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# Child Abuse & Neglect



## Giving a voice to traumatized youth—Experiences with Trauma-Focused Cognitive Behavioral Therapy<sup>☆,☆☆</sup>



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### ABSTRACT

The efficacy of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has been shown in several randomized controlled trials. However, to our knowledge no one has studied the TF-CBT model from a user's perspective. The objective of this study was to explore traumatized youths' experiences of receiving TF-CBT. Thirty youths between 11 and 17 years old ( $M = 15$ ,  $SD = 1.8$ ) were interviewed using a semi-structured interview guide after they had received TF-CBT as part of an effectiveness trial. The interviews were analyzed according to thematic analysis. The youths' responses were grouped into four themes: (1) expectations, (2) experiences of talking to the therapist and sharing information, (3) experiences of trauma narrative work, and (4) experiences of change and change processes. Findings showed how an initial fear of talking about traumatic events and not knowing what to expect from therapy was reduced when the youth experienced the therapist as empathetic and knowledgeable. Talking to the therapist was experienced as positive because of the therapist's expertise, neutrality, empathy, and confidentiality. Talking about the trauma was perceived as difficult but also as most helpful. Learning skills for reducing stress was also perceived as helpful. Important change processes were described as resuming normal functioning and getting "back on track," or as acquiring new perspectives and "moving forward." Because TF-CBT is recommended as a first line treatment for traumatized youth and treating posttraumatic stress may entail special challenges, understanding more about how youths experience this mode of treatment contributes to our knowledge base and may help us tailor interventions.

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### Introduction

In recent years an increasing amount of literature documenting children's views of the services they use has been published (Armstrong, Hill, & Secker, 2000; Dance & Rushton, 2005; Lightfoot & Sloper, 2003; Young, Nicholson, & Davies, 1995). In a literature review of adolescents' views of doctors, other healthcare professionals, educational psychologists, mental health, and social workers, Freake, Barley, and Kent (2007) identified 12 themes that emerged concerning the youths' experiences of receiving help from such professionals. Some of the important themes for the youths were: "What I

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tell them is confidential”; “They explain things and give me advice”; “They listen to me”; “They are kind, caring, sympathetic, understanding”; “I can trust them”; “They are competent, experienced, and qualified”; “They are nonjudgmental”; and “I feel comfortable and it’s easy to talk.” In this review, a large range of professional settings were examined, and the results give us important insights into how youths would like to be treated by adult professionals. However, none of the reviewed studies were with traumatized youths in therapy.

Although some such studies are emerging, research into children’s experiences with psychotherapy is still limited (Davis & Wright, 2008; Freake et al., 2007). Importantly, studies show that children can convey important information about how they experience therapy when asked. For instance, some studies have shown that many children did not know why they were coming to therapy or how they were supposed to act in the sessions, leaving them anxious in the first meetings (Jensen et al., 2010; Lobatto, 2002). Day, Carey, and Surgenor (2006) found that children thought it was important that the therapist was sensitive to when they were ready to talk about difficult topics. In a recent study, Donnellan, Murray, and Harrison (2013) examined adolescents’ experiences with cognitive behavioral therapy. In this study, the youths highlighted the importance of engagement and the therapeutic relationship in addition to issues related to change factors and deliverance. Such research is important because it can help us understand how to deliver therapy in a way that is useful and meaningful to these children. Listening to children can improve the quality of therapeutic work with children. Studies examining traumatized youths’ perceptions of therapy are nonetheless virtually nonexistent.

For children who have experienced trauma and suffer from post-traumatic stress symptoms, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is recommended as a first line treatment both in the practice parameters of the American Academy of Child and Adolescent Psychiatry (Cohen et al., 2010) and in the UK (NICE, 2005). TF-CBT is a component-based, manual-guided, short-term intervention. The treatment consists of psycho-education about trauma and trauma reactions, stress-management training, work with affect expression and modulation skills, creation of a trauma narrative and alteration of maladaptive appraisals. The parents are involved in the therapy process to a large degree through conjoint and separate sessions (Cohen, Mannarino, & Deblinger, 2006).

Despite the fact that several studies have documented the effectiveness of TF-CBT for reducing a range of symptoms in children suffering after traumas (Silverman et al., 2008), no one has yet studied the TF-CBT model from a user’s perspective. Therefore, we know little about what children themselves experience as helpful. Because therapeutic work with traumatized children who struggle with posttraumatic stress symptoms may entail specific challenges, gaining greater knowledge from the children themselves about what is experienced as difficult or helpful in therapy may bring the field a step closer to helping the many children who suffer from traumatic experiences.

One specific challenge facing therapists working with traumatized children is how to get children to collaborate in the necessary therapeutic tasks. One core component considered necessary in the treatment of posttraumatic stress reactions is working through the child’s trauma history. However, this is often challenging because talking about the trauma can result in re-experiencing the trauma and is therefore something children try to avoid. Additionally, Creed and Kendall (2005) found that children who were pressured by their therapist to talk about something that caused anxiety subsequently evaluated the therapeutic working alliance as poor. Because several studies have shown that a good therapeutic working alliance between the therapist and the client is a key factor in ensuring good outcomes in therapy (Shirk & Karver, 2003), including youths receiving TF-CBT (authors’ own publication), it is essential for a therapist to know how to balance the need to address troubling issues with the child’s avoidance of these issues. Better knowledge of how this is experienced from the child’s perspective may give valuable insights into this dilemma.

Another challenge for therapy with traumatized children is that they have often experienced what Pynoos (1994) depicts as “a fracture of the protective shield.” In other words, the children experience a reduced confidence in their parents’ and other adults’ ability to protect them from danger. In line with this, Janoff-Bulman (1992) describes how experiencing a traumatic event can lead to changes in people’s core assumptions about themselves and the world so that they no longer feel that the world is a safe place, that other people are good and trustworthy, or that they can control negative events. Reduced trust in other people can create challenges for the therapist’s work in establishing a good therapeutic alliance, because the therapist cannot assume that the child will have positive expectations of therapy or trust the therapists’ good intentions (Jensen et al., 2010). Thus, understanding more about traumatized children’s expectations of therapy may be important in guiding therapists during the initial phase of treatment.

We also know little about how youths perceive change and change processes. In the previously mentioned study by Donnellan et al. (2013), the youths described changes as an absence of difficulties or as changes in their sense of self. Some youths also described change as allowing them to do things they used to do as opposed to developing new perspectives and moving forward in their lives. In the psychotherapy literature, agreement on goals and on the therapeutic tasks needed to achieve these goals is often described as pivotal for treatment outcomes (Shirk, Karver, & Brown, 2011). Understanding more about what youths consider to be important therapeutic changes and achievements may aid therapists in attaining a good therapeutic collaboration and in enhancing treatment outcomes.

This paper seeks to bridge knowledge gaps and enhance therapy methods by exploring traumatized children’s experiences with receiving TF-CBT.

## Method

### Background

Thirty traumatized youths who participated in an effectiveness study testing whether TF-CBT is superior to therapy as usual (TAU) in eight regular mental health clinics were interviewed. All participants were referred for treatment through standard procedures. Youths reporting exposure to at least one traumatic event and presenting with posttraumatic stress symptom scores of 15 or higher on the Child Post-traumatic Symptom Scale (CPSS; Foa, Johnson, Feeny, & Treadwell, 2001) were eligible for the study. Mean post-traumatic stress levels at pre-treatment were 26.8 ( $SD=7.5$ ). The majority of the sample (66.7%) met diagnostic criteria for posttraumatic stress disorder (PTSD) using the CAPS-CA (Nader et al., 2004). In addition, 72.8% of the youths scored above the clinical cutoff for depression (MFQ; Angold, Costello, Messer, & Pickles, 1995), 66.4% scored above the cutoff for anxiety (SCARED; Birmaher et al., 1999) and 59.1% scored above the cutoff for other behavioral and attention problems (SDQ; Goodman, 2001). The adolescents reported being exposed to an average of 3.6 different types of traumatizing events ( $SD=1.8$ , range 1–10). When asked to specify which event they perceived as the “worst event” at intake 32.5% reported exposure to domestic violence and physical abuse, 29.1% reported sexual abuse, 18.0% reported violent attacks outside the family context, 16.6% reported traumatic loss (i.e., sudden death of a caregiver or a close person), and the remaining 4.0% reported exposure to accidents or other forms of non-interpersonal traumas. On an average, the time between the last traumatic experience and the referral to therapy was 30 months ( $SD=32.8$ ). The majority of participants had at least one European-born parent (81.4%) and lived in one-parent households (63.6%). The exclusion criteria were acute suicidal behavior, psychosis, or the need for an interpreter.

The TF-CBT therapists ( $n=26$ ) volunteered to receive training in TF-CBT and provide therapy to the participants who were randomly selected to receive TF-CBT. Most of them were psychologists (80.8%,  $n=21$ ); 7.7% ( $n=2$ ) were psychiatrists; 7.7% ( $n=2$ ) were educational therapists (masters of education and additional clinical training); and 3.8% ( $n=1$ ) were clinical social workers (a bachelor-level degree with additional clinical training). On average, therapists had 10.2 years of experience ( $SD=6.4$ , range 3–28). All of the therapists received between four and six days of initial training. Treatment adherence was supported through initial session-by-session supervision provided by trained TF-CBT therapists based on reviews of audio-recorded sessions. Fidelity was controlled for by using the TF-CBT Fidelity Checklist (Deblinger, Cohen, Mannarino, Murray, & Epstein, 2008). Results from the study showed that the youths receiving TF-CBT reported significantly lower levels of post-traumatic stress symptoms, depression, and general mental health symptoms compared to the youths in the TAU group (for a more detailed description of the study see author’s own publication).

### The Participants

The 30 youths interviewed in the present study were 11–17 years old ( $M=15$ ,  $SD=1.8$ ), 23 were girls and seven were boys, and all had received TF-CBT. They had all experienced at least one traumatic incident ( $M=3.3$  different types of traumas) such as sexual abuse, domestic violence, violence from peers, life threatening accidents, or the sudden death of a parent. Most of the youths had completed their treatment except for four youths who had ended treatment prematurely. Dropout was defined as not completing 6 sessions of TF-CBT. Seven of the youths had parents with a minority background (Table 1).

### Procedure

The youths who received TF-CBT were asked to participate in the interview study 1–3 weeks after they had completed treatment. They gave their informed consent as a part of the effectiveness study. After thirty youths had been interviewed, saturation was obtained (no prominent new themes emerged), and further recruitment was considered unnecessary. The interviews were carried out by the authors over the phone and tape recorded. We chose telephone interviews as an easy and convenient way to get in touch with the youths and to enhance the chances that they would participate. To ensure confidentiality, the youths were initially asked if they were in a place where they could talk privately, and if not, arrangements were made to contact them again.

The interviewers were 3 clinical psychologists (the authors acted as two of the interviewers), and they were not involved in the youths’ therapy. In preparation for the interviews, we collected information about what type of traumatic incident(s) the youth had experienced and whether they had dropped out of treatment or not. The study was approved by the Regional Committee for Medical and Health Research.

### The Interviews

A semi-structured interview guide was used. Because the aim of the study was to explore the youth’s views of therapy, we first asked several broadly formulated open-ended questions about therapy expectations and perceived help. We then asked focused questions about working with the trauma narrative, the youths’ views on confidentiality and having parents involved in therapy, because these are salient parts of TF-CBT. Lastly, we further explored the youths’ sentiments about therapy by asking them to give advice to children and therapists. The following questions were asked:

**Table 1**  
Participants sex, age and own perceived worst trauma.

Sex	Age	Own perceived worst trauma
Boy	11 years	Violent bullying at school
Boy	11 years	Violent bullying at school
Girl	15 years	Sexual abuse
Girl	16 years	Sexual abuse
Girl	16 years	Rape
Boy	17 years	Violent bullying at school
Girl	15 years	Rape
Girl	15 years	Violence from step-father
Boy	16 years	Threats of violence within family
Girl	15 years	Violence from mother's boyfriend
Girl	15 years	Witness to domestic violence
Boy	14 years	Violence from father and witness to domestic violence
Girl	15 years	Sexual abuse by step-brother
Girl	11 years	Friend killed
Boy	15 years	Mugged
Girl	15 years	Violence from peers
Girl	17 years	Father in serious accident
Girl	16 years	Sexual abuse outside family
Girl	15 years	Threats of violence outside family
Girl	11 years	Rape
Girl	17 years	Violence from mother
Girl	16 years	Violence outside family
Girl	15 years	Sexual abuse from step-father
Boy	15 years	Threats of violence and witness to violence
Girl	15 years	Sexual abuse from father
Girl	17 years	Violence from father
Girl	15 years	Violence from father and brother
Girl	13 years	Violence outside family
Girl	17 years	Sexual abuse from grandfather
Girl	16 years	Witness to domestic violence

- Tell me about how you experienced coming to the clinic?
- Do you feel that you received help with the problems you had?
- If you think back on how you were doing before you came to the clinic and how you are doing today, has anything changed? Why do you think this has changed?
- Did you and your therapist talk much about the difficult things that have happened to you? What was that like?
- Did your therapist talk to your parents without you being present? What did you think about that?
- Do you think it is different talking to a therapist than to your parents or other adults? What is different?
- If you were to give some advice to therapists who work with children who are struggling, what advice would you give?
- If you met another boy/girl at your own age who had experienced something difficult and who was struggling, what would you recommend they do?

### Analyses

The interviews were transcribed and analyzed according to thematic analysis. Thematic analysis is a flexible and theory driven method that is used to identify, analyze, and report patterns or themes in qualitative data (Braun & Clarke, 2006). Thematic analysis consists of five phases. The first phase involved becoming familiar with the data, which includes reading and rereading the data transcripts and making initial notes. The second phase involved generating preliminary codes identifying data that seems significant across the entire dataset. The coding was performed by extracting parts of the youths' answers that could indicate potential patterns. The interviews were systematically reviewed and sentences with significant meaning were given codes. For instance the sentence "I dreaded coming to therapy" was coded under "negative expectations" and the sentence "I feel much better today" was coded under "descriptions of change." We then sorted all the data using the codes. The third phase involved searching for salient themes into which the codes could be grouped. By searching through all of the coded data we found aspects of the data that seemed to make up superordinate themes that represented patterns in the data. We then sorted the codes into the different themes. For instance, one theme was "changing expectations," which included codes describing expectations and descriptions of what it was like to come to the clinic the first time. The fourth phase involved reviewing the themes and checking for their applicability across cases. Some of the themes were expanded to include more codes. For example, different descriptions of the therapist (e.g., liking and not liking) and aspects of what it was like to talk to the therapist (e.g., difficult or not difficult) were gathered under the theme "talking to the therapist" because these codes seemed to describe different aspects of the same phenomena. The last phase involved defining and naming the final themes. Finally, all interviews were re-read again to check whether the themes were consistent with the content in the interviews. From this process of analysis, four main superordinate themes emerged

and were labeled: (1) changing expectations, (2) talking to the therapist and sharing information, (3) working through the trauma narrative, and (4) change and change processes. To reduce researcher bias, both authors were involved in analyzing the data (Hill et al., 2005). The data were analyzed separately and then discussed. Differences were resolved by discussion and consensus (Hill et al., 2005). The findings are reported below along with selected quotes to illustrate the youths' views.

## Results

### *Changing Expectations*

When the youths talked about what it was like to come to the clinic the first time, about one-third (11) said they had not thought much about how it was going to be and described neither positive nor negative expectations. Only two of the youths had entirely positive expectations about coming to therapy; both of these youths had seen a therapist before and had positive experiences with this therapy. However, about half (17) of the youths said that they felt scared. The reasons for their anxiety were related to not knowing what therapy is and therefore not knowing what to expect, talking to an unfamiliar person and whether they would like their therapist. A 16-year-old girl said:

“When you are going to sit down and talk to another person about personal stuff and the other person doesn't know you and you don't know the person. . . in the beginning you are wondering what things will be like and what they will expect from you.”

A few (2) were particularly worried that the therapist was going to ask personal questions and pressure them to talk. Some (5) mentioned that they felt anxious about having to talk about the traumatic incidents. A 15-year-old girl said: “*I dreaded telling a strange lady what I had experienced.*”

Worrying about not getting along with the therapist was also mentioned as an initial concern by a few of the youths. For instance, one girl was worried that the therapist would be silent and “not talk back.” She had been to a therapist before whom she did not like, and this seemed to have affected her expectations.

Despite an initial anxiousness about coming to therapy, a few (6) described an immediate sense of relief after the first session. This seemed to be associated with experiencing the therapist as nice and someone who helped them feel safe. A 17-year-old girl said: “*When I saw her, (the therapist) she seemed really nice and she was very calm and very laid back and she didn't make me feel stressed. I felt I could relax.*”

A few (3) said they had not known why the therapist was asking the questions she was asking or why they were doing different assignments in therapy. For the therapist to clarify what was going to happen and why seemed to be important in helping the youths experience therapy as meaningful and safe.

### *Talking to the Therapist and Sharing Information*

A little over half of the youths (18) said it was easier to talk to the therapist than to their parents or other adults. They give four explanations for this: (1) the therapist's expertise, (2) the therapist's neutral position, (3) the therapist's ability to understand and communicate empathy, and (4) the therapist's confidentiality.

Some youths (6) reported that it was easier to talk to the therapist because the therapist was an expert and knew how to talk to people in a way that helped them. These youths highlighted the therapist's education and experience in working with other children. One 16-year-old girl said: “*the psychologist has studied how the patient may feel, and how he can make the patient feel better, and they know how they are supposed to talk and what to say and not say.*” In these reports one can see an understanding that talking in therapy represents something different from talking to other people in everyday life.

Many of the youths had experienced serious traumatic events, which may have been difficult for the parents to hear about. Some youths (8) felt it was easier to talk to the therapist because they felt (s)he could handle hearing about the traumatic incident to a larger extent than could their parents and that they did not need to be sensitive to the therapist's feelings. In this sense, the therapy room became a neutral place where the trauma could be explored. For instance, one 13-year-old girl said:

“It was nice talking to her because I knew I got help at the same time. . . . And then I wanted to talk to her a lot more than Mommy because I knew Mommy could not do anything about it. The only thing I knew when I talked to Mommy was that I made her more and more upset.”

A few youths (4) also said it was nice to talk to a person who did not know them in the same way that their parents know them. Two mentioned that it was nice to have a special place where they could talk and that talking in therapy felt more focused than talking to their parents. One 11-year-old girl said: “*I have Mommy all the time, but the therapist I can go to once a week and talk a little more and we are just doing that, not preparing dinner at the same time and stuff.*”

In addition, being understood was important and was mentioned by several youths. Some (4) said that they felt the therapist understood them better than did other adults or friends. Some (4) attributed the feeling of being understood to the therapist's knowledge of trauma reactions, which made him/her capable of understanding the child's difficulties. For instance, one 14-year-old boy said: “*But other adults. . . It's not certain that they will understand you, right? And maybe they*

think you are crazy. They can easily misunderstand.” Others said that they felt the therapist understood better how horrific the incident had been and therefore took them more seriously. Four also mentioned the importance of the therapist’s ability to communicate understanding and empathy. One 16-year-old girl explained:

“My friends said ‘Oh, everything will be all right, I understand, I know. . .’ and that bothered me very, very much. I wanted to punch them! Because they don’t know and they don’t understand! So there’s no point in saying that. However, when I went to (the therapist’s name) she never said ‘I understand’, she said ‘I think it would have been the same for me if I had been in your situation’. She never said ‘Oh, I know how you are feeling’.”

Some (5) also said it was easier to talk to the therapist than to others because of the therapist’s commitment to confidentiality. At the same time, about half of the youths (14) said that it was okay that the therapist spoke to their parents and shared some information. Having the therapist help convey the child’s trauma experiences and helping to share these experiences with the parents was described as positive by many of the youths (9). One 17-year-old girl said: “I wasn’t able to tell my mom about what had happened and how I felt, so it was nice that the therapist could talk to her about that.” Some youths (4) mentioned that they thought it was reassuring that their parents had received information about normal reactions to traumas and how they could handle their child’s reactions. One 15-year-old girl said “I thought it was okay that mummy spoke to the therapist because then she got information about what she could do regarding what had happened to me.” Three of the youths mentioned particularly that it was good that the parents got information about what they were doing in therapy. However, some (6) mentioned that it was important to them that they had agreed on what information could be shared. Some of the youths (4) who had not made this type of agreement said they felt nervous about what type of information their parents would receive. A 16-year-old girl said: “It felt rather bad. . . knowing that they may be talking about you, but not knowing what they are talking about.” Only a few youths (5) reported that talking to the therapist was more difficult than talking to their parents. Three of these explained that this was because the therapist did not know them as well as their parents. A 15-year-old girl said: “It is better to talk to Mom because Mom knows me. I only talked to the therapist about problems. Mom knows me when I am happy and she knows what is best for me. I prefer to talk to Mom. I don’t like getting to know new people and telling them all about my problems.”

#### *Working Through the Trauma Narrative*

An important part of TF-CBT is working through the trauma narrative in which the child talks about what has happened. The rationale for working through the trauma narrative is that exposure to the story helps the youths gain mastery over both reminders of the traumatic event and avoidance symptoms, helps correct distorted cognitions, and helps the youths to contextualize their traumatic experiences within their life. In such a situation the therapist expects the display of emotions.

When the youths were asked about what it was like to talk about the traumatic incident(s), two-third (20) of them reported that this was very difficult and that they had initially felt sad or scared. One 17-year-old girl said: “I started crying even when we only talked about doing it because I felt so scared.” Another 16-year-old girl said: “I was shivering and feeling tense in my whole body.” An 11-year-old boy said that he felt so scared that he had to leave the room and take a break to calm himself down.

Although talking about the traumatic incident was described as difficult and emotionally upsetting, many of the youths (8) showed understanding of why it was important to talk about it. This can be explained by the fact that the importance of working through the trauma story had been explained to them as part of the psycho-education component of their therapy. Many of the youths (13) reported that, although it was emotionally upsetting at the onset, they felt less upset during the process. A 15-year-old girl who had been assaulted said: “The whole purpose of the treatment was that the assault was to become like an ordinary memory and not something to be afraid of. And that turned out very well. The first time she read the story we had written out loud, I started crying, but after a while she could read it many times and I could read it myself without feeling overwhelmed.” Three youths mentioned that doing breathing exercises during the trauma narrative work was helpful for handling their emotions. A 15-year-old girl who had experienced sexual abuse said: “She (the therapist) said that if it was difficult we could stop and do some breathing exercises and that helped very much.”

Five youths said that talking about the traumatic incident did not become easier for them during therapy. Three of these youths dropped out of therapy. Two refused to talk about their trauma at all, and one girl said that she needed more time. The others reported that they felt worse after talking about the trauma and that this never changed. There may be many reasons that working with the trauma history turned out to be difficult for these youths. Three youths expressed a feeling of not being heard and that they felt pressured to talk. A 17-year-old girl said:

“It was the fact that I had to drag up the things that had happened and that I didn’t have time to think about it and that I felt pressured to talk about it when I didn’t feel ready. I wished we could have done it another time when I was more ready and that I could have decided when, but I felt that I couldn’t. . . that I had to say it right away. And when I said ‘no’ many times and that I couldn’t do it, she didn’t listen to me so at the end I had to say it to her. That was difficult for me.”

A 15-year-old girl explained that she felt she had recovered from the incident, did not need to work through the narrative, and that she became frustrated when the therapist did not believe her. She said: “It was okay to talk about it in the beginning,



but I got over it by myself quite fast and then it was quite frustrating that I had to talk about it every session when I really had forgotten about it. . . . I said it many times, but she always thought that I was just trying to keep it inside and that I wasn't over it."

In this situation, it is possible that the therapist misinterpreted the girls' reluctance as avoidance, when it may have been that the trauma story was sufficiently worked through.

### Change and Change Processes

After their treatment, most of the youths (25) described experiencing a positive change. A consistent finding is that many of the youths expressed the feeling that therapy was helpful (23). Change was described both as an absence of symptoms and as changes in how they thought, acted, and felt about themselves.

Some youths described having less trouble sleeping (4) and concentrating (3), feeling less anxious (4), and feeling less irritated (3). Quite a few (8) also said they did not think about the traumatic incident as much anymore. However, the most common description of change was that they felt happier and less depressed (10). A 15-year-old boy said: *"I'm in a much better mood and stuff. . . . I even heard it from a class mate. . . . and normally we boys don't talk about each other's mood and that kind of stuff, but I was actually told that I have become a much happier person. . . ."* These changes are mostly descriptions related to what things were like before the traumas and as an absence of problems or symptoms.

Another common description of change was in terms of altered thinking patterns (6). Some of the youths (3) said they experienced changes in how they thought about the traumatic incident, and others (3) said they experienced changes in how they thought about life in general and about their future. A 14-year-old boy said: *"I used to think negatively. . . . that life sucks. . . . That there wasn't any hope for me and that I would turn out to be a bad person. . . . But after starting therapy I started to think that things change and it's only me that controls the possibilities and that I should start doing my best and if I get. . . . when I get the chance I shouldn't lose it."* These changes point to future coping and are described as changes in their perceptions of self-control and agency. The youths attributed their change to the therapy and/or conditions outside therapy. Most of the youths (18) explained the change as a consequence of therapy. Many of the youths (9) said that it was helpful to learn techniques such as breathing exercises that they could use to deal with difficult emotions. However, the most frequent description of why the youths changed is that they had been able to talk about what had happened with someone (20). Many said it was a relief to be able to share their thoughts and feelings. An 11-year-old girl said: *"There has been a big change because before I thought a lot about the incident and then I had stomach aches all the time. . . . but when I came to the clinic they helped me talk about it so now. . . . now I feel much better."*

Seven youths reported that the therapy was not a helpful experience. Three of these said that they had experienced positive changes in how they felt about themselves. However, they did not attribute these changes to therapy but to changes in other areas of their life, for example to the fact that their parents had received help or that they had been catching up with old friends. The four others that did not perceive therapy as helpful dropped out of therapy. These said that this was because they did not get along with their therapist. One 15-year-old girl said: *"Since I didn't get along with the therapist I didn't get much out of it really."* Three said that talking about the traumatic incident only made them feel worse.

Two-thirds of the youths (20) said that they would recommend another child seek therapy or talk to someone if they experienced something difficult and were having a difficult time. This was also true of the youths who did not find therapy helpful. They explained that even though they themselves had not found therapy helpful, they thought that others might have a different experience. A 15-year-old girl said: *"If that person had, for example, experienced the same thing as me, then I would have recommended that they found someone to talk to right away, because it helps so much. Because it is almost dangerous in a way to be by yourself and think. . . . I used to cut myself and if I hadn't found someone to talk to, I could have. . . . cut myself again. Because I had so much anxiety and stuff. It's really just about believing in oneself and not being afraid of receiving help. That is the most important thing."*

### Discussion

Many therapists have found that working with traumatized youths is challenging, and talking about the traumatic events seems to be particularly demanding (Allen & Johnson, 2012). However, the data from the present study suggest that youths view working with their trauma stories as one of the most helpful interventions. Moreover, although about half of the youths in the study expressed anxiety upon initially engaging in treatment, they were often swiftly put to ease when they found the therapist to be kind, empathetic, and knowledgeable. Providing information about the rationale for treatment was also considered helpful, and almost all the youths felt that therapy had been useful. These findings are important because numerous studies have documented that in order for trauma treatment to be effective the methods used must include some form of exposure work (Cohen, Mannarino, Deblinger, & Berliner, 2009).

The finding that many youths emphasized issues related to confidentiality, receiving information and advice, being listened to, trust and understanding, and the therapists' clinical competency mirror the findings in a review of what adolescents say is important to them when meeting professionals (Freake et al., 2007). Traumatized youths are in this sense no different than other youths seeking services. Nonetheless, some distinctive issues were raised by the youths in this study, which may prove useful to clinicians working with trauma patients. These are related to avoidance of trauma related themes, issues of confidentiality and sharing information with parents, and change processes.

### *Dealing with Avoidance*

The fact that so many of the youths expressed negative expectations about coming to therapy is noteworthy and may reflect the core symptom of posttraumatic stress, namely avoidance. In particular, the youths described feeling anxious about talking about their trauma history with a person they did not know. Because many traumatized youths have experienced a breach in their core conception of adults as trustworthy and capable of protecting them from harm, they may be more sensitive in areas related to trust and alliance than are other young people seeking help. The findings from the study show that this initial reluctance diminished quickly for most of the youths. The youths explained that experiencing the therapist as nice and trustworthy and that they knew what to expect was important to them. These features may be considered important in all therapeutic processes but may be particularly important for traumatized youth. It may be that several of the components in TF-CBT contributed to this change in sentiments. In the TF-CBT protocol, the emphasis is on providing continuing psycho-education about the child's symptoms, normalizing reactions, and explaining the rationale for the interventions. Explaining what one is doing and why seems to be one way of helping youths feel safe and also emphasizes collaboration and agency, which may be important for the development of the therapeutic alliance. [Creed and Kendall \(2005\)](#) found that establishing a cooperative relationship between the child and the therapist contributed to establishing a good therapeutic alliance. Particularly, it seems that explaining to youths why it is important to talk about the traumatic incident and how this can lead to symptom reduction can motivate them to endure discomfort during the exposure process. Providing gradual exposure to the traumatic experience and teaching the young person skills to help them handle overwhelming emotions may also help them experience working through the trauma as helpful and something they can manage. Additionally, gradual exposure may contribute to a feeling of collaboration where the child does not feel under pressure to talk.

Interestingly, four of the youths who reported negative views of the therapy and a reluctance to talk about their traumas dropped out of therapy. This underscores the importance of the therapist being sensitive to the youth's feelings throughout the therapy process and carefully monitors the working alliance. The therapists who successfully managed the balance between getting the young person to talk about the traumatic incident without pressuring them seem to be the ones that the youths were most satisfied with. This can be explained by the youths' need to feel in control. It can also be explained by adolescents' need for autonomy. [Church \(1994\)](#) found that therapists who used techniques that took into account adolescents' need for independence and autonomy, for example by focusing on cooperation and confidentiality, were considered the best therapists by the adolescents. The fact that the majority of the youths said that talking about the traumatic event was important for them to get better shows that even though it may be uncomfortable it is possible to conduct a process of exposure to the trauma incident in ways perceived as meaningful and useful by the youth. Authors and others (2013) found that relationship processes are important but that alliance alone is not sufficient for therapeutic change in the absence of specific trauma-focused components. However, a strong alliance may help the therapist use the techniques that are necessary to reduce the symptoms.

Additionally, because of the youths' reluctance and fear related to talking about their traumatic experiences, it seems especially important that the therapist appears confident about the trauma exposure work and that the therapist can regulate any of the youths' emotions that may arise. Exposure work may be challenging for therapists when the traumatized youth displays strong emotions during the narrative exposure work. Conveying confidence in the importance of exposure to the youths and being able to handle the youths' expressions may be very important for being successful in completing the narrative. Furthermore, because many youths conveyed a sensitivity toward others reactions to the trauma, it is important that the therapist is able to handle their own reactions.

### *Confidentiality and Sharing Information with Parents*

Many of the youths interviewed in this study felt they could not share their experiences with their parents or friends. Although this also may be true for youths suffering from other disorders, it may be a particular challenge for traumatized youth. As mentioned above, aspects related to avoidance and re-experiencing may make talking especially challenging for youths who suffer from post-trauma symptoms. In addition, many of the traumatic experiences the youths had, such as sexual abuse, produced feelings of shame and were therefore difficult to talk about. Also some youths had experienced traumas that their parents may feel responsible for, such as domestic violence. Therefore, they may be reluctant to share experiences with the parent that was the victim of the violence in consideration of their feelings. Lastly, some of the youths' experiences may have been difficult to share because they themselves may have felt responsible for what happened, for instance if they had been drinking before they were assaulted.

Therefore, it is understandable that many youths reported that the therapist's oath of confidentiality was important to them. [Harbour \(2004\)](#) argues that understanding children's rights to confidentiality requires taking into account both the interest of the child in maintaining confidentiality and the necessity to override their privacy, for example when they reveal information that parents need to know in order to protect their child. This can be a difficult matter of professional judgment. Based on this study, it seems that making clear agreements about what type of information must be shared is important. In regard to information that the child does not want to share, it may be appropriate to investigate why the child does not want to share this information. For example, if a child does not want the parents to know what they have experienced because they want to protect their parents' feelings, it can be important to explain further why the therapist



thinks it important to share the narrative. Because it is the parents who are responsible for the on-going care of the child, it is important that the child's trauma history is something they can talk about with them so that the parents can continue supporting the child after treatment. It is also important for the child to know that their parents can tolerate hearing what they have been through because this may help to re-establish their view of their parents as a "Protective shield" (Pynoos, 1994). It is worth noting that although the youths were concerned with confidentiality and predictability in what was to be shared in sessions with their parents or in separate sessions many explained that the sharing of information was helpful and appreciated.

### *Understanding Change Processes*

Most of the youths in this study experienced changes, and they attributed these changes to the therapy they received. Many of the youths mentioned working with the trauma-narratives and learning skills to cope with stress and trauma-reminders as the most helpful. Some youths experienced positive changes but attributed these to either changes in their parents or other changes in their lives. The changes the youths describe are altered mood, behavioral changes, changes in thinking or changes in self-worth. These are similar to the changes that youths involved in CBT described (Donnellan et al., 2013). They can be described as getting "back on track" or changes that help them "move forward". These therapeutic goals may be described both as an absence of symptoms and as gaining new knowledge and insight that may result in future mastery and enhanced sense of self. TF-CBT aims to target symptoms, and the goal is symptom reduction and improved functioning in several domains. This is achieved by teaching skills so youths can master trauma reminders, stress reactions, and unhelpful appraisals (Cohen et al., 2006). For traumatized youths who have experienced loss of control and feelings of helplessness, gaining mastery may lead to heightened feelings of agency, self-worth and hope.

It is worth mentioning that four youths who did not experience therapy as helpful dropped out of therapy. These youths also explained that they did not like their therapist. This could possibly underline the importance of the therapeutic alliance in instigating change. In order for youths to engage in the tasks considered necessary for change and to minimize drop-out, there must be a positive working alliance (authors own publication).

### *Strengths and Limitations*

This study has some strengths and limitations that are worth mentioning. The strength of this study is that this is the first study to examine how evidence-based treatment for traumatized young people is experienced from a user's perspective. It is a further significant strength that the youths were interviewed by clinicians not involved in the therapy. Studies have shown that youths may be reluctant to give critical opinions when interviewed by their own therapists. However, one possible limitation is that the interviews were conducted over the phone. Telephone interviewing is often considered a less suitable method than face-to-face interviewing because it reduces access to nonverbal communication and contextual information (Novic, 2008). On the other hand, Carr (1999) argues that telephone interviewing has been shown to provide at least as rich and valuable data as face-to-face interviewing. An important advantage of conducting interviews over the phone is that some interviewees may feel more anonymity and therefore feel it easier to talk about sensitive or shameful topics (Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). Because of the explorative nature of this study, we asked broadly formulated questions about the youths' therapy experiences. More specific questions about the particular components of TF-CBT would have given even greater insights to how the youths experienced working with the model. Future research could build on the findings of this study and explore in more detail the specific challenges of working with a trauma-focused intervention and the best means of dealing with these challenges. Nonetheless, learning more from the youths who choose to drop-out of treatment may give us valuable information on how to tailor treatment interventions.

Research into youths' experiences of therapy is limited, particularly for youths who have been traumatized. This study shows that youths can give valuable insights into expectations, challenges, and successes in therapies with severely traumatized youths when asked. Several studies have demonstrated the effectiveness of TF-CBT for these youths, and the model is being implemented worldwide. The findings in this study add a valuable perspective on how and why the model may be so helpful and provides us with information on possible pitfalls to avoid. The study demonstrates the importance of handling negative expectations to therapy, being empathetic and trustworthy, coping with the youths' fear and avoidance, being sensitive to the youths' emotional expression, and openly discussing the sharing of information with parents and youths. In this work, it may be helpful to know that the youths in this study valued the trauma narrative work as the most helpful.

However, this study is only a starting point and future research can elaborate on these findings in several ways. It would be interesting to ask more focused questions regarding the different components of TF-CBT and how to overcome specific challenges. Also because this study relied on retrospective reports, it would be interesting to interview the youths at different time points during therapy and explore changes in experiences and how they may relate to the alliance or particular components of the therapy. Additionally, future research could explore more closely the ways different trauma experiences may influence the therapeutic process and the youths' experiences.

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