Perceptions of Counselors Regarding the Effectiveness of Interventions for Traumatized Children

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Limited research exists to guide counselors of traumatized children as they search for effective interventions. The authors conducted a multicase study to examine counselors' perceptions in regard to the effectiveness of interventions for children who have experienced trauma. Six counselors who work with traumatized children were contacted and interviewed. Two participants were registered play therapists, and the remaining counselors specialized in working with traumatized children in a variety of clinical settings; however, all 6 participants used therapeutic play skills when counseling traumatized children. Four significant themes emerged from the data analysis and are presented along with implications for counselors.

Keywords: play therapy, trauma, children, counselors, evidence-based

In the mental health field, few topics have generated a more intense discussion than the controversy over the use of evidence-based interventions (EBIs)—that is, treatments supported by empirical evidence (Weisz, Jensen-Doss, & Hawley, 2006). In a *Newsweek* article, Begley (2009) emphasized the claim that a large number of psychotherapists are divided about the role of science or even reject it all together. Professionals who agree with evidence-based interventions (EBI) have argued that they should be used instead of interventions that have not been classified as EBI (see, e.g., Chambless & Hollon, 1998; Nathan & Gorman, 1998). However, some professionals feel that more emphasis on EBIs is misguided because it moves psychotherapy further toward the medical model (Hunsberger, 2007; Thomason, 2010).

In February, 2001, President Bush announced the formation of the New Freedom Commission on Mental Health to address the problems in the mental health services that allow American's to "fall through the system's cracks" (Hogan, 2002, p. 1). The *Interim Report* continued to explain that, "Despite this range of effective, state-of-the-art treatments and best practices, many interventions and supports do not reach the people who need them because of complex reimbursement policies" (Hogan, 2002, p. 68). For example, if Medicaid, Medicare, and private payers are going to implement EBIs, then Medicaid and Medicare must remain current with research and continuously reexamine reimbursement policies.

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The Commission (Hogan, 2002) also recognized that necessary components of EBIs, such as home visits, cannot be billed through Medicaid or Medicare because they have not been proven as EBIs; therefore, clients would not receive full clinical benefits from EBIs.

The Commission also heard stories from consumers, families, advocates, and public and private providers about the *workforce crisis* in mental health care (Hogan, 2002, p. 70). According to the Commission Report (Hogan, 2002), the workforce crisis in mental health care exists because there are a lack of clinicians and those clinicians who are available are not trained in EBIs. Another reason for the workforce crisis is that many of the education and training programs for clinicians are not developing or disseminating EBIs.

In the United States, children and youth have an "alarmingly high prevalence" of mental health problems (Huang et al., 2005, p. 169). Children who are traumatized by specific experiences are at risk for long-term mental health problems (Levine & Kline, 2007). According to Perry (2009), there are crucial opportunities during which the neural systems of the brain must be activated or they will fail to develop. The development of attachment between an infant and his or her primary caregiver is one important system of the brain that operates this way. Therefore, early mental health intervention can reduce the long-term impacts associated with traumatic events (Perry, 2009).

In Texas, the U.S. Department of Health and Human Services (2005) reported that of 6 million children (0–18 years of age), over 62,000 were victims of abuse. Furthermore, 63% of victimized children were between 0 and 7 years of age. Approximately 70% of the abuse was neglect, 23% was physical abuse, over 4% was medical neglect, and over 11% was sexual abuse. Despite the high levels of abuse and mental health problems facing our children, our nation has failed to develop a comprehensive, systematic approach to handle the crisis in children's mental health (Huang et al., 2005).

To solidify the gaps in children's mental health interventions, identifying and disseminating evidence-based interventions has become a priority in the mental health community for the treatment of children and adolescents (Glied & Cuellar, 2003). The Code of Ethics of the American Counseling Association (2005) directs "Counselors [to] use techniques/procedures/modalities that are grounded in theory and/or have an empirical or scientific foundation" (p. 11). Moreover, several professional groups have embraced the use of EBIs for that reason. For example, professional school psychologists formed a task force in the mid-1990s (Weisz, Jensen-Doss, & Hawley, 2006). Professional school psychologists also formed a task force on EBIs.

Nicholas Cummings, a past president of the American Psychological Association (APA) and recipient of the APA Award for Distinguished Professional contributions and the APF Gold Medal Award for Life Achievement in the Practice of Psychology (APA, 2003), predicted and encouraged the integration of psychotherapy into the managed health care system. One of his most important predictions was the divergence of evidence based clinical interventions from general psychotherapy (Thomason, 2010). Cummings also declared that evidence-based interventions are supported legally and morally.

However, Thomason (2010) also reported drawbacks to the effectiveness of EBIs including that many empirically supported treatments have not been identified. Because the intervention has not been identified, it might imply that those

interventions are not effective, which is not the case. Similarly, if third-party payers limit payment to EBIs, then clinicians who do not use them could become vulnerable to the malpractice insurance industry. The result is that psychotherapy begins to become more aligned with the medical community and long-term interventions will not be supported by financial institutions.

Proponents of evidence-based interventions have said that interventions that have been scientifically tested and shown to work are more likely to improve the conditions of our clients than interventions that have not been scientifically validated (Weisz, Jensen-Doss, & Hawley, 2006). For example, Thomason (2010) maintained that if there are differences among different treatments in their benefits, then information on such differences should be available. Thus, requiring clinicians to remain informed about the effectiveness of EBIs.

It is evident that the mental health field is changing to accommodate the practical needs of third-party payers and not the individualized needs of the families (Urquiza, 2010). Practitioners in the mental health field who use third-party payers are required to provide more effective and scientifically proven treatments to families in crisis (2010). However, in a study funded by the Substance Abuse Mental Health Services Administration (SAMHSA) significant barriers were identified in implementing evidence-based interventions such as a lack of training and little instruction on how to handle obstacles to implementation (Corcoran & Vandiver, 1996).

Clinicians have continually used integrative therapeutic interventions in their practice, because they have found that methods from single theoretical orientations are often insufficient for treating the deep emotional wounds that result from traumatic experiences (Gil, 2006; James, 1989; Schafer, 1994; Terr, 1983;). Corey (2000) maintained that how a therapist works with traumatized children varies according to training and theoretical background.

TRAUMA IN CHILDREN

The high prevalence of trauma exposure among children (e.g., sexual-physical abuse, severe traffic accidents, natural disasters, experiencing or witnessing violence) has become the focus of researchers and clinicians (Feeny, Treadwell, Foa, & March, 2004). According to *The New Freedom Commission on Mental Health* (Hogan, 2002), the impact of trauma and the long-term effects of trauma are essential to understand because undiagnosed trauma in children has implications for the mental health system. Therefore, it is important to understand how children are affected by trauma and what interventions clinicians are using to reduce the psychological impact of the traumatic event or events.

Although the literature provides information about numerous interventions for clinicians from which to choose (i.e., play therapy; Bratton & Ray, 2000, & Bratton, Ray, Rhine, & Jones, 2005; and cognitive–behavioral; Allen & Johnson, in press), little can be found in regard to the clinicians' perceptions about what they believe to be effective interventions when treating traumatized children. In a recent nationwide survey conducted by Allen and Johnson (in press), they found that 78% of clinicians in the United States reported being trained in and using trauma-focused cognitive–behavioral interventions in clinical practice.

Much of the current research supports the use of cognitive–behavioral interventions for traumatized children (Allen & Johnson, in press; CDC, 2008); however, other interventions such as play therapy and eye movement desensitization and reprocessing have also been viewed as a developmentally appropriate treatment (Bratton & Ray, 2000; Silverman et al., 2008). Survey studies have found that clinicians prefer combined therapeutic approaches from cognitive, behavioral, and psychodynamic orientations (Prochaska & Norcross, 2007). In light of the current complexities of EBIs, two questions guided this study: "What are the interventions used by counselors who work with traumatized children?" and "What kind of understanding of evidence-based interventions do counselors have and how does that influence their use of other counseling interventions?"

RATIONALE FOR THIS STUDY

Few topics have caused such debate as the advantages and disadvantages of evidence-based interventions in the field of psychotherapy (Weis et al., 2006). Governing bodies such as the American Psychological Association (APA) argued that evidence-based interventions should be used instead of interventions that have not been shown to be empirically supported (APA, 2006). Others reported that these manual-guided treatments have limitations and restrict a counselor's creativity when handling challenging clients (e.g., Addis & Waltz, 2002; Strupp & Anderson, 1997).

In light of the current controversy (Thomason, 2010) over the effectiveness of EBIs, the primary goal of this study was to gain an understanding about what clinicians are finding effective in their clinical practice when working with maladaptive children. As stated in the introductory section, much of the empirical support for traumatized children includes the implementation of cognitive–behavioral interventions but does not include other effective treatment modalities such as play therapy. Several meta-analytic reviews of research studies have found strong support for play therapy interventions (Bratton & Ray, 2000; LeBlanc & Ritchie, 2001).

METHOD

A multicase design was used because the study focused on one major topic and then selected individualized minicases to understand the presenting concern (Stake, 2006). In a multicase design, the bounded case is composed of minicases, which share a common characteristic (i.e., working with traumatized children). Stake (2006) called this type of design a "quintain." The quintain becomes the umbrella to the mini cases. This method allowed the first two researchers to explore counselors in a variety of therapeutic environments (e.g., a community clinic, independent practice, and a privately funded clinical setting), thereby adding validity to the study (Stake, 2006).

Role of the Researcher

In qualitative research, researchers must bracket their expectations and biases (Patton, 2002). The first researcher began this study with a set of expectations and biases. For example, I counsel children who have been affected by trauma. In my practice, I also prefer individualized treatment plans when working with children and their families. Furthermore, I acknowledge a bias in favor of play therapy as a developmentally appropriate intervention for the treatment of children who have been affected by trauma. The second and third authors' bias are toward not using EBI and focusing on what works with each client.

Trustworthiness

In qualitative research, trustworthiness is described as a way of adding credibility, validity, and rigor to the study (Creswell, 2007). To add credibility to this study, the researchers used multiple sources of data. Triangulation of data is the process of corroborating evidence from different sources (e.g., a supervisor and a clinician), types of data (e.g., field notes and interviews), or methods of data collection (Creswell, 2007).

We took several steps to ensure credibility of the study. First, reflexive journaling was used during the research study to write about personal experiences and to address personal biases. Second, the interview questions were piloted with all members of the research team to verify that the interview questions would gather meaningful data. Third, following the data collection, we debriefed with one another to increase objectivity.

Participants and Recruitment Procedures

On receiving approval from the university institutional review board, participants were chosen using purposeful maximum variation sampling. Maximum variation sampling was used to obtain a diverse clinical perspective. According to Patton (2002), this strategy for purposeful sampling aims at capturing central themes that include variation. Thus, when choosing a small and diverse sample size, the data will reveal high-quality cases and shared patterns that emerge from their array of experience.

The research participants met the following criteria: They have provided counseling for traumatized children and have had training in trauma counseling. The initial participant, Angie, was a former colleague of the principle researcher in a mental health clinic and she provided the names of potential participants. The remaining 5 participants were contacted by telephone to establish eligibility and willingness to participate. During that time, they were informed about the purpose of the study, the right to withdraw from the study, data collection protocol, and any confidentiality concerns.

Six people ranging in age from 25 to 62 were selected for participation in the study. One of the participants was Black and 5 were White. The work environment of the participants consisted of the following: 2 of the participants were registered

play therapists in independent practice; 2 of the participants worked in community mental health clinics; one of the participants was an intern at a mental health clinic; and one of the participants worked at a privately funded clinic. Because of the diverse clinical experience, the researcher was able to capture core experiences and shared features of each clinician's experience in counseling traumatized children.

Each participant had a different level of training in trauma: One had 25 hr in 1 year; one had 100 hr in 10 years; one had 20 hr in15 years; one had 200 hr in 6 years; one had 1,000 hr in 30 years; and one had 500 hr in 11 years. The average age of participants' clients was 7.

According to Stake (2006), triangulation of data brings credibility to the research study. To establish triangulation, the first author collected data from numerous sources, including a written open-ended question, a semistructured interview, and observational field notes. Participants assigned themselves fictitious names to maintain confidentiality. Before the interview, each participant was asked to write down their definition of an evidence-based intervention when counseling children who have been impacted by trauma. From their response, I was able to determine how to guide the semistructured interview. For example, Lois (who is supervised by Susan) said, "I know what she (Susan) tells me. I haven't really sat down and read something that's evidence based or whatever . . . ." Another example of multiple sources of data collection includes my reflective journal where I recorded my thoughts and feelings that I felt were relevant to the process. For example, after my interview with Sarah (who was a counseling intern), I wrote about how I wished she would receive some training in play therapy. Journaling allowed me to acknowledge my preference for play and not let it negatively influence the research study. Observations of the participants also occurred during the interviews to examine participants' nonverbal responses to the interview questions. I noticed how Lois became uncomfortable when she talked about EBI. She looked in the other direction and quickly changed the subject. In addition to observing the participants, semistructured interviews were conducted to gain an understanding of interventions used with traumatized children and the counselors' understanding of evidence-based interventions.

Prior to participating in the interview, participants also completed a demographic questionnaire. Responses to the questionnaire provided information regarding the participant's age, gender, ethnicity, primary theoretical orientation, employment setting, and trauma training. The demographic questionnaire also included the one open-ended question, which asked participants to give their definition for an evidence-based intervention when working with trauma and children.

We, as the research team, developed questions based on our experiences in counseling children and based on the literature review. The participants responded to the following six grand tour items: (a) Describe your experience as a counselor who works with traumatized children; (b) Describe the interventions you use for treating traumatized children; (c) How do you determine what type of intervention to use for a child who has experienced trauma? (d) What is your familiarity with evidence-based interventions and how they are used with children? and (e) What would your perspective be if your job asked you to use an evidence-based intervention?

Data Analysis

Miles and Huberman (1994) stated, "We strongly recommend early analysis. It helps the field-worker cycle back and forth between thinking about the existing data and generating strategies for collecting new, often better, data" (p. 50). To begin the early collection of data, the primary author began journaling meaningful thoughts and ideas during the research study. For example, I described how each one of the participants became animated when they told about successful interventions used with clients. They were very proud of their hard work, and I wondered if they ever had an opportunity to explain what works for them in the counseling setting.

Each interview was digitally recorded, transcribed verbatim, and supplemented with observational field notes. The interviews were analyzed for content to establish common themes using hand analysis. According to Creswell (2007), hand analysis of qualitative data allows the data to be marked by hand and divided into common parts. Then the text is color coded and transferred onto index cards. Hand analysis allows the researcher to have a hands-on feel for the data without the intrusion of a computer. I used a different color index card and marker to identify common themes, and then the themes were combined by similarities. Using the constant comparative method, which also allows data to be analyzed early in the study (Patton, 2002), the interviews were compared to each other as they were transcribed. Finally, similarities and differences from the interviews were combined with the open-ended question and the observational field-notes by using the color-coded system. After the digital recordings were transcribed and verified for accuracy, they were deleted to maintain confidentiality.

RESULTS

Through the data analysis process, the following themes emerged: (a) building a relationship, (b) individualized treatment, (c) integrative interventions, and (d) resistance to implementing evidence-based interventions. These themes are defined and described in the following sections.

Building a Relationship

All 6 participants described the importance of building a relationship, as having a positive therapeutic alliance with clients. As participants spoke about the therapeutic process, building a relationship was the first component for all of their sessions. Sarah (a new counselor) said, "Allowing the kids to kind of feel in control of the session" does what? Finish your sentence is there more here? Chris, who has been providing counseling to children for 10 years, explained, "The first thing is just to start a rapport . . ." She also said, "If there is not a good connection, I don't care what you know, you're not going to get any work done." Angie stated that, "Eighty percent is the relationship, and 20% specific interventions." She goes on to explain,

"I think a lot of therapy is the relationship, and not so much what the child works with." When Mary spoke about the process, she said,

> It takes nurturing when the brain is developing in that area for it to be able to grow . . . it takes safety. You have to start with the basic stuff before you can graduate onto the next area, so Maslow's hierarchy is a triangle that points up, and the brain is kind of like a triangle that points down.

Susan said,

> We have found that onion that you have to peel and build the trust and know what they are safe to share some of that. Now you can make an environment and you can create a safety for them . . . like in group.

Lois explained that when she begins the session, "I usually ask them what kind of things they like to do for fun . . . so they can feel free to express themselves however they want to."

Individualized Treatment

Five of the 6 participants stated that each case is conceptualized based on what is best for the child. Sarah discussed the importance of modifying plans by stating, "We have had kids do a, you know, you just modify it based on their age and their interest." Sarah also explained that when she does a trauma narrative, "If the kid is four, I mean, in order to process their narratives, they might do paintings, drawing." Chris spoke about how much a mystery each child is when she said, "Each kid has their own [what?], and it's part of the fun of it and just learning to pay attention to them, to figure out what will work." Angie who has been working with maltreated children for 15 years said, "Every kid is different, and they are not all going to cooperate . . . you have to fit your client. My client is not going to fit me." She also explained, "I'm not into the cookie cutter." Mary, who bases her case conceptualizations on brain development, explained, "It's therapy with a neuro-biological under penning, like how do we, how do we direct therapy as a part of the brain needs it." As Lois spoke about individualized treatments, she said, "Like making suggestions of what they should paint, versus just telling them to paint."

Integrative Interventions

A common theme in the participant interviews was the idea of using integrative interventions to fit the needs of the child. Five of the 6 participants gave examples of how they used an integrative therapeutic modality, and Sarah indicated the opposite. Chris was quoted saying, "I do the stuff that fits me, and that I have seen work." Angie explained,

> I will use parts of TF-CBT, mostly, I will do the psycho-educational part, I will do the relaxation part, and then some of them I will do a narrative with. I might try it on for size, and if they go with it then okay.

When asked about integrative interventions, Mary stated, "I stay up on what is current. And I do a lot of case consultations . . . I try to get feedback from what

other people are using." When Susan discussed a male client, she said, "Particularly guys, they do not do so well in individual. You can't push someone and say this is what you need to do know . . . I see them and meet them where they are." Lois stated that, "Maybe nondirective is a good base, and then if necessary I use directive. If I feel like they need it. It depends on where the kid is at, what they have gone through."

Conversely, Sarah explained that,

> They are children, are more creative type things, so whether it is play therapy, or games that we used, but mostly it is trauma-focused cognitive. Give me a symptom, and I will give you an intervention. So that is what I am learning with TF-CBT, that they have interventions for certain behaviors, so I am constantly consulting with my supervisor on which one to use, but I still want to stay true to the issue . . . which is processing the trauma.

Resistance to Evidence-Based Interventions

The final theme that emerged from the study was resistance to evidence-based interventions. This theme was common among 5 of the 6 participants. For example, Angie explained how it is difficult to force clients to talk about their trauma. One of her older clients stated, "If you make me talk about my trauma, I will get up and I will leave and never come back." Angie further clarified the difficulty by saying, "I don't want to double traumatize them." In relation to this theme, she stated, "It's pretty much shoved down our throat and that's what we are going to do." Angie also explained, "Did not want anybody telling me to do something that I didn't feel would be successful for every single client. Not every client will benefit [from] the same thing." When I asked Mary what her familiarity with evidence-based interventions was, she said, "I don't know that I have ever read a definition of what evidence-based is . . . I try to stay up on what is current by reading the play therapy journal."

Conversely, Sarah was quoted as saying,

> I'm finding with this model (TF-CBT), it is more okay by the 15th or 16th session, you should be here, and I'm like okay that makes more sense to me, versus okay what do I use, what do I do, besides just sitting and building rapport.

Sarah seemed to find that being given more direction during the counseling sessions, "The easier it was to know what your outcomes were, and know that you are helping clients."

Limitations

The qualitative data acquired from this study offered insights into counselors who work with traumatized children in an urban, southern community. As a result, caution should be used when attempting to transfer the results of this study to rural populations due to the geographical nature of this study. All participants in the study were female, which demonstrates a gender limitation. Transferability was further limited because the study only had one African American participant, and

no other ethnic minority groups were represented (e.g., Hispanic, Asian American, or Native American).

DISCUSSION AND IMPLICATIONS

In today's world when there is growing pressure on professionals to justify their interventions and to work in an evidence-based context, it becomes imperative that child counselors begin to tell their stories. Counselors need to "find ways of conveying the nature of their therapeutic endeavor" (Barrows, 2001, p. 372). This study provides a voice for counselors who are providing services to children who have been affected by trauma. The findings of this study also provided insights in regard to the perceptions of counselors who work with traumatized children about their perceptions of evidence-based interventions. Play therapy was a major component for clinicians in this study. Although, only 2 participants were registered play therapists, all 6 participants used therapeutic play therapy techniques when working with traumatized children. Ryan and Needham (2001) posited that nondirective play therapy avoids treatment difficulties and is more likely to be used with more directive treatment approaches. The child is believed to have the ability to heal from the traumatic experience, given an environment of unconditional positive regard and empathy by the therapist. For example, Chris said, "I like to use sand tray with traumatized children." Angie explained, "And then of course play therapy . . . sand tray." Mary said, "I almost always begin with child-centered play therapy and then other things can be brought in." Susan said, "Create a therapeutic group play environment where they can be themselves as well as do something fun." Finally, Lois explained, "I find like a lot more art works with kids that are traumatized and I like to use clay with kids that have gone through any kind of traumatic event."

Snow, Wolff, Hudspeth, and Etheridge (2009) stated that, "As practitioners share their experiences and read of others' experiences in case studies using play therapy, the support for the use of play therapy naturally speaks to the clinician's world view" (p. 242). Participants from this study are choosing interventions based on what they have discovered through years of experience that are developmentally appropriate for the child.

Another main factor that emerged from this study was the clinician's resistance to evidence-based interventions. The less experienced counselor showed more acceptance for the use of evidence-based interventions. On the other hand, if counselors had been practicing for a while, they expressed more resistance to EBI. For example, Susan (the clinical supervision) stated, "It just does not work for everybody. I like to know who is saying this works. They obviously have never worked with kids."

A third major outcome of this study was how clinicians prefer to choose an intervention unique for every child. Similarly, we found that the majority of counselors use interventions that lead to positive outcomes with their clients. In light of the many reasons there are for the use of TF-CBT's effectiveness (Allen & Johnson, in press; Chambless & Hollon, 1998), it was not well received by the majority of counselors in this study as the only treatment intervention. Counselors used part of the protocol but did not use it in its entirety, particularly the retelling

of the trauma narrative. Counselors appeared skeptical of the concept that one intervention can be effective for all children.

This study is a beginning to the exploration into the perceptions and experiences of counselors who are working with traumatized children. On the basis of the findings of this study research should continue to focus on what factors influence a counselor's choice of interventions. We hope that the experiences of counselors will continue to be explored in the future.

Given the workforce crisis in mental health care (Hogan, 2002) counselor educators should inform mental health workers of the impact of EBIs on the counseling field. Training facilities should also prepare students to work in interdisciplinary environments that require counselors to utilize EBIs. One recommendation is to invite professionals and faculty from other disciplines into practicum classes to discuss how the mental health community can work together to better serve our clients.

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