game. So just the creative aspects of it. And kids who are just amazingly creative more so than adults, because I’ve done trauma narratives with adults and I don’t wanna say they suck, but they kinda do versus kids who are a lot more expressive. And I think TF-CBT facilitates that creative process.” (P1).

“In each component, you find what works for that. You know, psychoeducation, that kid might really love handouts, that other kid might love videos, there is a part in the psycho education, one of the suggested interventions is the radio show. Right, and so you teach all the stuff about psycho education, and then you bring in a kid for a radio show and they’re gonna be the expert.” (P2).

“And so using that model of having a higher portion being on the beginning skills of the emotion regulation pieces, really understanding that with complex trauma that’s heavily affected. That trauma has pervasive effects and impacting the client’s ability to regulate their emotions. So, we spend higher time on those beginning prac skills, recognizing that complex trauma has big effects. And then when we got to the trauma narrative piece, and just as the treatment people recommend, we have them pick one trauma that they wanna go through first, and we really do the trauma narrative based on that trauma. Hopefully, we ask them to pick the most distressing trauma, but again, they can pick whatever trauma they want, and then at the completion of that, if they wanna go through another trauma narrative with the secondary trauma, they can do that a third trauma they can do that as well.” (P4).

“And continuing with the trauma work, she did just an incredible narrative, she also does rap and she’s very talented as far as writing raps, and so she did her narrative in the form of rap, and that was something for her that she was able to do. She was really able to express it in a way that was meaningful for her, and her grandmother who raised her, you know came in for the conjoint session with the trauma narrative. And it was just such a rewarding experience because to see the transformation, you know that really started with that crisis, where she started to trust and she started to you know go with it and do it full out.” (P5).

“There’s a study that was done about how important is to tell your story and give your experience, and that’s why I like that it has a narrative component, because there are other models that say, ‘Hey, we don’t go into that, we don’t process, we don’t re-process,
we don’t introduce the story... There’s other research saying that a narrative is pretty important, so I like that, and then the gradual exposure part of it, you’re offering micro-doses and then increasing that. I think that builds out people’s tolerance level to that discomfort that I think is necessary. Otherwise, how do you really know that they’re prepared to handle that next conversation or how they’re gonna deal with future issues? So, I again applaud those primary components to the model.” (P7).

**Subtheme: Incorporation of the Family System**

The participants reported the advantages that TF-CBT provides in using the family system in treatment as well as the importance of family dynamics in this population. Six out of the eight participants spoke to the model’s strengths in its use of parent or caregiver engagement and how it affected the relationships between the child, parents, and clinician.

“And so, coming from an attachment child-parent psychotherapy background as well, I don’t think that we can do treatment just with the kids because they’re gonna have to return back to the family. So, the family was included quite a bit in sessions.... And this is why parents were so open to having me there because they were participating in their treatment with their kids, and I would also use a lot of music in the treatments and in the coping strategies and interventions and parents would help with that too. So, there was one particular child who loved music, and so we had coping strategies with music, and we had a dance that we would do, and mom had to kinda know about some of this. One time she secretly recorded it and put it on Facebook with me dancing too and the child dancing. So, this was a whole family thing, so if I only saw one child, everybody did coping strategies and music and stuff.” (P1).

“TF-CBT... I just like it. I like it. I feel like it works well, I feel like kids really seem to enjoy the model and enjoy the different components, and it includes family work too, so families are learning it as well. They’re learning the skills that then they can help the kids practice and the narrative, like the narrative, that’s the hardest part. But when they share the narrative with the caregiver, and I see the caregiver respond appropriately and provide support, and that kid is just so vulnerable and just so exposed, but is getting the support they need. That’s magic. That really is, I talk about therapy, not being magic, but that’s magic, and so nothing else gets me riled up like that does, and so that’s why it’s TF-CBT for me.” (P2).

“With the African-American family that I’m thinking of that I did do TF-CBT with, it took a lot of collaterals, but she was, the mom was able to support and listen. And so, it was great, turned out great.” (P3).

“And I think the parenting skills, once we have the parents on board for the parenting skills, it was a huge difference for the parents to use less negative words, less commands, less instructions, less just like negative interactions with their kids... And so, starting to
create more compassion within that relationship with me to watch that unfold and to see how the kid just ate it up… To see how that changed the parents’ mood and affect, how it changed the way the parent viewed the child, all those things was really neat to see the parents starting to shift just a little bit in some of their parenting skills. Because parenting doesn’t come with a manual, and so there’s a lot of skills that most people gain huge amounts from with that approach.” (P4).

“Not necessarily sessions, but I would in juvenile hall, I really saw the benefit of including the family as well, not just the adolescent. So, we weren’t allowed to do family therapy, but we were allowed, and I saw this benefiting the family as a whole, just talking to the parents, offering them support or like asking them about what does so and so like. Getting more information, and the families really loved that, and I felt like it gave them a piece of mind like, yes, I don’t like that they’re in juvey, but there’s someone that’s trying to help. And we would get that, we would get feedback like, ‘Hey, these families are very appreciative of you contacting them.’ Because it’s like, okay, there’s someone in there that cares about their child.” (P6).

Four out of eight participants also endorsed the importance of the family system as a means of continuing treatment and skill building both inside and outside TF-CBT sessions.

Moreover, how participants utilize family members to create dialogue around cultural issues.

Below are quotes from four participants:

“So we kind of used the people around her being such positive role models and looking very diverse, and so we came up with a lot of social stories around that and aunt was very helpful in guiding that discussion too, because honestly, I’m not African-American. So how can I speak to this child about what she looks like on the outside when I don’t look like her either.” (P1).

“Both, so I tell my caregivers one of the biggest factors in knowing if a child’s gonna do well or be successful or be able to survive and thrive to this traumatic experience, is their caregiver support. How supportive is the family? If a family is supportive... That doesn’t guarantee anything I know, but it really sets the stage for much better work, for much better results for kids that feel better because they’re supported in their family. If kids are not supported by their family, it sometimes feels like, Look, we can do this for the, but they’re gonna go right back to dysfunction, they’re gonna go right back to being minimized, to being emotionally abused possibly. So that’s one the biggest biggest factors is the parent support.” (P2).

“So having parental involvement helps with the generalization of skills, but also because I think of the closeness between family members and the value that is placed on family members. That’s just a crucial, central part to daily living, extended and not extended family to have it naturally built into the TF-CBT module. That’s not something I had to
add or embellish on, that’s just a basic part of TF-CBT. I think that is built really well for this population.” (P4).

“We’re really honing in on the trauma aspect of it, and we identify in the model, a person that the youth identifies as being the person that’s gonna sustain them emotionally once they have that identified. We don’t really spend too much time about, why didn’t you pick someone else? So it just seems like... I wanna say in the majority anecdotally, 90% of the cases, it’s always gonna be like a mom or a grand mom. That’s gonna be the one that’s identified as the support person in the model.” (P7).

**Subtheme: Indicators of Symptom Reduction after TF-CBT Treatment**

Seven out of the eight participants reported how TF-CBT significantly reduced trauma symptoms. The participants shared the indications that their client’s trauma symptoms have decreased via changed behaviors, increased coping skills, ability to voice their emotions, increased vulnerability, and an overall sense of empowerment. In addition, participants shared the specific assessments they used to measure changes in symptoms, such as the UCLA PTSD index, the youth outcome questionnaire (YOQ), and the child and adolescent trauma screen (CATS).

“I focus a lot on awareness and education, psycho education and have another story. I have examples through stories. So this one child, she actually went on YouTube, and I don’t know how she figured out how to spell sexual abuse, but I did have her write it out quite a bit. And so, she looked for videos that talked about that, and she got educated on it for herself outside of sessions, and she wanted to share those videos with me, some of them were super helpful that I had never heard of before. This was an African-American child, and she like shared these videos and I was like, ‘wow, she’s doing homework outside of our sessions,’ and that to me was very impactful.” (P1).

“I also see kids changing their own language, they’re better at saying how they feel, so when they’re having those temper tantrums, they can scream like, ‘I’m frustrated.’ And it’s like, sure, they’re still screaming it, but at least they’re using their words. They’re using feeling words and it does. Just them saying, ‘I’m frustrated’ decreases how long the temper tantrum is. It can decrease the frequency in the temper tantrum, and so them learning those skills of how to cope with their anger or cope with these feelings that come up. I also talk about there’s no negative feelings, it’s just how do we allow our feelings to serve us, and if they’re no longer serving us, how do we cope with them? How do we ride through them in an effective way? So, sadness, anger, all those feelings are there for a reason, let them have their reason, and then let them serve you and then kind of come
through with them. So, a lot of kiddos have gotten so much better at coping with those big feelings, with talking more with their caregivers, and then just the goals being that there’s good progress on those goals. That’s how I know it’s working.” (P2).

“I was definitely skeptical when I first started, but I would say 99% effective. I would say with virtually all of the clients that I’ve used it with, that there’s been significant reduction of symptoms and they were able to be discharged from treatment.” (P3).

“I would say all clients who complete the course of TF-CBT that we’ve seen improvements. It’s just that, it’s the degree of improvement, how they navigate the improvements that varies. So, I think it really depends on the degree of trust we are able to establish and how fully they’re engaging and willingness as well. In particularly with young men, as far as being able to address things that are gonna bring up difficult emotions, vulnerability, that kind of thing. So, we see varying degrees of improvement, but I would say across the board, we see improvement.” (P5).

“I have, especially with anxiety and depression. The mindfulness techniques, I feel like has been very... What’s the word I’m looking for? It’s been very effective in terms of not being judgmental of the thoughts and feelings, and actually being okay with feelings rather than avoiding. And that’s why I feel like I use that in particular the most, because I feel like the breathing and everything is beneficial to everyone. But yeah, I have seen a reduction in symptoms in that.” (P6).

They all seem to walk out with little nuggets of relaxation skills and affects. So, we push a lot about knowing your body and trusting your body. So, we really push a lot of that, we try and get them... during the narrative phase, we try and get them to where typically there’s some level of guilt or fault, so we try and move away from that for them. So, if they can walk out feeling like, ‘Hey, it’s not my fault, or other people are to blame. I know how to share my feelings.’ Or a big one, almost everyone says, ‘Hey, thanks, I feel like I can speak my feelings more.’ Empowerment is another one that we try and get people to feel. The last phase of it, is safety planning, we come up with concrete ideas, we practice 911 calls, we practice looking up law enforcement, suicide hotlines. So ultimately, those are really the main components of people walking out and the parents being really grateful that we’ve had conversations that are typically conversations that no one wants to have.” (P7).

“Definitely I mean, just based on the outcome measures, it was a lot of decrease in anxiety symptoms, better sleep habits, identifying feelings more easily, or at all. Being able to identify a range, a spectrum of feelings rather than just mad, sad, glad, afraid, and coping. Which is huge. Coping is a privilege, and I believe that coping skills have to do with a lot of times your resources. Whether that be physical resources or mental resources and emotional resources or just you don’t know what you don’t know. So, if I come from a family where my parents cope with violence or my co-parents cope with using substances or things like that, that’s what I know to cope.” (P8).
Furthermore, five out of eight participants reported specific measures they used to assess for symptom reduction, before, during, or after TF-CBT interventions. Below are quotes from five participants:

“So, we used to fill out the UCLA PTSD index, the Child Trauma index, all kinds of stuff to measure treatment outcomes, and I would say honestly, 100% would improve, some significant margin, some not so much, but there was always improvement in that. The good thing is, I was also a part of a research study where we would record our sessions and track our outcomes and for TF-CBT specifically, and every single patient that participated showed some level of improvement, some on the significant end where we just terminated treatment afterwards.” (P1).

“So decreased nightmares, decreased emotional dysregulation to trauma reminders, decreased triggers, flashbacks. So, when we do the measures before and after, we’re almost always seeing a decrease in those specific PTSD kind of symptoms.” (P2).

“We typically do pre and posttest assessment of trauma symptoms and the UCLA PTSD reaction index is one that we use. Particularly if somebody who’s 18 or younger, we’ll use that, that’s kinda what that’s normed on. And we do typically see a reduction in symptoms from pre-to post test. One of the issues with that, is sometimes when clients do a pre-test, they’re doing assessments, an intake, there might be less than forthcoming as far as symptoms and that kind of thing.” (P5).

“So, we use a couple of measures here. Back in the day, we used to use the UCLA PTSD RI and the youth outcome questionnaire or the YOQ. So, we did pre-measure. So, before we start the full boat of TF-CBT, basically we do an orientation on what TF-CBT is, and then we initiate the pre-measure. We do dropout rates kind of impacted this next statistic quite a bit, but we actually did for the ones we could get the post measures, went through the full boat of TF-CBT and compared that data. One of the outlier indicators was for avoidance, so when families were avoidant, it minimized... Those numbers actually went up, but really, the key thing to that has consistent families all seem to walk out with a more higher end knowledge base of trauma, flashbacks, triggers.” (P7).

“I used the UCLA PTSD index. I’ve used the CATS, I think it’s called CATS. And the other one I think it’s just called the PTSD questionnaire. But I don’t think they’re all the best. They all miss stuff. Again, if we’re just talking about specific racial trauma, like none of them ask questions about that.” (P8).

**Theme C: Hindrances to Treatment Unrelated to TF-CBT**

The challenges that the participants endure when treating the African American population was explored as a means of comprehending obstacles to treatment that are not
addressed in the TF-CBT model. Subthemes include barriers for families and a distrust in systems. It is important to note that this theme includes hindrances found within the African American community, whether TF-CBT was or was not used by the participants.

**Subtheme: Barriers for Families**

Three out of the eight participants described barriers they noticed with families, which resulted in a negative impact on client care, such as chasing down clients, parental substance use, low socio-economic status that led to a lack of transportation, lack of childcare and other fundamental necessities.

“As far as are they gonna bring the clients to sessions? Are they gonna make sure that that area is available for them? If they’re not gonna do that, then we can’t help these kids. Yeah, I used to work in wrap-around, and when I worked in wrap around, I went into the homes, and so at those times, I used to... Sometimes I felt like I would track down and stalk my clients because it’s like they were sleeping or they scheduled a meeting or ‘oh I forgot.’ Really, it’s the same freaking time every week. So, there’d be times like, okay, and I’m outside their house waiting for them to come back and they’re like, ‘Oh, you’re here.’ So there was... I used to kind of push through a lot of those barriers when I worked in the field.” (P2).

“Most of them were low socio-economic status, which came with a lot of barriers for transportation primarily, so my patients take a bus for two hours to come see me for my 45-minute session. Because this was before telehealth, so there was just a lot of complications around that as well, and child care for other siblings... But that was difficult doing trauma work, trying to be creative and asking my co-workers to help babysit during my session time so we could do a trauma narrative and share that with the mom. So, childcare barriers, transportation barriers. My last client had significant substance-use, her mom was significantly using substances that was impairing her ability to work well with her daughter... Yeah, I think those would be top main barriers that kind of played out during our sessions, that impacted treatment.” (P4).

“If they do not have food, if they cannot pay their rent, they don’t care about meeting with me, and that is okay. I’m not gonna be upset about that, but then you have the agency telling you that you have to meet a certain productivity expectation and this and that. So that it’s just a tight rope that you’re walking constantly and it’s difficult.” (P8).
Subtheme: Distrust in Systems

Four out of the eight participants described their experiences of putting in additional effort to build trust with their African American clients, given historical trauma that led to this population building a general distrust in the mental health and authoritative systems. Below are quotes from three participants:

“Definitely, I think there’s an extra step, an extra effort that has to happen to make sure that the trust is there. Especially, if the Department of Children and Family Services has been involved, which is just one case, they’re gonna definitely see you as more of the system. So, just building that trust, really reviewing the limits of confidentiality, engaging in rapport-building. I think it is important for all of our clients, but even more important, when there’s a history of historical trauma between races. I mean, duh.” (P3).

“And some of the youth that I’m working with, one that I’m currently working with has had significant experiences that affect his ability to trust anyone, but particularly somebody who is Caucasian. And so that’s a barrier as well as my experiences growing up um very different than the population that I’m working with and so I think that those are factors that might affect someone’s ability to trust and be able to kind of... Yeah, trust that I have their best interest in mind or I’m... I’m in their corner.” (P5).

“Like you said, you’re trying not to be a part of the system. But you are a part of the system. Let’s be real. You’re a part of the system. So, it’s hard, it’s hard. And I think that I’ve definitely had to check my own biases several times, whether it be whatever privilege, pick one. Whether it be economic status or race or whatever. Employment, whatever privilege you pick, I’ve definitely had to check my bias so many times and be like, ‘Okay, [name omitted], you can build rapport all day, you can say, ‘You know, I’m not just a white lady with a badge.’ But you are, and until you kind of earn that trust and... That sucks too, right? Because sometimes you do have to be the bad guy, and setting those boundaries and saying, this is my professional role, this is how I yearn to be different.” (P8).

Theme D: Addressing Cultural Mismatch Between Therapist and Client

The participants discussed their experiences in having a cultural mismatch with their African American clients. Subthemes include the cultural mismatch as a barrier to treatment as well as how they addressed this mismatch.
Subtheme: Cultural Mismatch as a Barrier to Effective Treatment

Three out of the eight participants reported the ways in which they felt that a mismatch in cultural identities between the clinician and client served as a hindrance to treatment and an overall discomfort within the therapeutic relationship. Below are quotes from three participants:

“Like I said, I’m often culturally matched and that most of my kiddos are Hispanic. But I’ve worked with White kids, I’ve worked with Asian children, I worked with Black kids, and so I still think that it can be effective. I think it really comes down to the engagement more than anything else. But are these kiddos, would they have done better with a therapist that match them? And so, I do... I wonder about that because right now we’re pushing to have more Black therapists to hire more, because we want to be able to have Black kiddos, Black clients come into our center and feel comfortable... Feel that they have a connection.” (P2).

“So, with African-Americans, obviously, there’s a long history of historical trauma that plays a role. There’s each member of the therapeutic relationship bringing their own preconceptions and implicit bias. So definitely, I think sometimes there’s a pre-conception of me that I’m biased, or that I’m racist, or that I’m a snob, or that I’ve never experienced any difficulties, or that I don’t care. Just based on my appearance. And of course, I feel like over the last four years, that only probably got worse to be honest.” (P3).

“And I think, I know different cultures identify and define trauma in different ways, and that’s important to at least, even if you don’t know, to at least be open to hearing about. And then especially, especially with the African American community, there’s racial trauma and microaggressions and things like that. That in my experience, I’m still a white lady at the end of the day, and it might not be something that comes up in my trauma narrative, right? So, it might not be something that feels safe enough to come up with me because it’s like ultimately, you don’t get it.” (P8).

Three of these participants shared their reflections on how significant it would be for treatment if clinicians strengthened their cultural competency or if their mental health settings recruited more Black identified therapists.

“I’m actually part of a group right now within my agency, it’s our anti-racism group, for lack of a better name. And so we’re talking a lot about implementing more strategies and trying to get more Black therapists to our team to reflect better the population that we serve, because right now, we have a lot of really wonderful bilingual Hispanic therapists, including myself, but we don’t necessarily have a lot of black therapists. And so, we’re
trying to analyze that, we’re getting some consultation as far as, are we meeting our population, while are we doing what we say that we wanna do? We say that we’re anti-racists. Are we really anti-racists? Are we doing this? And so those are some of the ways in which I’m still very much in. I’m trying to learn and broaden my understanding as a clinician too, as far as my clients that I serve, am I serving them appropriately? Am I making sure that this model meets them, not that they’re needing to meet the model?” (P2).

“So it’s an issue that is across the board, I think in every clinic, you can’t always provide a clinician of the same culture to that client that desperately needs services at that time, so we have to develop our cultural competency. It’s a huge issue.” (P3).

“It’s true, and you have to be willing to do that, that has to be a choice, and you have to be willing to be uncomfortable. Are you okay being the only non-black person in the room? Because you gotta be. You gotta be okay to do that and listen and hear the stuff that might be hard for you to hear as a white person or as a fill in the blank person. You gotta be willing to do that, because that’s when you’re really gonna learn. It’s not gonna be in a book, it’s not gonna be in a presentation, it’s not gonna be in a class, it’s not gonna be the training, it’s just... I would definitely say I did not learn the most from all those things. This just hasn’t been my experience. I learned more from exposure.” (P8).

**Subtheme: How Clinicians Address the Cultural Mismatch**

Four out of the eight participants shared how they attempted to address the cultural mismatch when working with African American clients in an effort to bridge the cultural gap in the therapeutic alliance. Below are four of the quotes:

“And so for me, I give up my background, but I also let them know, you’re the family, you’re the expert, you know your kid, I’m here to kind of assist and help, but I’m not gonna be the expert, and so... I think that really helps.” (P2).

“I think, I don’t try to say that I can relate with experiences, in fact, the opposite, say I don’t know what it’s like to have been through what you’ve been through. I’ll be very honest as far as my background, that it’s very different in their background, even though I haven’t had those experiences that I don’t feel that it’s necessary that I’ve had, but I haven’t used this an analogy.” (P5).

“I feel like you get it just from the mere fact that I’m Latina and we’re just minorities and we have that shared... We have that commonality, I feel like it doesn’t need to be spoken, it’s felt in the room. And I feel like that is so therapeutic and that’s so helpful too, ‘cause it’s kind of hard to explain someone that’s not of a person of color to explain what it’s like to live with being a minority. And so I feel like that’s so beneficial and I feel like it
just really does break down all these barriers, and I feel like you do good work because it’s more raw and real and it’s not awkward.” (P6).

“Just be authentic, I’m not gonna walk in and try to be cool because you’re young or try to use the certain lingo or anything, because I think that’s how you’re supposed to talk. Like, I’m gonna be myself and ultimately across the board, African-American and Latino, white, whoever, ultimately, authenticity, authenticity will cut through everything else, I mean, in my opinion, that’s the ultimate thing, just to be authentic with the clients that you meet, because they’ll smell through it, especially teens oh my gosh.” (P8).

**Theme E: Tailoring the Model to Address Client Needs**

The participants shared their methods in tailoring the TF-CBT model to better suit their African American clients’ presenting needs. Their processes to address those needs fell into two subthemes that include the use of additional interventions alongside TF-CBT, and a suggestion for a framework to address culture.

**Subtheme: Using Interventions in Conjunction with TF-CBT**

Seven out of the eight participants reported using additional interventions alongside TF-CBT to compensate for symptoms that the model either fails to address or symptoms that it was not designed to treat.

“I’m also trained and certified as a child parent psychotherapist, CPP for short, which is Birth to Five trauma. And it focuses on attachment, so I incorporated a lot of the techniques with TF-CBT, so I used it in conjunction.” (P1).

“Each component, you can do it the way that it’s gonna meet your kid, and so with relaxation, I bring in grounding, I bring in mindfulness because that really works for me as a clinician, and I find that it’s really helpful for a lot of my kids. If it’s not, then we look for other things.” (P2).

“I’ve tended to do, depending on the age and also the diagnoses of the client, I will use CBT, additionally, Seeking Safety, also DBT. So, if someone is addressing the trauma and treatment, but then they also, after we finish the TF-CBT components, there’s still a lot of emotional dysregulation, self-harming then I’ll definitely use those interventions as well.” (P3).

“Yeah, I mean TF-CBT specifically focused on trauma. PCIT was more behavior management. So, what we would do at our clinic was if the child had significant behavior
problems that were impacting them in school and that were more urgent, we would have them go through PCIT first, and then once their behaviors were a little bit more manageable. If there were behaviors that were interfering with their school performance or any more urgent behavioral needs, we would happen to do PCIT first, and then we would have them do TF-CBT. So that was a long treatment time, so they could go through all that. But typically, if they were hitting, throwing chairs, biting, spitting, they weren’t gonna be successful in TF-CBT, just because their behaviors were at such a high level of severity that they needed some behavior management first. Especially considering the age ranges, depending on if they were within that age range, but... I think doing the trauma work it... TF-CBT worked well with patients who have some of their behaviors a little bit more managed if that was the concern for deciding which treatment to use then.” (P4).

“But yeah, I guess motivational interviewing is... It’s pretty important as far as building rapport and helping clients find their own reasons as far as doing the work and that kind of thing, and recognize the benefit on their own.” (P5).

“I used a lot of CBT, psycho-dynamic in terms of theory, that’s what I did. And I also... I don’t know if there’s a proper name for it, but I used a lot of music into working with juvenile hall especially.” (P6).

“Umm, grounding. They’re kind of intertwined with the TF-CBT model, but grounding, mindfulness with TF-CBT. Which is kind of, again, incorporating some solution-focused and socratic questioning, things like that, but they all kind of align with the model.” (P8).

**Subtheme: A Framework to Explore Culture**

Seven out of the eight participants reported a recommendation for the creators of the model to include a framework or cultural adaptation for African Americans in the TF-CBT model. These participants expressed an overall disappointment in the model’s “one size fits all” mentality which unequivocally fails to acknowledge the unique differences in trauma experiences.

“I’ve only worked with adults recently, but I know the discussion of Black Lives Matter has been in my sessions with some people looking at the trauma from all the stuff that’s been going on recently. And that needs to be addressed I think in some ways, like us as providers to always get the education needed. I sometimes don’t know what to say and how to respond, just validating and hearing people is my go-to, but sometimes I don’t know either what the proper response is or what I should do or what I should say.” (P1).
“Definitely, I feel like it’s not even addressed at all in TF-CBT. I don’t remember anything in my training at all... I think their perspective is, that it doesn’t need to be adapted. The research so robust and in cross-cultural populations, so there’s really nothing you need to do... I mean, that’s the most I got. They didn’t say that, but that’s the message I got. And so I feel like any cultural adaptation has had to be broadened by me, and this is true also with my Spanish speaking clients... Absolutely... So no, I think overall, the whole psychotherapy providing system needs a lot more on cultural barriers and how to adapt for different cultural populations, 100%. And they always say they’re gonna do it, they never do.” (P3).

“I think the only thing that’s coming to mind is a question that you kind of alluded to was the importance of talking about race in sessions, if there is a difference in the clinician provider... I think that’s something I’ve learned recently, but I don’t think I did well as a student was to say, ‘Hey, I’m a white female, you’re a African-American female, and how is this gonna impact our relationship,’ knowing that it’s an elephant in the room that I think white providers and other providers need to bring up. Because their clients aren’t gonna bring it up for them, but I think it needs to be addressed to help build that rapport. Just recognizing racial differences in the room, and so I wish as a student, I would have done that more in our supervision around having racial discussions as far as discrepancies in therapy. I think I’ve done that more and as I’ve been licensed in my career, but I don’t think as a student, I was trained to have those conversations openly and transparently as well as... Now, I wish I would have.” (P4).

“Probably in my doctoral program, I don’t think that there was this much focus on cultural sensitivity as far as the education and that kind of thing, but we did you know have classes that addressed it. And then other trainings along the way, I don’t know that I could be specific but like for instance, just attended a training on Tuesday on implicit bias and looking at implicit bias and that kind of thing, but specifically working with African American adolescents or young adults, I don’t know that there’s anything been specific to that, but more cultural sensitivity and that kind of thing.” (P5).

“Yeah, and I can say that with a lot of modalities, but with this one in particular, I don’t think that it tailors to the African-American population or the Latino population too. No, and I’m not quite sure if it’s just people who aren’t well-informed or... I don’t know what it is, but I almost feel like it’s people. I feel like that people don’t really know the cultures they are teaching about it, and I just I don’t know.” (P6).

“I do wish that there were more African-American specific data to it, which is why I was really happy last year when Dr. Metzger gave her podcast and was able to speak to her professional opinions and her clinical impressions in regards to TF-CBT, African-American black families... but I felt like that was a really good foundational building point for us, and I think Jada that’s why I’m really happy that you’re doing this, hoping that you’re gonna expand on that ... Yeah, because again, one of the early ones that I did was culturally modified TF-CBT and working with Latino populations. I would love to attend the one that says culturally modified TF-CBT and working with African-American populations. To my knowledge, that does not exist, but it could.” (P7).
“Yeah, the creators probably wouldn’t be happy with this in general, because I just do what I need to do... It’s not a one-size-fits-all, which again is definitely culturally incompetent. If you think when you develop something and you think that this just will fit any and every person, you’ve already shot yourself in the foot because there’s cultural differences you really have to take into account... But grain of salt, there are lapses, especially if we’re talking to TF-CBT. There are areas they need to improve. Like I said, their questionnaires are outdated and lack a lot of cultural competency in a lot of material that should be in them, and then if there is no theory or practice that’s one size fits all. Ultimately, it was created by two white people, and so we all have our own biases... So there’s areas for improvement definitely, but I think specifically with the African-American community, there definitely needs to be improvements made and yea.” (P8).
CHAPTER V
DISCUSSION

Summary of Results

The intent of this study was to examine clinicians’ perspectives on the effectiveness of Trauma-Focused Cognitive Behavioral Therapy with African American children who have experienced trauma. At the time of this study, the literature that specifically explored clinicians’ perspectives on TF-CBT’s effectiveness with African American children has been limited. Some of the studies that included African American children as participants failed to acknowledge the additional cumulative trauma that manifests within the African American community, such as community violence and intergenerational trauma (Mullen-Gonzalez, 2012). The current study used in-depth, semi-structured, individual interviews to explore clinicians’ experiences with the TF-CBT model. This researcher used the qualitative approach of Thematic Analysis to synthesize clinicians’ experiences of the effectiveness of TF-CBT with African American children. Five significant themes and twelve subthemes emerged from the data analysis, which are explained below.

Discussion of Themes

This section explores how each theme, and related subthemes, that emerged from the data reinforces or contrasts previous findings from the literature. Five overarching themes and twelve subthemes illustrate the eight participants’ experiences in utilizing TF-CBT with African American children as well as the participants’ perspectives on the model. The themes are as follows: experiences working with African American children and families, effective components of TF-CBT, hindrances to treatment not related to the TF-CBT model, addressing cultural mismatch, and tailoring the model to address client needs.
Discussion of Theme A: Experiences Working with African American Children and Families. This theme explored the participants’ experiences while working with African American children and their families. This theme is comprised of the following subthemes: strengths of the family system and various forms of trauma experienced by families.

Three participants realized that the family system served as a strength when working with African American communities. They expressed joy in being able to collaborate and work as a team with African American families. Although there is no empirical research on this topic to date, sociologist and author, McAdoo (2007) examined the history and importance of the Black family in the United States in her book, Black Families. McAdoo (2007) described the Black family as a central source of cultivation and sharing of love, care, and reciprocity fundamental to human development and exchange. The conceptualization of the Black family is viewed as a rich resource of learning what it means to be African American and human in the fullest sense (McAdoo, 2007). One participant pointed out the significance of the matriarch role in African American families as a consistent figure. This is consistent with McAdoo’s (2007) findings who reveal the female provider as a source of economic, material, and emotional support for their children. This challenges the notion of viewing the nuclear family as the only means of stability and support to ensure survival. She encourages the reader to explore the ways in which female led households can be supported to allow the present day African American family to thrive in an unsupportive Western society. Limited research exists that specifically explores what makes the family system serve as a strength when treating African American children. Psychologist, Anderson (2019) provided a commentary on resiliency in Black families involved in the social welfare system. The sole focus on the deficits of Black children fails to acknowledge the role that the family takes in providing the necessary skills for these children to navigate a tumultuous
world (Anderson, 2019). In sum, the strength of the Black family should always be recognized and explored when treating Black children as a means of understanding the protective factors that have been passed down for generations. The present study highlights the need for research to be conducted on why the family system serves as a strength in the treatment of African American children.

Participants in the current study spoke about the various forms of trauma or traumatic events that their clients’ experience, such as community violence, domestic violence, sexual abuse, family separation, poverty, generational trauma and systemic trauma from the prison industrial system and education system. This is consistent with the findings from TF-CBT developers, Cohen et al. (2018) who thoroughly explain the TF-CBT model, its components, and intention to treat trauma-related disorders. The authors state that childhood trauma is inherently complex and trauma responses are not limited to one diagnostic entity such as posttraumatic stress disorder (Cohen et al., 2018). This finding is also consistent with the National Child Traumatic Stress Network’s (2016) explanation of the numerous types of trauma amid the African American population which include: racial trauma, victim or witness to community violence, system-induced trauma, intergenerational trauma, witness to domestic violence, childhood abuse, traumatic grief, and complex trauma.

Three of the participants specifically discussed generational trauma that was presented during family therapy sessions. Jacobs and Davis (2017) define intergenerational trauma as race-based traumatic stress, societal trauma, racist incident-based trauma, emotional abusiveness, and racism. In addition, behaviors, healthy or unhealthy, that are learned as adaptations to traumatic experiences are passed down from one generation to the next. The participants shared that they encouraged the clients’ parents to seek individual therapy after noticing their unresolved traumas
surfacing in sessions. Moreover, they noticed that parents indirectly benefit from some of the components based in the TF-CBT model. Participants in this study mentioned their observations of these parents utilizing some of the skills taught in the TF-CBT model, such as the relaxation, affective, and cognitive processing skills. Moreover, how the parenting skills component increases the parents’ ability to effectively communicate with their children. An exploratory study using thematic analysis of historical texts conducted by Henderson et al. (2021) examined the historical evidence of healing among enslaved people of African ancestry on Southern plantations. Henderson et al., (2021) found that enslaved people experienced healing as a multistep process: (a) identifying the problem; (b) consulting with healer and spiritual guides; (c) utilizing the guidance to address their physical and emotional distress. The authors encourage clinicians to explore African American client’s application of healing practices and behaviors to limit the transmission of intergenerational trauma. While no specific data exists quantifying the number of African Americans who identify with experiencing intergenerational trauma, clinicians should continue to encourage caretakers to utilize individual services to avoid disruptions in treatment and promote generational healing.

**Discussion of Theme B: Effective Components of TF-CBT.** This theme explored which preexisting components of the TF-CBT model participants found to be the most effective when working with African American clients. This was captured in the subthemes: use of structure as a guide, components that address trauma symptoms, and the incorporation of the family system.

Four out of the eight participants discussed how they found the structural component of the TF-CBT model as beneficial to its efficacy and use. There has yet to be a study that explores why clinicians enjoy the use of a structured model when specifically working with the African
American population. However, a qualitative study examining nineteen Zambian counselors’ perceptions on the use of TF-CBT to address mental health problems in Zambian children support the experiences of these four participants (Murray et al., 2014). Seven of their participants found the structure of TF-CBT to be useful and easy to follow, thus supporting this subtheme. It is important to note that similar to the current study where half of the participants found the structure as beneficial, less than half of the participants in the research conducted by Murray et al., (2014) found it useful, thus indicating a mixed finding.

Participants of the current study reported their satisfaction with the TF-CBT models’ ability to address trauma symptoms through its framework, in particular the trauma narrative component. This is consistent with previous research that examined the changes in trauma narrations for 24 mixed-ethnic youth who received TF-CBT treatment as well as the relationship between the changes and PTSD. Results showed that these youth were able to construct more organized narratives with a stronger internal focus (Knutsen & Jensen, 2019). Furthermore, researchers Connors et al. (2021) conducted a mixed methods study assessing 31 clinicians’ perspectives on the appropriateness of TF-CBT implementation in 13 urban public schools and found that PRAC skills (psychoeducation/parenting skills, relaxation skills, affective skills, cognitive processing skills) were generally more effective opposed to the trauma narrative given limitations to school setting conditions. There is a parallel to the current study, wherein six participants found the PRAC component of the TF-CBT modality to be effective with their African American clients.

Lastly, six out of the eight participants reported the efficacy in parent or caregiver engagement and its impact on client treatment within and outside of sessions. The role of the caregiver being immersed in treatment is essential to the healing of the child’s trauma as TF-
CBT provides parenting skills, psychoeducation, and conjoint sessions. Pertaining to the strength of their presence, Loos et al. (2020) conducted a study examining the working alliance of therapist, caregivers, and patients using the working alliance inventory (WAI-S) and the clinician-administered PTSD scale for children and adolescents (CAPS-CA) to measure symptom reduction in 76 children with the utilization of TF-CBT. The researchers found that caregivers play a key role in the success of TF-CBT based on their examination of the working alliances between the therapist, child, and caregiver. Participants in the current study spoke to the model’s strengths in its use of parent or caregiver engagement and how it affected the relationships between the child, parents, and clinician. Moreover, they endorsed the importance of the family system as a means of continuing treatment and skill building both inside and outside TF-CBT sessions.

Seven out of the eight participants discussed the indicators of reduction of their client’s trauma symptoms after TF-CBT treatment. The participants shared the indications that their client’s trauma symptoms have decreased via changed behaviors, increased coping skills, ability to voice their emotions, increased vulnerability, and an overall sense of empowerment. Furthermore, the participants shared which measurements they used to assess for symptom reduction, with the UCLA PTSD index being one of more commonly used measures. There are no existing studies that examine the decrease of trauma symptoms with African American children after implementing TF-CBT. However, Knutsen et al., (2018) investigate the changes in trauma symptoms, depression, and cognitions in a diverse group of traumatized youth during utilization of TF-CBT. They found that post-traumatic stress symptoms, cognitions and depression decreased over time after TF-CBT treatment, thus supporting the changes that the participants in the current study suggest. The participants in the current study shared the
indicators that their client's trauma symptoms have decreased via changed behaviors, increased coping skills, ability to voice their emotions, increased vulnerability, and an overall sense of empowerment.

**Discussion of Theme C: Hindrances to Treatment not Related to the TF-CBT Model.** This theme focuses on the hindrances to treatment that the participants noticed when working with African American children and their families. These hindrances were encompassed into two subthemes: barriers for families and distrust in systems.

Three out of eight participants described barriers that their clients faced during treatment, such as the caregiver’s inability to prioritize their child’s therapy, parental substance use, and low socio-economic status that led to a lack of transportation, lack of childcare, and other fundamental necessities. As it currently stands, African Americans continuously encounter impenetrable obstacles when obtaining effective mental health services. Burkett (2017) describes these hindrances as a maze of obstacles built of systemic oppression, institutional inequalities, and structural disparities. In a systematic review of qualitative and quantitative studies from 2000 to 2017, researchers Planey et al. (2019) examined the barriers and facilitators to mental health help-seeking for Black youth. Their findings revealed seven themes related to barriers: child-related factors, clinician and therapeutic factors, stigma, religion, affordability, availability, and accessibility. In addition to the barriers that participants in the current study noticed, they shared their efforts to decrease barriers for their clients. It is important to include that while these barriers exist, there are effective methods to increase accessibility to mental health care for this population. Kuwaii-Bogue et al., (2017) advocated for a culture-specific integrated care framework to minimize these barriers, which include cultural competency trainings, family and client psychoeducation, transportation and childcare services, and relationships between active
social supports in African American communities, such as the church, and mental health facilities to provide effective and collaborative care.

In addition to concrete barriers, participants discussed their experiences of putting in additional effort to build trust with their African American clients, given historical trauma that led to this population building a general distrust in the mental health and other authoritative systems. This is consistent with empirically based data that African Americans underutilize medical and mental health services when compared to other ethnic groups due to historical misdiagnosis, healthy cultural mistrust, inadequate treatment, cost of care, and provider’s cultural bias (NAMI, 2009).

Previous literature has explored the connection of historical trauma leading to a general distrust in the healthcare system, particularly in this case the mental health care system. Historical trauma can be defined as a shared collective memory of a particular cultural group (Burkett, 2017). Sociologist, McAdoo (2007) explores the feelings of mistrust being attributed to mental health professionals promoting non-African American orientations toward mental health. Additionally, authors and psychiatrists, Griffith et al. (2019) alluded to the early conditioning of mistrust due to the high rates of Black children being referred from their school system for behavioral problems to mental health systems. The participants in the current study alluded to their efforts to overcome this barrier, which included reviewing confidentiality, focusing on building rapport, being mindful of historical trauma and its current impact, and checking their personal biases. Therefore, clinicians must work to alleviate this population’s negative perception of therapy services for effective treatment.

Discussion of Theme D: Addressing Cultural Mismatch Between Therapist and Client. Three participants discussed the ways in which they feel that a mismatch in cultural
identities between the clinician and client can serve as an overall discomfort within the therapeutic relationship. Two participants who identify as White shared concerns that their racial identity would lead clients to preconceptions that they are biased, racist, or simply will not understand the Black experience. This finding is consistent with research conducted by La Roche et al. (2003) who provided ten clinical considerations in addressing cultural differences in psychotherapy. In one of their guidelines, the researchers encouraged clinicians to explore how their cultural competency will impact the therapeutic relationship and the way that cultural differences are addressed. In relation to the participants in the current study who shared their fears of being viewed as racist or bias, it is important to note that these assumptions can demonstrate a lack of cultural competency on the behalf of the therapist based on their own discomfort in discussing a cultural mismatch.

Moreover, this finding correlates with existing research by Thompson et al. (2004) examining the attitudes of 201 African Americans regarding psychotherapy, psychotherapists, and barriers to treatment. The researchers revealed that if African American clients felt uncomfortable and misunderstood in a mixed-race therapeutic relationship, that they would not return for services (Thompson et al., 2004). This notion reveals that it is the therapist’s job to determine if bringing up topics around cultural dynamics would make the client feel more at ease or uncomfortable. Participants in the current study shared their reflections on how significant it would be for treatment if clinicians strengthened their cultural competency or if their mental health settings recruited more Black identified therapists.

In addition, participants discussed how they attempted to address the cultural mismatch with their African American clients. They discussed their attempts to create a collaborative playing field, acknowledge the cultural differences, and being authentic in the therapeutic
alliance. Participants reported that they wanted to help their client’s feel more comfortable in the therapeutic relationship and to break down barriers, especially because they did not share the same ethnic identity. Participants did not specify if their self-disclosure with this population was a learned skill in their training or where exactly the pull to be transparent originated. This finding is consistent with the above described research conducted by Thompson et al. (2004), which also identified that participants indicated that they looked for subtle cues to determine therapists’ cultural sensitivity and attitudes, such as ethnic minority reading material in the waiting room, diversity in art therapy, and the therapists’ reactions to their financial, legal, employment, or discrimination issues. Moreover, the researchers found that participants expressed they would limit the amount they disclosed if the therapist seemed overwhelmed or unwilling to discuss the previously listed issues. In sum, the participants of the current study who indicated using different methods to address cultural mismatch with their African American clients can be seen as attempts at cultural sensitivity.

Discussion of Theme E: Tailoring the Model to Address Client Needs. Participants discussed the need to use additional interventions alongside the TF-CBT intervention to better suit their clients’ needs. A framework to explore the family’s cultural background was suggested as a modification to the TF-CBT model to improve trauma treatment. Their experiences were captured in the subthemes: using interventions in conjunction with TF-CBT and a framework to explore culture.

Seven out of the eight participants reported using additional interventions alongside TF-CBT to compensate for symptoms that the model either fails to address or for symptoms that it was not designed to treat, including anxiety, self-harming behaviors, and depression. It is
important to note that TF-CBT was designed to address and decrease trauma related symptoms. Although the intent of the study is to focus on clinicians’ perspectives on the effectiveness of TF-CBT, other modalities should be explored to understand what additional interventions are effective in treating comorbid disorders with African American children. Participants shared that they utilized PCIT\(^1\) for behavior management, Birth to Five\(^2\) for younger children to address attachment issues, DBT for self-harming and emotional dysregulation, Motivational Interviewing for rapport building, and psychodynamic theory to conceptualize their client’s case. The participants showed an adept ability to adapt to their clients’ needs and not focus solely on treating the trauma symptoms as other symptoms can take precedence depending on the child. Some researchers examined the use of TF-CBT alongside other modalities, such as Pleines (2019) who investigated the literature related to TF-CBT with an attachment-informed approach to highlight how the TF-CBT model can enhance clinicians’ understanding of the importance of the caregiver role in treatment to address complex and intergenerational trauma.

In addition, Gibbs (2013) researched the effectiveness of an integrated trauma focused model, using TF-CBT, trauma-focused art therapy (TF-ART), and Afrocentric psychotherapy (ACP) that was evaluated by an expert evaluation panel, on African American children suffering from trauma. He discovered that his review and the judges’ analysis supported this model to be a strength-based treatment due to its culturally specific components. This study builds on the current literature to examine effective ways to incorporate culturally congruent modifications to the TF-CBT model for African American children.

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\(^{1}\) PCIT or parent-child interaction therapy is an evidence-based approach for children aged 2-7 with externalizing behaviors (Phillips et al., 2022)

\(^{2}\) Birth to Five is a program that addresses children’s health and education in the early years of development
Relatedly, participants shared a recommendation for the creators of the TF-CBT model to include a framework or cultural adaptation for African Americans. Their overall disappointment in the model’s “one size fits all” mentality corroborates the aim of the present study. This is supported by research conducted by Michelson (2010) who examined therapist’s perspectives on the effectiveness of TF-CBT in treating children with complex trauma. Michelson (2010) interviewed twelve female graduate level therapists who were all professionally trained in TF-CBT, and they noted that there needs to be more research that specifically looks at trauma in Black and Latinx families and the traumatic impact of community violence. Moreover, Kuwaii-Bogue et al. (2017), advocate for a culture-specific integrated care framework to minimize barriers, which include cultural competency trainings, family and client psychoeducation, transportation and childcare services, and relationships between active social supports in African American communities, such as the church, and mental health facilities to provide effective and collaborative care.

Limited studies explore the integration of cultural adaptations to the TF-CBT model to address and treat racial trauma, particularly for African Americans. Dr. Isha Metzger, a TF-CBT certified psychologist and director of the EMPOWER lab in Georgia, focuses her research on taking a strength-based approach to prevention for Black youth (Metzger, n.d.). Additionally, a recent study conducted by Metzger et al. (2021) explored the integration of racial socialization into TF-CBT for African American youth to help them overcome stressors related to being an ethnic minority. They proposed a framework within the PRACTICE components of TF-CBT for clinicians to utilize strategies that include racial socialization messages and practices that promote African American healing and psychological wellness. Furthermore, professors, Phipps and Thorne (2019) proposed a community-based TF-CBT model to address cultural trauma in
African American youth between the ages of 12-14. They intentionally focused on a group approach that could be utilized in a school setting, church, or community center to decrease the individualistic, Eurocentric approach to treatment that is found in the traditional TF-CBT model (Phipps & Thorne, 2019). Comparisons to the proposed cultural adaptations to the TF-CBT model are listed in (Appendix E).

**Researcher Reflexivity**

This section will examine my role as a researcher and how I addressed any issues that surfaced throughout the process. Reflexivity can be seen as the assumption that the researcher should engage in continuous self-critique and the explanation of how my lived experiences may or may not have influenced the stages of the research process (Dowling, 2006). Similar to the children who are the focus of this study, I also identify as an African American who was exposed to traumatic events in my early childhood, which led to my interest in exploring the most effective interventions in treating trauma related symptoms. My subjective experiences were pertinent long before the start of this research and persisted throughout the process in my dedication to promote awareness of issues related to implementing evidence-based practices to African American children. Given that I shared fewer identities with the participants of this study, I found more ease in remaining objective during the interview phase. I recognized the role that I played being African American and conducting research on African American children with the impact it had on my non-African American participants. This racial mismatch in identities, between researcher and participant, could have led to participants discomfort in sharing their true experiences with TF-CBT and this population. Moreover, participants could have knowingly or unknowingly attempted to appease this researcher in their responses. In regard to seven of out the eight participants being certified in the TF-CBT model, their responses
about its effectiveness could also have been subdued with regard to the TF-CBT model’s insufficiency when working with African Americans can negatively impact them. I utilized reflective journaling while conducting each participant’s interview, encompassing my feelings and reflections (Braun & Clarke, 2006). I examined my reflections to try to minimize how they might interfere with the data analysis. My process of reflexivity was a fundamental component in informing how clinicians’ perspectives on the effectiveness of TF-CBT with African American children was represented.

**Strengths and Limitations**

Various strengths surfaced throughout the process of this study. Variability among the participants’ ages (29 – 60) and number of African American children each served a range between 1-100, showcased a span of clinical experiences while utilizing TF-CBT with this population over 2-21 years. Moreover, it is important to note that seven out of the eight participants were formally trained and certified in the TF-CBT model. This study’s in-depth, semi-structured interviews permitted a profound understanding of clinicians’ experiences in utilizing TF-CBT with the African American community. Due to the limited literature and research focusing on clinicians’ perspectives on the effectiveness of TF-CBT with African American children who experienced trauma, this project played a key role in expanding on this topic.

Despite the project’s contributions to the expansion of cultural competency in the TF-CBT model, there are a couple of limitations that could inform future research. Given the qualitative nature of this project, the relatively small yet deliberate sample size (n=8) withholds a generalizability of the results that could have been attainable via a larger sample. It is possible that a replication of this study with a quantitative methodology and larger sample size could
generate different results. Next, the deficiency in African American participants prevented an understanding of the perspectives of this model when the client and clinician share an ethnic identity.

**Recommendations for Future Research**

The limitations discussed provide a framework for future research. The notable themes (participants’ experiences in working with African American children and their families, participants’ perspectives on what they found useful in the TF-CBT model, the hindrances to treatment for the African American community that are not addressed in the TF-CBT model, how they addressed cultural mismatch, and how they tailored TF-CBT interventions to meet the needs of their clients) could be further examined with a larger sample and a quantitative approach.

Future research efforts can further examine a larger and more diverse sample of clinicians’ perspectives on the use of the model with this population. First, by ensuring a range in cultural identities of clinicians to gather additional ways of thinking to make this intervention more adaptable. Additionally, it would be useful to specifically explore African American clinicians’ perspectives on TF-CBT when working with this population. Second, exploration of how telepsychotherapy impacts the clinician’s ability to effectively treat this population given various barriers that can exist. Lastly, an incorporation of a wider scale recruitment method to garner a deeper understanding of clinicians’ experiences nationwide.

Regarding the clinical implications of this study, the results indicate that there is a need for more cultural trainings with the TF-CBT model. On a larger scale, this study highlighted the importance of more education on African American history and culture within the field of psychology and the American educational system.
Conclusion

The purpose of this project was to explore clinicians’ perspectives on the effectiveness of trauma-focused cognitive behavioral therapy with African American children. In addition, was to highlight the various facets of trauma that African Americans encounter in childhood, the barriers in place that prevent them from receiving adequate mental health care, and to promote awareness of issues related to implementing evidence-based practices to African American children. The overall results indicate that while TF-CBT consists of components that are effective in treating trauma symptoms, it is not an effective intervention when treating African American children. There is a high need for a culturally competent model specifically suited for the African American population as well as cultural trainings to increase clinicians’ cultural awareness and how they impact treatment. A culturally adapted TF-CBT model should incorporate specific methods that address the traumas and barriers that African American children face within the PRACTICE framework for it to be effective. TF-CBT developers should expand on the findings in this project by examining suggested cultural adaptations for African Americans and its efficacy in reducing trauma and promoting healing in the Black community. Lastly, future research should examine the efficacy of the culturally adapted model with the African American population.
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https://doi.org/10.1007/s10566-022-09694-w


https://doi.org/10.1016/j.childyouth.2019.04.001


Appendix A

SCREENING TOOL

Phone Screening Questions

1. Do you have a graduate degree in mental health care?
   a. Inclusion criteria: has a graduate degree in mental health care
   b. Exclusion criteria: does not have a graduate degree in mental health care

2. Have you received professional training in Trauma-Focused Cognitive Behavioral Therapy?
   a. Inclusion criteria: has received professional training in TF-CBT
   b. Exclusion criteria: has not received professional training in TF-CBT

3. Have you treated African American children who have experienced trauma with TF-CBT?
   a. Inclusion criteria: has treated African American children who have experienced trauma with TF-CBT
   b. Exclusion criteria: has not treated African American children who have experienced trauma with TF-CBT

Scheduling Questions

1. Do you prefer to complete your interview in person at University of San Francisco or through Zoom, a free video conferencing service?
   a. If in person interview:
      i. The University of San Francisco, Hilltop Campus 2130 Fulton Street, San Francisco, CA 94117
   b. If Zoom interview:
i. What email address can I use to share the project’s consent form and the link to our Zoom meeting?

2. Would you prefer that I send you a reminder text or email before your scheduled interview?
Appendix B

INFORMED CONSENT INDIVIDUAL INTERVIEW

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Below is a description of the research procedures and an explanation of your rights as a research participant. You should read this information carefully. If you agree to participate, you will sign in the space provided to indicate that you have read and understand the information on this consent form. You are entitled to and will receive a copy of this form.

You have been asked to participate in a research study conducted by Jada Carter, a doctoral student in the School of Nursing and Health Professions at the University of San Francisco. The faculty supervisor for this study is Dr. Brac Selph, PsyD, a licensed clinical psychologist and professor in the School of Nursing and Health Professions at the University of San Francisco.

WHAT THE STUDY IS ABOUT:

The purpose of this study is to learn about the experiences of clinicians who treat African American children with trauma using trauma focused cognitive behavioral therapy (TF-CBT).

WHAT WE WILL ASK YOU TO DO:

During this study, you will be asked to talk about your experiences as a clinician who has used TF-CBT with African American children who have experienced some form of trauma.

DURATION AND LOCATION OF THE STUDY:

Your participation in this study will involve one interview session that lasts no longer than 90 minutes. The interview will take place in a private room at the University of San Francisco library or over Zoom video conferencing, based on availability and location.

- **The University of San Francisco, Hilltop Campus** 2130 Fulton Street, San Francisco, CA 94117

POTENTIAL RISKS AND DISCOMFORTS:

The research procedures described above may involve minimal potential discomfort in discussing some issues while you participate in this study. There are no anticipated risks to you that are greater than those encountered in everyday life. The issues discussed during this interview have each been selected by the researcher and her dissertation committee to minimize
the potential for psychological discomfort. Due to the nature of this research topic, you may encounter some emotional discomfort while responding to questions. If you wish, you may choose to withdraw your consent and discontinue your participation at any time during the study without penalty.

**BENEFITS:**

You will receive no direct benefit from your participation in this study. However, you may gain more insight into your own experiences or perhaps think more critically about treatment for African American children. The possible benefits for others include increased awareness and insight for mental health providers who provide services to African American children and families who encounter barriers to mental health care.

**PRIVACY/CONFIDENTIALITY:**

Any data you provide in this study will be kept private and confidential unless the law requires disclosure. In any report we publish, we will not include information that will make it possible to identify you or any individual participant. Specifically, we will keep private research records that identify you, to the extent allowed by law.

The researcher will ask you to select a pseudonym so that the only place your name will appear in our records is on the consent form and in our data spreadsheet, which links your name to a pseudonym and your data; only the research team will have access to this information. The only exceptions to this are if we are asked to share the research files for audit purposes with the University of San Francisco Institutional Review Board ethics committee.

The researcher will utilize a recording device to capture the responses of the participants. The recordings of this session will be kept in a locked cabinet at the University of San Francisco. The names of participants will not appear in the transcribed records of this study. Certain people may need to see the study records. The only person(s) who will have access to see these records are: the study staff, and the University of San Francisco Institutional Review Board, and its staff.

The records of this study may be used in publications and presentations. If the results of this study are published or presented, you will be notified, and we will not include information that will make it possible to identify you or any individual participant.

The researcher has created an email account for the sole purpose of this study. This email account will be used to communicate with participants and will be deactivated following the completion of this study.
The researcher will destroy confidential information, such as the participant’s emails, phone number, audio recordings, and other personal information provided within one year following the completion of this study.

**COMPENSATION/PAYMENT FOR PARTICIPATION:**

You will receive a gift card valued at $20 for your participation in this study following the completion of the interview.

**VOLUNTARY NATURE OF THE STUDY:**

Your participation is voluntary, and you may refuse to withdraw or cease to participate at any time without penalty or loss of benefits. Furthermore, you may skip any questions that make uncomfortable and discontinue your participation at any time without penalty or loss of benefits. The researcher has the right to withdraw you from participation in the study at any time.

**OFFER TO ANSWER QUESTIONS:**

Please ask any questions you have now. If you have questions later, you should contact the principal investigator: Jada Carter at (510) 435-6237 or [dissertation email address]. You may also reach the dissertation chair of this study, Dr. Brac Selph, at rselph@usfca.edu. If you have questions or concerns about your rights as a participant in this study, you may contact the University of San Francisco Institutional Review Board at IRBPHS@usfca.edu.

I have read the above information. Any questions I have asked have been answered by the researcher. I agree to participate in this research project and I will receive a copy of this consent form.

---

**PARTICIPANTS SIGNATURE**

**DATE**
Appendix C

DEMOGRAPHIC QUESTIONNAIRE

Name: __________________________________________

Assigned Code: ________

Today’s Date: _______/_____/___________

Age: ________

Gender:

___ Female
___ Male
___ Non-binary, Intersex
___ Transgender
___ Prefer to not answer
___ Prefer to self-describe: __________________________

I identify my ethnicity as:

___ African American
___ Black: _______________________
___ Latinx or Hispanic
___ Chinese
___ Vietnamese
___ Japanese
___ Korean
___ Southeast Asian
___ American Indian, Alaskan Native
___ Indian
___ Middle Eastern
___ White Caucasian
___ More than one race
   Please specify: ____________________________________
___ Prefer to not answer
___ Prefer to self-describe: __________________________

Graduate Discipline:

___ Marriage and Family Therapist
___ Clinical Social Worker
___ Psychologist
___ Psychiatrist
___ Other: __________________________
1. How many years have you been practicing as a licensed clinician/psychologist?

2. What type of treatment settings do you work in (community mental health, hospital, private practice, academia, etc.)?

3. How many years have you been engaged in therapeutic work with African American children?

4. What type of professional training did you receive in TF-CBT? When was the last time you were professionally trained in the model?

5. Approximately, how many African American children have you worked with implementing TF-CBT?

6. How many years have you worked with African American children with trauma?

7. If any, what additional approaches or interventions have you used with TF-CBT?

8. What type of education or training have you received on African American culture and history?
Appendix D

INTERVIEW QUESTIONS

- How has your experience been working with African American children?
- How effective do you find TF-CBT as a trauma informed modality with this population?
- How effective do you find TF-CBT as a culturally informed modality with this population?
- If any, what strengths or improvements have you observed in your clients during and after treatment with TF-CBT? What percentage of clients have you seen improvements in?
- Why do you use TF-CBT when working with African American children and families?
- Do your cultural identities play a role in your work with this population? Why or why not?
- Is there anything you would like to add?
## Appendix E

### Recommended Culturally Informed Models for TF-CBT with African Americans

<table>
<thead>
<tr>
<th>PRACTICE Component</th>
<th>TF-CBT Model</th>
<th>RS Integration</th>
<th>Community-Based Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRAC:</strong> Stabilization skills</td>
<td>Psychoeducation and parenting skills</td>
<td>Psychoeducation about trauma impact; parenting skills to address traumatic behavior responses and enhance support</td>
<td>Inquire about cognitive and attitudinal barriers, beliefs on mental health and provide psychoeducation; RS as a protective factor</td>
</tr>
<tr>
<td><strong>Relaxation skills</strong></td>
<td>Relaxation skills to reverse physiological trauma responses</td>
<td>Assess beliefs and how the child and family relax and cope with stress</td>
<td>Exploration of spiritual beliefs and practices; connection to how they cope with racism and discrimination</td>
</tr>
<tr>
<td><strong>Affective skills</strong></td>
<td>Affective skills to address emotional trauma dysregulation</td>
<td>Identify feelings associated with previous experiences with racial discrimination; provide strategies to acknowledge racial stressor by appraising the source of affective change</td>
<td>Use of mindfulness exercises and role play to broaden emotional vocabulary, control emotional expression, and to practice new ways of communicating emotions</td>
</tr>
<tr>
<td>Cognitive processing skills</td>
<td>Cognitive processing skills to understand connections among thoughts, feelings, and behaviors; generate more accurate and helpful thoughts</td>
<td>Process and role-play techniques that teach children how to behave in hypothetical situations</td>
<td>Use of role play for reflection on micro aggressive behaviors and to correct stereotypes; reflection upon within-group microaggressions to filter out negative self-images</td>
</tr>
<tr>
<td><strong>T:</strong> Trauma narration and processing</td>
<td>Trauma Narration</td>
<td>Trauma narration and processing to describe and cognitively process the child’s personal trauma experiences</td>
<td>Assess the child’s/caregiver’s understanding of cultural norms around trauma narratives; consider culturally relevant forms of communication</td>
</tr>
<tr>
<td><strong>ICE:</strong> Consolidation</td>
<td>In vivo exposure</td>
<td>In vivo mastery to address overgeneralized fear and avoidance of innocuous trauma reminder</td>
<td>Allow clients the opportunity to practice skills to reduce negative cognitions, emotions, and behaviors in response to future triggering racial encounters</td>
</tr>
<tr>
<td>Conjoint sessions</td>
<td>Conjoint child-parent sessions to enhance communication about the child’s trauma experiences and parent-child communication</td>
<td>Discuss successes of RS activities that were assigned in treatment and the impact they had on client’s racial identity</td>
<td>Use of family to shape a balanced picture of the past and present and a healthy self-image</td>
</tr>
<tr>
<td>Enhancing safety</td>
<td>Enhancing safety and future development to address these issues</td>
<td>Develop safety plan that equips youth with how to respond for future experiences with discrimination and racism; identify signs of danger</td>
<td>Teaching safety and protective factors; use of role models beyond the family system; use of role play to solicit support of family, church, and community</td>
</tr>
</tbody>
</table>