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<ins>Walden University</ins>

College of Social and Behavioral Sciences

This is to certify that the doctoral study by

Shayla Valencia Polk

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the review committee have been made.

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Walden University
2021

Abstract

Integrating TF-CBT and Play Therapy: Promoting Resilience in Child Sexual Assault Survivors

by

Shayla Polk

MSW, Louisiana State University, 2015

BA, University of Louisiana at Lafayette, 2013

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Social Work

Walden University

May 2021

Abstract

Licensed social workers and counselors provide services to children who experience child sexual assault (CSA), which disrupt their normal childhood developmental processes. Trauma outcomes include symptoms related to somatization, inability to cope, feelings of helplessness, decreased self-esteem, difficulty expressing proper emotions, anxiety, depression, and posttraumatic stress disorder. Trauma-focused cognitive-behavioral therapy (TF-CBT) combined with play therapy can be helpful for CSA survivors. Still, it is not yet fully understood how therapists perceive the combined approach or how it fosters resiliency in children who experience sexual assault. The purpose of this action research study was (a) to explore the experiences and perspectives of trauma-informed licensed social workers and counselors who use a combined approach to TF-CBT and play therapy in treating children who were sexually abused and (b) to understand factors that increase resiliency in CSA survivors. The research question was guided by resilience theory, a strengths-based conceptual framework. An action research study with a qualitative research design was used with expert sampling to conduct a focus group with six participants. The data were transcribed and coded using thematic analysis. In vivio and descriptive coding, methods were used to identify themes. Findings revealed that alleviating trauma outcomes was possible with appropriate psychotherapy treatment, thus increasing resiliency outcomes. This study's results promote positive social change and efficacy on integrating TF-CBT and play therapy, strategies to increase resilience and vicarious resilience.

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Dedication

I dedicate this study to all survivors of sexual assault. You are not broken, you are not a victim, you are whole, you are a survivor. May you continue to thrive and prosper.

I also dedicate this study to all trauma therapists who devote their time and effort to meet their clients' needs to the best of their ability. You are supported in your endeavors. You make the world a better place.

To my family, I dedicate this study to all of you; your love, encouragement, and unwavering support throughout this journey were unfathomable. Your support allowed me to keep my dream alive, and now I can share this dream with others. I just want to express my heartfelt gratitude by saying thank you.

Acknowledgments

To my committee--my chair, Dr. Susan Parlier; second committee member, Dr. Mary Larscheid, and URR, Dr. Kristin Richards--thank you for dedicating your time and efforts to help me complete this journey.

To my family--my parents, Clarence and Gwendolyn, you have been my steady support system, and I thank you both for instilling in me the drive to pursue all my goals and dreams with vigor. I honestly could not have done it without your love and support. To my sisters, Voneishia, Destiny, and Acqualyn, thank you all for being my almond butter to my jelly. Your sisterly support made a world of difference throughout every phase of this journey. I pray we always uphold and cherish this sisterly bond; I love ya'll. Specifically to Destiny, thanks for putting up with my anxiety, long nights, and venting throughout this project; I know you were tired of me because I was tired of myself, but you consistently urged me on. To my brothers, Cornelious and Horatio, I love you both. To my niece, Aronda, I love you, and I hope to continue to make you proud. Also, Haven, Mayson, Sariah, and Hannah, Auntie Shay, love you.

To my fellow doctoral support system who were also on their journey but still found the time to support my journey--the doctoral sisterhood, the Lord knew what he was doing when he placed all of you amazing women in my life. Your support on this journey sustained me, especially when I had no energy or drive; I could not have finished without you all. We did this together. To J. C. Thomas, thank you for being my accountability partner, the best cohort support, and for encouraging me faithfully throughout this journey. Now I am handing the baton back to you; finish strong.

To my friends, I could name you all, but I don't have to because you know who you are. Every step of this journey, you were present, through the struggle, and now the success. Thank you for sticking around and understanding the journey and the process. I am forever grateful that I have every one of you in my life.

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Section 1: Foundation of the Study and Literature Review

Introduction

Trauma-focused cognitive behavioral therapy (TF-CBT) is a psychotherapy treatment that is often used with child sexual assault (CSA) survivors. Psychotherapists use TF-CBT to teach CSA survivors effective communication skills, body safety education, trauma processing, coping mechanisms, and emotional regulation skills through psychoeducation (Ruiz, 2016). Ruiz (2016) found that children who complete at least 3 months of TF-CBT show a decrease in anxiety, depressed mood, posttraumatic stress disorder (PTSD), and dissociation linked to experiencing sexual trauma.

As an intern at a children's advocacy center, I participated in the therapeutic methods of TF-CBT and play therapy with CSA survivors, a technique I solely used during my first 6 months. Following educational training in play therapy, I incorporated the modality into TF-CBT treatment with clients for the last 6 months of the internship. Therapists use play therapy to treat children's emotional and behavioral needs through play, teaching them to express symbolic language (Tornero & Capella, 2017). As a component of psychotherapy with children who have suffered sexual abuse, play therapy can be adapted by therapists to meet the child's needs while maintaining the goals of treatment (Tornero & Capella, 2017). Play therapy allows children to act out different aspects of trauma associated with sexual abuse through trauma play, which can be repetitive, more direct, and less imaginative than typical child play(Tornero & Capella, 2017). During the latter half of my internship, I became interested in the intersection of

TF-CBT and play therapy in psychotherapy as a means for building resiliency in CSA survivors.

Child sexual assualt happens across all demographics, in all communities, and across all cultures and socioeconomic backgrounds (Murray et al., 2014). Survivors of CSA might develop somatization, borderline personality disorder, anxiety, PTSD, depression, or dissociative identity disorder as coping methods. In addition, some survivors engage in poor social and interpersonal relationships and inappropriate sexual behavior (Foster & Hagedorn, 2014; Matulis et al., 2014; Murray et al., 2014; Nair & Shukla, 2017). The adverse effects of CSA on the survivor's mental health can result in a range of mental health disorders, the symptoms of which therapists can minimize through preventive interventions. Preventive interventions include the use of psychoeducation, cognitive and behavioral strategies, and developmentally appropriate psychotherapy techniques (Domhardt et al., 2015; Foster & Hagedorn, 2014; Matulis et al., 2014; Murray et al., 2014; Nair & Shukla, 2017).

Structured TF-CBT is one of the therapeutic interventions for child survivors of sexual abuse. The developers of TF-CBT focused their psychotherapeutic treatment method toward providing service to children and adolescents who had experienced trauma or received a mental health diagnosis as a result of trauma (Diehle et al., 2015; Jensen et al., 2014; Lenz & Hollenbaugh, 2015; Ramirez de Arellano et al., 2014). TF-CBT is a combination of behavioral and cognitive theory with a focus on trauma interventions (Cohen et al., 2018; Murray et al., 2013; Ramirez de Arellano et al., 2014). The psychotherapy method, TF-CBT is centered around the trauma and cognitive aspects

of the child or adolescent and includes psychoeducation, cognitive coping, and trauma narrative and processing (Allen & Hoskowitz, 2017).

Other therapists prefer using nondirective experiential approach involving play therapy with CSA survivors as opposed to TF-CBT (Allen & Hoskowitz, 2017). Therapists use play therapy to treat children impacted by sexual abuse that has disrupted their developmental processes and psychological functioning (Tornero & Capella, 2017). Yet, Allen and Hoskowitz (2017) found several studies that promoted TF-CBT and play therapy for use with CSA survivors. Incorporating TF-CBT and play therapy may facilitate the development of resilience in children who survive sexual abuse, research suggests (Allen and Hoskowitz, 2017). Some children and adolescents pass through a self-motivated developmental process of positive adaptation in light of CSA or adversity, a state defined as resiliency (Domhardt et al., 2015).Resilience may foster positive social change for children who experience CSA through continued evidenced-based research and practices that aid in increasing resiliency. Resiliency theory promotes a strengths-based approach to understanding healthy development in a child who has experienced disrupted developmental process because of trauma (Zimmerman, 2013). In this study, I used resiliency theory to explore the experiences of trauma-informed licensed social workers and counselors who work with CSA survivors and use a strengths-based approach of TF-CBT and play therapy. I wanted to explore therapists' experiences in helping children overcome the disruption of child development as a result of sexual assault. In alignment with Ravitch and Carl (2016) and Rubin and Rubin (2012), this study had a focus on lived experiences that are both complex and subjective. Social

researchers who conduct qualitative studies use a naturalistic approach that focuses on how a person determines reality based on personal experiences and perceptions (Rubin & Rubin, 2012). In alignment with Ravitch and Carl (2016) and Rubin and Rubin (2012), this study focused on lived experiences that are both complex and subjective.

The study sample consisted of social workers and counselors working at schools, private agencies, and children's advocacy centers in South Louisiana. For the purposes of this study, licensed social workers were licensed master's social workers (LMSWs) or licensed clinical social workers (LCSWs) licensed by the Louisiana State Board of Social Workers (LABSW) who have been in practice and compliance with the LABSW for a minimum of 2 years. Licensed counselors were licensed professional counselors (LPCs) or provisional licensed professional counselors (PLPCs) licensed by the Licensed Professional Counselors Board (LPCB) of Louisiana who have been in practice and compliance with the LPCB for a minimum of 2 years. Data collected from the sample of trauma-informed licensed social workers and counselors provided information conducive to ongoing community support. Community support means contributing knowledge, skills, and techniques in the form of psychotherapy tools for child survivors of CSA as part of a broader effort to increase mental health services to children and families.

The following sections of this study include the problem statement, purpose of the study, research question, nature of the study, methodology, reliability, validity, and the conceptual framework. I describe the ethical procedures that align with the National Association of Social Workers (2017) Code of Ethics and review peer-reviewed academic journals, professional literature, and publish books. Using supporting literature,

I present information on this action research study with a qualitative inquiry and its participants. I also share information on data collection method, data analysis, and the ethical procedures used throughout the data analysis process. I report the data analysis findings as they relate to the research question and share how they align with the conceptual framework. Also, I share how these findings relate to social work practice and contribute to social change.

Problem Statement

Child sexual assault (CSA) has a high prevalence rate and has adverse effects on a child's mental health (Matulis et al., 2014). Despite experiencing CSA, some children and adolescents can develop protective factors leading to resiliency (Domhardt et al., 2014). Internal protective factors that are associated with the individuals and their environment include optimism, hope, self-esteem, control beliefs, interpersonal confidence, positive social attachment, locus of control, coping skills, and social supports (Domhardt et al., 2014).Children who experience sexual assault can develop these protective factors by participating in developmentally appropriate psychotherapy interventions.

This action research project derives from a literature review on the intersection of TF-CBT and play therapy with CSA survivors. In 1998, Knell focused on play and cognitive change by combining play therapy and cognitive-behavioral therapy (CBT). Springer et al. (2012) later introduced game-based cognitive-behavioral therapy with CSA survivors, incorporating developmentally appropriate games with CBT. Game-based cognitive-behavioral therapy helps to reduce anxiety, depression, anger, negative

behaviors, sexually inappropriate behaviors, and PTSD symptoms through psychoeducation and games in a psychotherapy session (Misurell et al., 2014). By exploring the nature of psychotherapy from the perspective of trauma-informed licensed social workers and counselors, I sought to provide insight into treatment outcomes as they relate to CSA survivors' resiliency.

Purpose Statement and Research Question

The purpose of this action research study was (a) to explore the experiences and perspectives of trauma-informed licensed social workers and counselors who use a combined approach to TF-CBT and play therapy in treatment with children who were sexually abused and (b) to understand factors that increase resiliency in CSA survivors. This study's research question was as follows: What are the experiences of trauma-informed licensed social workers and counselors when combining TF-CBT and play therapy in a psychotherapy session with CSA survivors? This project builds upon knowledge obtained from the experiences of social workers and counselors. The information gathered may help uncover techniques these social workers and counselors have found to be successful.

Nature of the Doctoral Project

The study of knowledge, or epistemology, in qualitative research studies centers on lived experiences, which are complex and subjective (Ravitch & Carl, 2016). Ravitch and Carl (2016) noted that ontology concerns the "nature of being or reality," as "there is not a single truth or reality" (p. 6). Hence, in a qualitative study, the researcher gathers data that can be understood, practiced, formed, and constituted.

This project contributes knowledge to the fields of social work and psychotherapy. The sample comprised licensed trauma-informed social workers and counselors who worked with CSA survivors. All of the participants were engaged in social work or counseling practice with children's advocacy centers, schools, or private practice agencies in South Louisiana.

Methodology

The goal of this action research project was to obtain an understanding of people and groups by analyzing and reflecting upon their situations, circumstances, and perceptions as related to their life experiences (see Ravitch & Carl, 2016). Action researchers do not generalize data; instead, they engage individuals to find solutions for addressing their identified problems and increasing effectiveness and efficiency related to the problem (Stringer, 2014). Qualitative research is unconstrained, enabling the exploration and description of the personal narratives of individuals and their values, actions, and belief systems (Erickson, 2011) to be understood, compared, and applicable to others (Stahl & King, 2020). Fundamentally, qualitative researchers focus on the differences in meaning shared by individuals from their perspective (Erickson, 2011). The qualitative inquiry provides researchers with narrated storytelling data that is rich and based off of human experiences (Stahl & King, 2020)

Action researchers collect various empirical materials such as case studies, firsthand experiences, interviews, artifacts, and observations (Denzin & Lincoln, 2013; Stringer, 2014). Qualitative researchers also explore various texts looking for common themes, meanings, and problems (Denzin & Lincoln, 2013). Qualitative research involves

engaging with individuals who are the experts on their own experiences (Ravitch & Carl, 2016). At the core of a qualitative study is the researcher's effort to understand the experiences of another, as shared by the individual participating in the study. A qualitative action research approach enables a researcher to capture the essence of "everyday, concrete, human experiences" (Stringer, 2014, p. 58), allowing for a better understanding by giving voice to people and their experiences.

The phenomena of interest in this project were social workers' and counselors' combination of TF-CBT and play therapy and the relationship between such treatment and the building of resiliency in children who have experienced sexual abuse. This project consisted of one recorded focus group interview with six trauma-informed social workers and counselors. At the time of the study, participants were employed at a children's advocacy center, school, or private practice agency in South Louisiana where they worked with CSA survivors.

The focus group was a scheduled interview with individuals who worked with the specific population of child survivors of sexual trauma. Researchers use focus groups to collect in-depth information on perceptions and behaviors to understand a particular issue or topic (Laureate Education, 2016a; Onwuegbuzie et al., 2009; Ravitch & Carl, 2016; Rubin & Rubin, 2012). Focus groups often consist of six to 12 individuals and last between 1 to 2 hours (Laureate Education, 2016b; Onwuegbuzie et al., 2009). The size of a focus group must be sufficient to provide detailed information to reach data saturation and ensure participants' comfort in sharing their thoughts, experiences, opinions, and belief systems (Onwuegbuzie et al., 2009; Ravitch & Carl, 2016; Rubin & Rubin, 2012).

The focus group for this study took place on Zoom, an online video and audio platform for meetings. Data from the focus group interview allowed for codes, subthemes, and themes to emerge. I used Rev.com, an online transcription service o transcribe the interviews verbatim using a human transcriber. A thorough analysis of data was conducted following transcriptionthrough coding, theme identification, and a summary (see Laureate Education, 2016a; Rubin & Rubin, 2012). A code is a word or phrase extracted from the data and used by a researcher to attach meaning as a means for explaining and describing what happened within the data (Laureate Education, 2016a; Ravitch & Carl, 2016; Saldaña, 2016). Themes emerge from the analysis as the result of coding (Saldaña, 2016).

Reflexivity

Throughout data collection, I used reflexive writing to record all activities and how my feelings and thoughts helped my interpretation and understanding. Reflexivity is researchers' systematic assessment of themselves, their positionalities, and their subjectivities (Ravitch & Carl, 2016). Reflexivity is a tool to foster self-awareness throughout the research process by writing reflective notes and memos regarding the researcher's role and influence, which could affect the interpretation and meaning of the data.

Bias

Bias in research occurs when researchers allow their own meanings and interpretations into the data, thus misinterpreting the study results (Babbie, 2017; Laureate Education, 2016a; Ravitch & Carl, 2016; Rubin & Rubin, 2012). My awareness

of the need to increase literature informing best practice among CSA and trauma therapists stemmed from my previous work with CSA survivors, during which time I learned of the lack of evidence-based psychotherapy treatments. In conducting this project, I hoped to gain an understanding of trauma-informed social workers' and counselors' experiences and perceptions regarding incorporating play with children while engaging in talk therapy as a way to strengthen their resiliency. Through reflexive writing, I sought to be aware of my experiences, assumptions, and opinions on combined TF-CBT and play therapy to minimize the potential for bias. I wanted to respect and understand the experiences of trauma therapists who are actively engaging in TF-CBT and play therapy with CSA survivors.

Significance of the Study

This action research project was a means for social workers and counselors to share their experiences in administering TF-CBT and play therapy in a clinical setting with sexually abused children who have experienced anxiety, control issues, depression, PTSD, or other mental health symptoms as a result of their traumatic experiences. The focus was on emerging research of evidence-based practice to address the gap in the literature on combined TF-CBT and play therapy. Recognizing that most children display resilience following a traumatic event, TF-CBT practitioners focus on preventing long-term adverse outcomes (Cohen et al., 2018). Play therapy is a means for decreasing negative outcomes in children through the art of play, allowing children to use developmentally appropriate play to overcome adversities (Kottman & Meany-Walen, 2016).

Implications for social change include the enhancement of continuing education, supervision, training, and community support. Ongoing social change for CSA survivors incorporates continued psychoeducation, the reduction of adverse outcomes, and the development of positive outcomes through coping skills, social supports, safety education, and the restoration of hope in CSA survivors and their families. Other implications for social change include the contributions this study will make to the field of social work on the intersection of TF-CBT and play therapy in clinical social work and counseling practice.

Conceptual Framework

Resilience theory was the conceptual framework for this study. According to Jabareen (2009), a conceptual framework is a construct whereby concepts play a vital role, providing an interpretative approach to social reality as well as understandings and elucidations of the study. Jabareen deemed conceptual frameworks indeterminist in nature, thus eliminating the need for a predicted outcome. A conceptual framework is qualitative in analysis, with data consisting of many discipline-oriented theories (Jabareen, 2009).

Resiliency is "the process of coping with stressors, adversity change, or opportunity in a manner that results in the identification, fortification, and the enrichment of protective factors" (Richardson, 2002, p. 308). The conceptual framework of resilience theory is strengths-based, aiding in understanding the development of children and adolescents and enabling a researcher to further intervention designs (Zimmerman, 2013). Greene (2002) explained that resiliency theory is a biopsychosocial and spiritual

phenomenon that includes individuals' engagement within their person-environment and the process of goodness of fit. A theoretical understanding of resilience theory emerged from research in the early 1980s and 1990s focused on children at risk, the study of risk, and its roots within the ecological context and strengths perspective (Greene, 2001).

As it relates to resilience theory, the ecological perspective focuses on the microsystem, mesosystems, exosystems, and macrosystem, all of which influence how individuals live their lives (Greene, 2002). Resilience theory is a means to identify risk factors likely to increase the development of a problem in a child, protective factors with regard to what can stop problems from occurring, and promotive factors by way of skills and assets. Resilience theory emerged from humanistic theories of human behavior adopted from the concept of self-actualization described by Maslow's hierarchy of needs (1968) and the person-centered approach to practice coined by Rogers (1951). The use of resilience theory in this study allowed for an understanding of the development of resiliency in CSA survivors through the experiences and perspectives of trauma-informed social workers and counselors.

Values and Ethics

Protecting participants' confidentiality in a research study is a vital component of ensuring that participants do not experience harm as a result of the study (Rubin & Rubin, 2012). It is essential for researchers to behave ethically by protecting the interviewees' confidentiality, treating the interviewees with respect, and upholding the agreements made between the interviewees and I (National Association of Social Workers [NASW], 2017; Rubin & Rubin, 2012). I supported and adhered to the values and ethics set forth

by the NASW (2017) through research that upholds the integrity of the field of social work.

Review of the Professional and Academic Literature

This project's motivation derived from the research question: What are trauma-informed licensed social workers' and counselors' professional experiences and perspectives when combining TF-CBT and play therapy in a psychotherapy session with CSA survivors? I used this question to guide the literature review. Key topics of the literature review include TF-CBT and play therapy as psychotherapy methods used in therapy sessions with CSA survivors; the definition of CSA; CSA statistics; and how CSA affects children's behavior, mental state, developmental milestones, and emotional stability.

My goal in conducting a literature review was to obtain background information and identify the research gap on combined TF-CBT and play therapy. The literature I searched for included books and peer-reviewed journal articles on resilience as a conceptual framework, looking at resiliency in children and vicarious resilience in trauma-informed licensed social workers and counselors. Also included in the search was information on action research theory, practice, and method as related to the project. Whereas these topics are directly applicable to the study and thus the focus of the literature review, little peer-reviewed research is available regarding the experiences of trauma-informed licensed social workers and counselors who utilize combined TF-CBT and play therapy in a psychotherapy setting with children who have been sexually

abused. Notwithstanding the moderate amount of literature collected, this review provided a foundation for the study.

The first step in the literature review was to search the following databases: Academic Search, Child Stats, Child Trends Databank, PsycINFO, Sage Journals, Social Services Abstracts, Social Work Abstracts, and SocINDEX. Keywords searched were *action research, action research and qualitative inquiry, child sexual abuse, child sexual assault, child sexual assault statistics, play therapy, play therapy* and *child sexual abuse, play therapy* and *trauma-focused cognitive behavioral therapy with child sexual abuse, resiliency, resilience theory, resilience theory* and *conceptual framework, trauma-focused cognitive behavioral therapy, trauma-focused cognitive behavioral therapy* and *child sexual abuse, trauma-focused cognitive behavioral therapy* and *play therapy in practice, trauma-informed definition, trauma-informed therapy, trauma-informed social work, trauma-informed counseling, trauma-informed psychotherapy*, and *vicarious resiliency*.

The key terms that were searched returned a range of information that aligned with the purpose of this action research project. The majority of the peer-reviewed journal articles and books used for this literature review were from the United States, with a few peer-reviewed journal articles from Europe and Scotland. Other fields researched outside of social work included action research, counseling, social services, psychiatry, psychotherapy, and qualitative research.

Methodology: Action Research

The term *action research* consists of two words with different focuses: “action refers to what you do” and “research refers to how you find out about what you do”

(McNiff, 2016, p. 9). Research is a democratic process to pursue the human purpose; its worldview is participatory and systematic, merging action and reflection with theory and practice through the contributions of participants (also termed stakeholders; Bradbury & Reason, 2015; Stringer, 2014). Bradbury and Reason (2015) examined common themes and commitments prevalent among action researchers to identify what makes such an approach important. They also looked at areas in which action researchers disagreed and ways to increase exploration for future action research studies. If not invited by the research subjects, some researchers view the study as not theirs; in addition, there is a common view of action research as more qualitative than action-oriented (Bradbury & Reason, 2015). Action researchers begin with a question that is heavily laden with purpose and must focus on the interest and agendas of the research participants.

Conceptual Framework: Resiliency

Based on their observations of survivors, practitioners are learning more about the benefit of interventions that foster an individual's strength and ability to self-right, thus increasing resilience-based practice (Greene, 2002). Resiliency incorporates key characteristics of resilience theory and concepts as applied to social work practice. Resilience theory is ecological and systematic, based on human behavior and the person in environment approach.

The historical context of resiliency started when social scientists began to conduct exploratory studies on risk, which later became the study of risk and resilience(Greene, 2002; Masten, 2014). *Resiliency* derives from the Latin word *resiliens*, which meant "to refer to pliant or elastic quality of substance" (Greene, 2002, p. 36). According to the

American Psychological Association (2012), resiliency is "the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress" (para. 3). Despite the similarity of these definitions, some researchers and practitioners argue for an empirically based definition of resiliency. Southwick et al. (2014) suggested the following:

> [A] stable trajectory of healthy functioning after a highly adverse event; a conscious effort to move forward in an insightful and integrated positive manner as a result of lessons learned from an adverse experience; the capacity of a dynamic system to adapt successfully to disturbances that threaten the viability, function, and development of that system; and a process to harness resources in order to sustain well-being. (p. 11)

Domhardt et al. (2015), Greene (2002), and Masten (2014) similarly stressed the need for continued research to establish an evidence-based definition of resilience, emphasizing that resilience is a complex construct that varies dependent upon individuals, families, organizations, society, and cultures. Scholars have studied the concept of resilience for decades, with various definitions and conceptualizations emerging (Domhardt et al., 2015); however, there is a rising consensus that resilience as a construct is two dimensional and includes the survivor's circumstances and positive adaptation.

Global concerns have renewed interest in resilience across various fields of research (Masten, 2014). The conceptual origins of resilience apply to many systems, both animate and inanimate (e.g., child, family, economy, climate) on diverse levels. The

concept of resilience pertaining to child development emerged during World War II, specific to children's trauma responses to the devastation caused by the war (Werner, 2000). Clinicians from various fields came together to help children psychologically, essentially launching the early stages of research regarding resilience in children (Masten, 2014). Masten (2014) discussed resilience models and methods, accomplishments and critiques, complex adaptive systems, and theoretical pathways and concluded that international efforts were needed to promote resilience. More importantly, Masten discussed how early researchers refined established models of resilience, paying special attention to culture, context, risk exposure, and adaptation in children exposed to adversity as well as their development of resiliency.

Resilience in Children

Maximizing resiliency in children at risk of psychological adjustment entails the teaching of protective processes or factors that promote healthy outcomes (Grych et al., 2015; Luthar & Eisenberg, 2017; Masten, 2014). Grych et al. (2015) adopted a strengths-based approach to resiliency using positive psychology to understand how individuals overcome adversity and build fulfilling lives after exposure to traumatic events. Several studies Grych et al. reviewed showed that protective factors had made a significant impact on children and adolescents who were exposed to violence, resulting in positive outcomes because of resiliency. Particularly, Grych et al. focused on the resilience portfolio model to draw on theory and previous research on resiliency to identify and understand individuals who live fulfilling lives following traumatic events. Resiliency and the use of the strengths perspective allow for the enhancement of an individual's

well-being after trauma. Similarly, the study of resiliency via the resilience portfolio model enhances prevention and intervention methods and the development of better assessment tools.

Domhardt et al. (2015) completed a systematic review of the literature on resilience in CSA survivors. From their review of 37 articles, Domhardt et al. summarized empirical studies regarding resilience in children who had been abused sexually and discussed protective factors that are directly linked to adaptative function following sexual assault. Findings showed that between 10% to 53% of CSA survivors with empirically supported protective factors in areas such as education, coping skills, interpersonal and emotional competence, social and environmental supports, and family support were able to develop and maintain a normal level of functioning in spite of sexual abuse. Domhardt et al. identified the main characteristics of resiliency, including personality traits such as openness and amicability, internal locus of control, self-efficacy, self-worth, cognitive appraisal, and optimism. The researchers also noted the environmental characteristics of resiliency, such as family, peer, and social support. Research on the aftermath of CSA with a focus on resilience could inform clinical practice and help develop a theoretical foundation for constructive mental health interventions across developmental periods for CSA survivors.

Luthar and Eisenberg (2017) compiled recommendations from several experts on how to increase the resilience and well-being of children at risk for psychological maladjustment. In their study, the researchers sought to promote psychological and behavioral interventions implementable in a real-world setting and having a positive

impact on children and their families. Luthar and Eisenberg focused on how resiliency develops through specific parenting behaviors such as nurturing and loving interactions, self-regulation, the development of coping mechanisms, education-related activities, and CBT. Conclusions showed that behavioral scientists could make a difference by creating and implementing sound and scientifically proven interventions to help children at risk of psychological maladjustment and unmet mental health needs.

Barron et al. (2015) looked at resiliency-informed evaluation in school-based prevention programs for children who had been sexually abused. Resilience theory was a critical framework with an ecological context because of its contribution to the assessment and interventions of programs and practices that benefit children who experienced sexual abuse. Barron et al. adapted their study to align with Videka, Goplan, and Bauta (2014), finding child abuse and resiliency were better understood when viewed through the lens of an ecological framework. Barron et al. initially looked at childhood resiliency on an individual level, then extended their research to explore intrinsic and extrinsic factors based on the child's environment, thus assessing efficacy within studies.

Vicarious Resilience

Working with trauma survivors often has positive outcomes on trauma-informed therapists, something known as vicarious resilience (Hernandez-Wolfe et al., 2015; Pack, 2013). Hernández et al. (2007) coined the term *vicarious resilience*, which they defined as the process by which trauma therapists learn and overcome adversity from their patients, leading to positive transformation and empowerment. Hernandez-Wolfe et al. (2015) conducted a qualitative exploratory study of vicarious resilience and vicarious

trauma, identifying how clients who experience trauma cope with hardship and intersectional characteristics to which their therapists are exposed while working with them. Hernandez-Wolfe et al. and Pack (2013) detailed how trauma therapists experience vicarious trauma due to the empathetic bond created between client and therapist. With their capacity to empathize, understand, and experience their clients' worlds vicariously, therapists learn how to overcome trauma from observing and participating in the therapeutic process; this is vicarious resilience (Hernandez-Wolfe et al., 2015). With their findings, Hernandez-Wolfe et al. illustrated a link between vicarious trauma and vicarious resilience, highlighting both negative and positive aspects of trauma therapy. Vicarious resilience occurs when trauma therapists attend to their self-care through meditation, mind-body practices, and personal therapy as a means for offsetting vicarious trauma.

Pack (2013) looked at vicarious resilience from a multilayered model of stress and trauma in social workers. The researcher found that social workers working with trauma survivors are heavily impacted by vicarious trauma, mostly within the first 5 years of practice. Vicarious trauma drives trauma social workers to find a strategic way to foster individual and professional resilience. Pack conducted in-depth interviews with social workers who work directly with individuals with traumatic experiences such as abuse and sexual assault. Social workers revealed that vicarious trauma was fleeting and quickly replaced with vicarious resilience due to their ability to bounce back and practice empathetic engagement with survivors of trauma. The application of protective factors such as personal and workplace supports, positive teamwork, and spirituality buffered

against vicarious trauma for the social workers and helped build vicarious resilience. Other areas that emerged in the study regarding vicarious resilience were the search for self, reauthorizing personal and professional identities, and the search beyond self, such as spirituality and personal and individual development.

Trauma-Focused Cognitive Behavioral Therapy

TF-CBT is a subtype of CBT, a combination of behavior therapy and cognitive therapy. Therapists practicing CBT use psychoeducation with CSA survivors and their families, helping them develop emotional regulation and coping skills (Springer et al., 2015). An empirically based method of psychotherapy, CBT is effective in improving clinical outcomes in children (Hancock et al., 2018). Behavior therapy came to the forefront of clinical practice sometime in the 1960s. It was based on a person’s ideas associated with human actions and how they are developed emotionally, sustained, or extinguished (Walsh, 2013). Behavior theory encourages the practitioner to focus on an individual’s external behaviors, which are more observable. Behavior theory allows the therapist to implement behavioral strategies when working with children and adolescents with cognitive or developmental disabilities. The three approaches to behavior theory are behavior analysis, which focuses on behavioral consequences; stimulus-response model, which centers on all environmental aspects that help maintain a person’s behavior; and social learning theory, which pertains to cognitive mediational processes.

Entering the helping profession in the 1950s and 1960s (Walsh, 2013), cognitive theory applies to individuals’ thoughts, belief systems, perceptions, and assumptions based on their life experiences. Cognitions include an individual’s belief system,

expectations, notions, concepts, outlook on life, characteristics of behavior, and attitude. The goal of cognitive interventions is to focus on internal mental processes, as in the field of social work.

TF-CBT, a well-established, evidence-based intervention (Jensen et al., 2014), is the combination of cognitive theory and behavioral theory. Therapists who practice TF-CBT utilize combine behavioral therapy principles with trauma-sensitive interventions and conjoint parent-child psychotherapy treatment. Cohen et al. (2004) developed TF-CBT as an approach to treat children and adolescents with emotional, behavioral, and mental health symptoms as a result of trauma. TF-CBT was a means to help victims of CSA and other traumatic experiences by moving the child or adolescent from the mindset of victim to survivor while reducing their anxiety, PTSD symptoms, and depression (Cohen et al., 2004; Everhart Newman et al., 2018). TF-CBT meets the criteria for evidence-based practice, with use in treatment to aid in the reduction of trauma-related signs and symptoms and behavioral problems stemming from traumatic experiences (Cohen et al., 2004; Cohen et al., 2018; Diehle et al., 2015; Jensen et al., 2014; Lenz & Hollenbaugh, 2015; Ramirez de Arellano et al., 2014; Rubin et al., 2017; Webb et al., 2014).

TF-CBT incorporates trauma-sensitive interventions along with CBT as a means for gradually exposing the child or adolescent's traumatic experience via various modes of treatment over 12 to 16 weeks (Cohen et al., 2004; Cohen et al., 2018; Jensen et al., 2014; Lenz & Hollenbaugh, 2015). TF-CBT therapists focus on the development of identifying and utilizing coping skills, psychoeducation, grounding techniques, mind-

body relaxation skills, mindfulness and breathing techniques, safety skills, cognitive reframing, in vivo exposure methods, trauma narration, trauma processing phase, conjoint child and parent sessions, and individual parent psychoeducation sessions (Cohen et al., 2004; Cohen et al., 2018; Jensen et al., 2014; Kirsch et al., 2018; Lenz & Hollenbaugh, 2015; Ramirez de Arellano et al., 2014; Webb et al., 2014).

Play Therapy

The number of children with emotional and behavioral problems is increasing in the United States, indicating the importance of child-centered play therapy (Lin & Bratton, 2015). Play therapy is a developmentally appropriate intervention used by therapists when working with children (Bratton et al., 2005; Green et al., 2015; Palmer et al., 2017). Play therapy is often appropriate for children who experienced complex trauma (Ryan et al., 2017). In trauma-informed play, therapists use regulatory activities to access specific brain regions. Trauma-informed play therapy helps children self-regulate, allows the integration of sensory play, and utilizes components of occupational therapy, all while maintaining a strengths-based approach. Play therapists need to recognize how building a therapeutic presence is important and pivotal to the play therapy process (Crenshaw & Kenney-Noziska, 2014). Common factors used in play therapy are a genuine client-therapist relationship, empathy, warmth, and authenticity (Crenshaw & Kenney-Noziska, 2014), along with directed techniques initiated by the therapists (Peabody & Schaefer, 2016).

In the first phase of play therapy, the therapist is the partner and encourager to help the child gain self-confidence and competence; the therapist shares power with the

child (Kottman, 2014). During the second phase, the therapist is active and exploratory to gather information regarding the child's values, morals, attitude, perception, thinking, and beliefs to form a lifestyle hypothesis. The third phase has the therapists being more nondirective and supportive of the child. In this phase, the therapist can build a partnership with the child, who is then more likely to open up and identify both conscious and unconscious thinking. In this phase, the client will evaluate his or her behaviors, perceptions, attitudes, and emotions. In the fourth phase, the therapist introduces the child to reorientation and reeducation, helping the child identify and learn coping mechanisms as well as strategies for increasing self-esteem, assertiveness, and social skills. Play for children in therapy may include puppets, figurines, sand tray, narrative writing, and expressive art, all of which can help children identify their coping strategies, providing an outlet to discuss and share their stories and traumas (Desmond et al., 2015).

Child Sexual Assault

CSA is one of the most common forms of abuse experienced by children (Márquez-Flores et al., 2016). Murray et al. (2014) defined CSA as any sexual activity with or in the presence of a child. Seth and Srivastava (2017) identified CSA as any type of sexual victimization involving minors. In a report to the Centers for Disease Control and Prevention, Leeb et al. (2008) defined CSA as "any completed or attempted (non-completed) sexual act, sexual contact with, or exploitation (i.e., noncontact sexual interaction) of a child by a caregiver" (p. 14).

Incidents of CSA affect children of all genders, socioeconomic statuses, cultures, and backgrounds (Murray et al., 2014). Perpetrators can be individuals from different

walks of life, socioeconomic conditions, cultures, and sexual orientations and could comprise friends, family, and strangers. CSA poses a threat to five percent to 20% of all children, with girls at a higher risk than boys (Aydin et al., 2016). Sexual abuse is an experience that is likely to impact the child, causing adverse outcomes (Ogunjimi et al., 2017).

Trauma survivors are at risk of poor health outcomes such as somatization, borderline personality disorder, social or health problems, anxiety, PTSD, high-risk sexual behaviors, cooccurring abuse, and a lack of relational skills (Bruce et al., 2013; Foster & Hagedorn, 2014; Murray et al., 2014; Nair & Shukla, 2017; Vicario et al., 2013). CSA survivors also experience symptoms such as flashbacks, triggers, intrusive thoughts, fear, anxiety, and resistance to counseling (Foster & Hagedorn, 2014). Ways to mitigate adverse outcomes in CSA survivors include interventions that are child appropriate and effective in treating trauma, tailoring the counseling approach to best meet the needs of the child (Foster & Hagedorn, 2014).

Psychotherapy Methods: TF-CBT and Play Therapy

Allen and Hoskowitz (2017) looked at structured TF-CBT and nonstructured play therapy as a therapeutic intervention for CSA survivors. Allen and Hoskowitz identified TF-CBT as a widely used therapeutic intervention for CSA survivors known for its effectiveness. Even so, unstructured play/experiential therapy has an extensive history and is often the preferred practice by many practicing clinicians.

Allen and Hoskowitz (2017) sought to determine whether incorporating structured and unstructured play/experiential therapy with TF-CBT would positively impact the

treatment of children who had been sexually abused. The sample comprised 260 CSA survivors and 108 clinicians. After in-person training on TF-CBT, 60% of the clinicians submitted 12 months of usable data. Participating children were clients at the Children Advocacy Center who worked with TF-CBT trained therapists. The therapists completed a questionnaire that detailed the treatment techniques for each child. Regression analyses showed significance in posttreatment outcomes for PTSD, anger, and anxiety; however, Allen and Hoskowitz found lower posttreatment scores with structured TF-CBT and higher scores with play therapy. There was no effect on the individual's interactions, and gender, race, and age did not affect the outcome of the study.

Following a search for academic literature on combining the two therapeutic methods of TF-CBT and play therapy, Allen and Hoskowitz (2017) reported inconclusive findings as to how combining the two treatment techniques could impact treatment outcome. Regardless, Allen and Hoskowitz provided information useful for therapists to ensure their clients who have endured sexual abuse can receive the best possible treatment. By utilizing the outcomes of the study, the clinician can determine whether combining structured TF-CBT would be beneficial to their clients by reducing mental health symptoms. Play and experiential therapy can aid in the reduction of fear, anger, and depression following CSA.

Slade and Warne (2016) studied TF-CBT and play therapy based on the prevalence of both psychotherapy methods in practice with abused children. The meta-analytic study was a means to examine the effectiveness of both methods using 10 articles: three on play therapy, six on TF-CBT, and one that combined TF-CBT and play

therapy=. Findings showed that children who participated in TF-CBT treatment improved more internally, whereas those who participated in play therapy had more improvement in externalizing behaviors.

GB-CBT individual model (GB-CBT-IM) is a therapeutic method used with children ages 4 to 17 years who are CSA survivors (Misurell et al., 2014). A combination of CBT with play therapy using developmentally appropriate games, GB-CBT-IM is an integrative approach using interventions tailored to best meet the needs of the child and the family. GB-CBT-IM targets behaviors and symptoms such as anxiety, anger, depression, sexual promiscuity, PTSD, and negative acts, all of which are common in CSA survivors. Data for Misurell et al.'s (2014) derived from six clinicians who administered GB-CBT-IM with 50 CSA participants. The outcomes of the study showed GB-CBT-IM was successful in improving trauma-related symptoms, sexually inappropriate behaviors, and behavioral problems while increasing the child's coping skills, safety skills, and education on abuse and its effects.

Summary

The use of TF-CBT and play therapy is widespread within the field of psychotherapy, considered best practice with children who have experienced abuse (Slade & Warne, 2016). However, there is not enough information in the present literature regarding TF-CBT and play therapy combined as an effective treatment for abused children. Children who have suffered sexual abuse can benefit from the use of TF-CBT to reduce symptoms of trauma through psychoeducation and the development of coping mechanisms (Cohen et al., 2004; Cohen et al., 2018; Diehle et al., 2015; Lenz &

Hollenbaugh, 2015; Ramirez de Arellano et al., 2014; Rubin et al., 2017; Jensen et al., 2014; Webb et al., 2014). Play via therapy is the link that connects children's personal experiences to their understanding of those experiences, allowing them to create coping and problem-solving skills (Bratton et al., 2005). TF-CBT and play therapy have shown success in building resilience in children who have suffered sexual abuse; however, there remains a lack of literature on the simultaneous use of these two evidence-based psychotherapy methods and how they may increase resiliency and stronger outcomes with sexually abused children (Allen & Hoskowitz, 2017).

Section 2: Research Design and Data Collection

Introduction

As a graduate student studying to receive my Master of Social Work (MSW) degree, I applied for an internship at a local children's advocacy center in South Louisiana. I was accepted as an intern in May 2014 and completed the internship in May 2015. As a student intern, I initially trained in TF-CBT to best meet the needs of my clients: children who had been sexually abused. It was at this time that I began to research literature on TF-CBT as a means for evidence-based practice. I practiced TF-CBT under the supervision of an LCSW, who was also a board-approved clinical supervisor. Halfway through my internship, my employer sent me to my first play therapy training session. Subsequently, I began combining both therapeutic methods with children who had been sexually abused and suffered from symptoms of PTSD; depression; and other mental, emotional, and behavior problems as a result of the abuse. During this time, I also relentlessly looked for literature on the intersection of TF-CBT and play therapy as it relates to symptoms in children who are sexually abused. The symptoms that are most common in CSA survivors are behavioral, mental, physical, and emotional in nature (Cohen et al., 2004; Everhart Newman et al., 2018). However, at that time, I was only able to locate literature on the therapeutic methods when used separately, as well as the symptoms that are likely to occur as a result of CSA.

Allen and Hoskowitz (2017) identified TF-CBT and play therapy as two methods of psychotherapy for CSA survivors, finding play therapy to be the preferred practice.TF-CBT is most commonly used with children and adolescents who experience trauma

(Cohen et al., 2004; Everhart Newman et al., 2018). Play therapy is another approach used to treat children's emotional and behavioral problems. Play psychotherapy focuses on the child's individual and developmental needs (Bratton et al., 2005).

There is little data on using TF-CBT and play therapy together to treat child survivors of sexual abuse due to limited research on the two combined therapeutic efforts. Like Slade and Warne (2016), I found there was not enough information in the existing literature regarding the use of intersecting TF-CBT and play therapy, despite both methods being evidence-based interventions for children who are CSA survivors. I proposed this action research study to address the research question by exploring the professional experiences and perspectives of trauma-informed licensed social workers and counselors who work with CSA survivors using a combined approach to treatment.

The conceptual framework of resilience theory enabled a focus on a strengths-based approach to resiliency. The existence of vicarious resilience in trauma therapists (hedrnandez-Wolfe et al., 2015; Pack 2013) and resiliency in children (Domhardt et al.) also factored into the use of the conceptual framework. An in-depth look at TF-CBT and play therapy as evidence-based practice for with trauma survivors accompanied my review of CSA in Section 1. In this section I discuss why an action research project with a qualitative inquiry was appropriate to address the purpose of the project. A description of the action research study follows. I also discuss the research design, methodology, data analysis, and ethical procedures. The section concludes with a summary of key points.

Research Design

The purpose of this action research study with a qualitative inquiry was to explore the experiences of trauma-informed licensed social workers and counselors and their psychotherapy treatment of children who were sexually abused. I also wanted to understand factors that increase resiliency in CSA survivors. The gap identified in the literature allowed for the following research question to emerge: What are the trauma-informed licensed social workers' and counselors' experiences and perspectives when combining TF-CBT and play therapy in a psychotherapy session with CSA survivors?

The interview subquestions to participants were as follows:

1. Identify your role: Are you a licensed social worker or licensed counselor?
2. Describe your perspectives on combining trauma-focused cognitive behavioral therapy and play therapy as an intervention with child sexual assault survivors?
3. Describe your rationale for adding play therapy to trauma-focused cognitive behavioral therapy?
4. Describe how you utilize the intersectionality of trauma-focused cognitive behavioral therapy and play therapy in a clinical setting with child sexual assault survivors, and what do you perceive as most effective therapeutically? For example, how do you prefer using this combined therapeutic method (one on one therapy or group therapy: art, music, miniatures, sandbox, sensory toys, etc.), and how do you perceive it to be most effective?

5. Vicarious trauma is experienced by trauma therapists' due to the empathetic bond created between the client and the therapists (Pack, 2013), and vicarious resilience is established when trauma therapists identify vicarious trauma; vicarious resilience is built through observing and participating in the therapeutic process with the client (Hernandez-Wolfe et al., 2015). What is your perception of vicarious resilience as a result of using play therapy and trauma-focused cognitive behavioral therapy with child sexual assault survivors?
6. In what ways have your experience with vicarious resilience aided in furthering your use of both play therapy and trauma-focused cognitive behavioral therapy with survivors?
7. In your experience, how has vicarious resilience impacted your clients positively or negatively?
8. In your experience, what is the most effective play therapy techniques to use in combination with trauma-focused cognitive behavioral therapy? For example, narrative play, sand tray, playing with toys, drawing, painting, etc.
9. Describe your experience in seeing increased resiliency in child sexual assault survivors following successful completion of therapy when using combined trauma-focused cognitive behavioral therapy and play therapy.
10. In your experiences, how has combining trauma-focused cognitive behavioral therapy and play therapy helped to decrease mental and physical symptoms

associated with child sexual abuse? Describe ways you came to this conclusion.

11. In your experience, did you run into any dilemmas when applying play therapy to trauma-focused cognitive behavioral therapy with child sexual assault survivors? Describe your dilemmas and how they were resolved.

The goal of the study was to build knowledge regarding psychotherapy methods for CSA survivors. The therapists in the study shared their experiences and their perspectives on the importance of play integrated into trauma talk therapy with child survivors of sexual assault. Furthermore, the therapists shared their knowledge and realistic experiences on the significance of resiliency, vicarious resiliency, self-care, parentification, and current challenges amid COVID-19.

Methodology

This action research project with a qualitative inquiry occurred using data I collected during a Zoom focus group after receiving consent from participants. Action research is unlike a quantitative or experimental approach because it does not result in generalizability. Instead, action research is a way to engage study participants to find solutions to their specific problems for increasing effectiveness and efficiency in relation to their work (Stringer, 2014).

Stringer (2014) described action research as a qualitative method of inquiry that focuses on a problem in need of investigation. Action research is systematic and rigorous and allows for explanations to increase individuals' understanding. Action research is more than problem-solving and is often used to inform and improve practice, increase

knowledge, and increase successful social action (McNiff, 2016; Stringer, 2014). Stringer proposed "the look, think, act routine" (p. 9) as one way to look at the framework of an action research process. Because action research is not linear, individuals should consider it a "spiral of activity" (Stringer, 2014, p. 9) that continually loops, allowing participants to engage in a step-by-step process until reaching project completion.

Qualitative research involves engaging with individuals who are the experts on their life experiences (Ravitch & Carl, 2016). There is no specific search for the truth in a qualitative study; instead, it is a means to discover and interpret people's experiences, perspectives, and other inquiry domains. The goal of a qualitative study is to obtain an understanding of people through observations and the telling of their experiences (Ravitch & Carl, 2016).

Participants

To gather the experiences and perspectives using a qualitative approach to research, I used licensed social workers and licensed counselors who utilize psychotherapy with child survivors of sexual assault. I used voluntary sampling and recruited individuals interested in participating in the study. The eligibility requirements included the following:

- Licensed social workers defined as a LMSW or LCSW licensed by the LABSW having been in practice and compliance with the LABSW for a minimum of 2 years.

- Licensed counselors defined as a LPC or a PLPC licensed by the LPCB of Louisiana having been in practice and compliance with the LPCB for a minimum of 2 years.
- Currently, practice a combined approach to therapy with CSA survivors using both TF-CBT and play therapy.

I recruited social workers and counselors who worked in private practice, K-12 schools, and children advocacy centers in South Louisiana via emails and phone calls (see Appendices A and B for the invitation email template and flyer, respectively). The email addresses and phone numbers were available to the public from their websites. The sample size consisted of six participants: one male, five females. The six participants—two LCSWs, three LPCs, and one PLPC—were asked to sign electronic consent forms that detailed the research project and procedures, their rights, and four sample questions. The consent forms were signed electronically, and the participants were given a final copy. I interviewed the participants via a Zoom focus group for 90 minutes utilizing a semistructured interview guide. The interview was video and audio-recorded on Zoom and downloaded to a flash drive.

Instrumentation

Based on the study's purpose, the research question, and the literature review, a semistructured interview guide (see Appendix C) was appropriate for collecting data from focus group participants. This guide contained 11 open-ended questions, the responses to which allowed me to answer the research question. The questions were both

probing and explanatory, with the data based on information used to discover and interpret people's experiences (Ravitch & Carl, 2016).

A semistructured interview guide was versatile,flexible, and useful, for the group interview (Kallio et al., 2016). A semistructured interview guide served as a foundation for exchanging information between the participants and I. The participants were able able to describe their work with CSA survivors, how they integrated TF-CBT and play therapy, the challenges they experienced and associated with trauma work, and how resiliency impacted their client and therapist relationships. The semistructured guide also allowed me to ask follow-up questions and gave the participants a chance to to express themselves verbally and in interchangeably.

Data Analysis

The audio-recorded data underwent verbatim transcription upon the procurement of a confidentiality agreement by the transcription service Rev.com. Upon receiving the transcript, I coded the data line by line, a coding approach proposed by Saldaña (2016). I then refined the codes into categories and subcategories, next comparing and consolidating them into themes and concepts as a means to analyze the data. Categorization enabled me to describe the information collected during the project to find commonalities, differences, patterns, and themes (Ravitch & Carl, 2016; Saldaña, 2016). Coding occured by transcribing and summarizing all data collected (Laureate Education, 2016a; Rubin & Rubin, 2012). Assigning meaning to the data through words or phrases allowed me to explain and describe what was happening within the data (Laureate Education, 2016a; Ravitch & Carl, 2016; Rubin & Rubin, 2012).

The codes were reviewed multiple times, providing varied perspectives to identify patterns across participants; thus, I was able to create themes for interpretation of data (Laureate Education, 2016a; Ravitch & Carl, 2016; Rubin & Rubin, 2012). I used in vivo coding because it is action-oriented and uses the participants' direct language (Saldaña, 2016). The second level of coding was descriptive and involved labeling the code using two or more words that described or covered the data's meaning (Rubin & Rubin, 2012; Saldaña, 2016). Following descriptive coding, the codes were put into categories and then subcategories, subsequently broken down into themes to achieve findings and ensure data saturation. I coded the data by hand using paper, pen, and highlighters. Once all my codes were identified, I noticed some of the in vivo codes were repetitive, which meant the data was saturated. I then used Microsoft Excell to help structure and organize the themes that were identified.

Reliability and Validity

Reliability and validity were necessary components of qualitative inquiry to ensure the findings' trustworthiness (Lincoln & Guba, 1985). Reliability showed the consistency and stability of the results, and validity referred to the truthfulness of the concept studied by the researcher (Babbie, 2017). Four components comprised trustworthiness: credibility, transferability, dependability, and confirmability (Laureate Education, 2016b).

A potential threat in qualitative research can be the tension between reliability and validity (Babbie, 2017). If tension arose in a study, the researcher had to choose between reliability and validity. When this happened, it was necessary to explore new

methods, theories, and analyses, such as triangulation. Triangulation was the collection of multiple sources of data to confirm analysis and interpretation (Laureate Education, 2016b). Another way to ensure validity was through credibility; credibility allowed for confirmability in research through recurrent patterns, themes, and data saturation (Babbie, 2017). Upon receipt of the focus group transcript, I read and coded the data two times, identified codes, themes, and subthemes to ensure data saturation for credibility.

Ethical Procedures

Adherence to ethical procedures was necessary when researching with human participants. I followed all ethical guidelines in compliance with the NASW and Walden University Institutional Review Board (IRB) in this action research project. According to the American Psychological Association’s (2017) Ethical Principles of Psychologists and Code of Conduct, I obtained institutional approval (07-02-21-0722256) before conducting this research and only used protocols approved for this action research study. Participants received, via email, information regarding the purpose of the study, the research question, the expected duration of the focus group, and all research procedures. The participants were informed that the interview would be an audio-recorded focus group interview with other participants present. Participants were also informed of the use of a semistructured interview guide and the lack of compensation for their participation. The informed consent document indicated that participating in the study was voluntary and that they may refuse to participate in the entire study or any part of the study at any time. I verbalized that the participants had the right not to answer questions they did not want to answer and were free to withdraw at any time without consequence.

As outlined by the American Psychological Association (2017), a discussion on privacy took place for ethical research. I obtained participants' signed permission to audio record the focus group interview, with the transcriptionist's required confidentiality statement. No reports coming out of this study will show the identities of individual participants. Details that identified participants, such as demographics, agency names, and affiliations, and the study's specific location, remained confidential. All data files were secured with password protection, using pseudonyms in place of participant names aligned with Walden University research privacy requirements (Walden University Research Ethics & Compliance, n.d.). I maintained truth throughout the study. I will keep all data and the analysis of the data for this research study for 5 years, stored safely and password-protected, per Walden University IRB requirements.

Summary

I used an online focus group as the sole source of data for this study. This study followed the guidelines of a qualitative method. During the interview, a group of participants were asked about their experiences on the intersectionality of TF-CBT and play therapy with CSA survivors, resiliency, and vicarious resiliency related to trauma therapy. The study was designed as action research that utilized the focus group interview to help understand a qualitative inquiry to participants' opinions, beliefs, challenges, dilemmas, and perceptions on the topic in a semistructured dialogue.

All data collected from the participants' 90-minute focus group interview underwent verbatim transcription and data analysis via coding, categories, subcategories, and themes and analyzed by hand. This study adhered to Walden University's

requirement for social change, providing information that will create dialogue, educate and help individuals better understand people and psychotherapy through the shared information on the experiences and perceptions of TF-CBT and play therapy with CSA survivors (Ravitch & Carl, 2016).

Section 3: Presentation of the Findings

Introduction

The purpose of this action research study was to explore the experiences and perspectives of licensed social workers and counselors who practice TF-CBT and play therapy concurrently with CSA survivors. In this qualitative study, I gathered information that allowed me to understand licensed social workers' and counselors' perspectives on the importance of combining two psychotherapy methods (TF-CBT and play therapy) with children who have experienced sexual trauma. I sought to answer one research question specific to trauma-informed social workers and counselors servicing children who had experienced sexual abuse, which was, What are the trauma-informed licensed social workers' and counselors' experiences and perspectives when combining TF-CBT and play therapy in a psychotherapy session with CSA survivors?

All data collected from the focus group underwent analysis using descriptive and in vivo coding. I analyzed the results to determine the categories, subcategories, and themes pertinent to answering the research question. In this section, I discuss the recruitment methods, data analysis techniques, validation techniques, data limitations, and findings. Section 3 also includes a presentation on the process used to analyze and summarize the data to answer the research question.

Data Analysis Techniques

After receiving IRB approval on July 2, 2020, I started recruiting licensed social workers and counselors in South Louisiana. The recruitment process took 3 months before I acquired enough volunteers interested in participating in the study. Data

collection occurred on October 17, 2020, in a 90-minute online focus group with participants who worked with CSA survivors. The sample comprised two LCSWs, three LPCs, and one PLPC. I used a semistructured interview guide that consisted of 11 open-ended questions. I observed the participants' verbal and nonverbal cues and responses throughout the video audio-recorded online focus group. All participants shared their agency affiliation and held licensure for 2 or more years.

Upon focus group completion, I uploaded the audio files to Rev.com for transcription. When I received the Microsoft Word transcripts, I reviewed the data line by line. I then listened to the audio recording and followed the transcript to ensure accurate verbatim transcription. I manually examined the transcripts, utilizing the recording to check for errors. I then began coding the data by hand. A description of coding techniques is in Table 1.

Table 1

Coding Techniques

In vivo	Descriptive	Categories
Each line of the transcribed focus group interview was manually coded line by line.	One capitalized word was used to summarize the transcribed data/excerpt from the data. Manually coded line by line.	Categorized by hand. Downsized codes and subcodes, and then put into categories. Categories allowed for themes to emerge within the data.
Each of those codes was action-oriented and used direct language (verbatim) from the transcribed interview.	Each code was counted by hand.	

I coded the data by hand, first with in vivo coding and second with descriptive coding. I used copies of the transcribed data and color-coded sticky notes to organize the codes, after which I sorted them into categories and subcategories. Patterns among the subcategories indicated eight themes within the data. I used Microsoft Excel to organize the categories and themes. The coding process took 2 weeks and 1 day; an example of the process is in Table 2.

Table 2

Sample of Organization of Themes in Microsoft Excel

Response	Theme	Subtheme	Theme
"Parent right next to them. And having to explain, 'Okay. It's okay that you don't have to keep correcting them every time that they start playing with the toy."(Elaine)	Parent right next to them	Parent present	Parentification
"The parent is sitting right there, and the child feels like they can't express themselves or they can't let loose because their parent is going to constantly correct them."(Gina)	Parent is sitting right there	Parent next to child	
	Parent is going to constantly correct them	Parent corrects child	

Validation Procedures

Reflexive Journaling

Bias in research occurs when researchers interpret the data using their own meanings, resulting in misinterpretations and affecting study outcomes (Babbie, 2017; Laureate Education, 2016a; Ravitch & Carl, 2016; Rubin & Rubin, 2012). Throughout

data analysis, reflexive journaling allowed me to be mindful and refrain from bias. I wrote down my reflections throughout the study and noted the participants' verbal and nonverbal cues during the focus group. My reflexive journal was a means of reflection during the data analysis process.

Triangulation, member checking, and peer debriefing were other ways used to validate the study. The peer was not a participant in this study and was neither a LCSW nor a counselor. Obtaining feedback from a peer debriefer allowed me to destress and share my thoughts and feelings throughout the data collection and analysis phases. The peer and I debriefed information on transcribed data, coding, subcoding, themes, and outcomes regarding data analysis, with the peer providing unbiased feedback.

Member Checking

The use of member checking was in alignment with Birt et al.'s (2016) practice and gave participants a chance to check their information or data analysis results. I sent the participants a copy of their transcripts to review, giving them the opportunity to ensure the accurate capture and presentation of their shared information and to make any clarifications they deemed necessary. None of the participants made any changes to the transcribed data.

Triangulation

Triangulation is a means to ensure reliability and validity in a qualitative study. Researchers who conduct triangulation use the richness and depth of multiple data sources, supporting a comprehensive and complete understanding of the material while avoiding bias (Heale & Forbes, 2013). Triangulation occurred throughout the study.

Although the participants all worked with CSA survivors, they served in different settings and with different age categories. The participants held various licensures and offered their personal views related to their counseling or social work. The participants' in-depth information came from their personal experiences and thoughts, providing richness to the study regarding human behavior in alignment with triangulation.

Issues Experienced During Data Collection

During the data collection phase, some issues emerged. To obtain volunteers for the study, I had to email agencies and participants at least three times to respond. Some agencies never responded. I moved to telephone calls, which worked better than emails. Phone calls allowed for verbal recruitment, which seemed to elicit individuals' interested even though most phone calls still did not render volunteers. After 3 months of recruitment, I obtained seven participants and scheduled the focus group at a time convenient to all. However, 4 days before the planned focus group interview, two participants dropped out of the study thus leaving insufficient participants for the interview. I then had to begin the recruitment phase again. I was able to secure two more participants before the scheduled focus group. On the day of the focus group, six of the seven participants who committed to the study attended. The volunteer who did not participate called later to report having lost electrical power due to a hurricane, something quite common in South Louisiana, and was unable to attend.

Limitations

One limitation was that four of the six participants were White, which restricted ethnic diversity. Only one male participated in the study, which limited the male

perspective. Another limitation was that some participants answered more focus group questions than others and engaged throughout the duration of the interview. No participants appeared guarded or concerned by the questions according to their body language, tone, and nonverbal cues. Some participants knew each other from previous work or psychotherapy agency engagements. It is not possible to determine if this affected the outcome of the study.

Findings

The participant pool—two LCSWs, three LPCs, and one PLPC—were one social work board-approved supervisor, one professional counselor supervisor, one certified trauma-focused cognitive behavior therapist, one registered play therapist supervisor, and two national certified counselors, one of whom was also a provisional licensed marriage and family therapist as well as board-certified in telemental health. All participants were licensed and had practiced psychotherapy in South Louisiana for two or more years. Three members shared they had taken a break from working with child trauma for over a year due to burnout but eventually returned to trauma therapy. All participants received a pseudonym to maintain their confidentiality. Table 3 presents participant characteristics.

Table 3

Study Participants' Demographics

Participant	Ethnicity	Gender	License	Credentials and certifications
Elaine	W	Female	LPC	TF-CBT and NCC
Kate	W	Female	LCSW	BACS
Tess	W	Female	LPC	NCC, PLMFT, and BCTM
Jade	AA	Female	LPC	PCS and RPT
Gina	AA	Female	PLPC	
Xander	W	Male	LCSW	

Note. W = White; AA = African American; CFT-CBT = certified trauma-focused cognitive behavior therapist; NCC = national certified counselor; BACS = board-approved clinical supervisor; PLMFT = provisional licensed marriage and family therapist; BCTM = board-certified telemental health therapist; PCS = professional counselor supervisor; RPT = registered play therapist.

The purpose of this study was to understand the experiences and perspectives of licensed social workers and counselors who practiced TF-CBT and play therapy with CSA survivors. I wanted to understand their reasons and purposes for combining both psychotherapy methods with child survivors. Furthermore, I sought to explore resiliency in both the therapist and client and the therapists' barriers, dilemmas, and limitations in providing services to this population. The participating social workers and counselors provided insight and knowledge regarding their therapeutic process and how to best meet the needs of the clients they serve. The focus group's findings supported the literature review information that children who have experienced sexual assault benefit from

trauma-informed psychotherapy practices and play therapy. The following discussion on themes will illustrate the alignment with the literature review.

Theme 1: Integration of Trauma and Play

Participants discussed their perspective on integrating trauma therapy and play therapy as it related to CSA survivors. Trauma was the main factor discussed as to why utilizing play was important. Several times, participants brought up play as a child's first language as well as the use of directive and nondirective play in a therapeutic setting. Kate, an LCSW, opened up the conversation by sharing why play is a necessary component of TF-CBT. She believed a child could benefit from the inclusion of play when "shame and self-blame come in because words can't describe what's happening." Furthermore, she stated that a child's "brain can't wrap around what's happening." A child could experience difficulty expressing feelings or thoughts through words. Kate said, "If [the children] don't have the ability to communicate how [they] feel about it" or have the "fear of talking about what happened or what might happen if [they] do talk about it," then play can become that outlet. Kate explained,

> Play is a child's first language, so they're able to communicate that through the use of sand tray or art or dollhouse or through even just nurturing play, aggressive play. And we don't have to interpret that they're still doing the work
>
> and allow them to interpret that for us.

Kate continued, "Sometimes there just are no words" and "when there are no words, there aren't words to express it. …So play is so important when we're working with kids who have experienced traumatic experiences, especially sexual trauma."

Elaine's response differed from Kate's as she expressed her difficulties in combining therapy methods, saying, "My perspective has kind of changed over time." She had been trained in play therapy—specifically, nondirective play therapy—which she used with her kids in therapy. When she started working at a children's advocacy center and using TF-CBT, Elaine experienced some difficulty in combining the approaches. She explained, "I've had some challenges in trying to find ways to merge the two. I use play therapy a lot with my kids in terms of using the model, but I don't do as much nondirective play therapy."

Jade uses the playroom doing mostly sand tray and dollhouse. She described her use of the playroom,

> It's a lot of just interactive and just kind of letting them play out whatever it is they need to play out. So I don't do a lot of nondirective play therapy. I tend to prefer directed play therapy, which seems to work.

Xander agreed with Kate and added to the discussion by recommending integrating play therapy beyond just TF-CBT:

> I kind of think, for me, the value comes from integrating most forms of therapy into play therapy, especially with littles. Trying to do a more direct approach is just so difficult in itself, but allowing kids to do kind of what they naturally do, which is play, generally using their imagination and allowing it to show you how it shapes the paradigms that they work on. I think it's too invaluable to ignore, regardless if it's trauma-focused or any other kind of any other schema that we tend to use. So, like I said, I don't know if there's anything specific to trauma-

> focused CBT, but just kind of integrating anything into play therapy, I think, would be incredibly useful.

Kate agreed with both Elaine and Xander; however, she delved further by discussing structure and directive play as an integral part of therapy. Kate referred to the use of “trauma narrative” as “more structured and directive when working with kids.” She said, “It’s so hard because they don’t want to do your agenda” and having to remember that “as clinicians, it’s really not our agenda.” She stressed, “It’s so hard for us to break out of that…but we really have to do this.” Kate believed that “going with their agenda” will allow the client “to get to where they need to be” because “they’re going to do that work.”

Kate discussed “doing things like trauma narrative,” which is a model form of therapy with steps “like one, two, three, four…they may go over into the worst part.” She expounded on how a trauma narrative allows the client to delve into “before the abuse happened,” “something that led up” to the abuse, or “grooming behaviors.” Kate asserted that any form of play is important, explaining, “Play is a child’s communication; it is the way they learn; it is the way they talk.”

Elaine expressed agreement with Kate. Elaine’s agency provides individual therapy and follows the TF-CBT model. She discussed the intersection of PT and TF-CBT:

> For me, it depends. It’s one of those that it depends on the kid. It depends on their age. It depends on their activity level. I have 4-year-olds [who] will sit there and just talk to me and are not interested in playing, but then I have some 6-year-olds

> [who] are bouncing off the walls and need and want to play, need to play, to be able to talk to me about what's going on.

She continued, "TF-CBT being components-based, I follow that, to the extent that if the kid needs something else, we bring it forward first, but I look at the component we're on."

Elaine provided an example of how she intersects TF-CBT and PT: "If we're on affect regulation, we're tossing around a thumb ball or…doing charades and being silly and making faces at each other. [That's how] I use play with what component we're on, but I also leave space" for the child to make the next move in the therapeutic process.

Kate added to the intersection aspect, stating, "Picking up the markers and playing" is something "you can incorporate into doing trauma-focused CBT and play therapy." She further explained how "expressive art is doing things like bringing movement" into the therapeutic process "just for the self-regulation aspect of it." Kate found that using play therapy through movement, mindfulness, watercolors, and drawing helps children self-regulate and take control of their nervous system.

Gina felt that the intersection of PT and TF-CBT was essential and shared how she used both in a therapeutic setting. Narrative therapy was also highly effective for her. She uses "superheroes" a lot with her kids, "way more than any other type of orientation." Gina explained,

> Superheroes are the easiest for my kids to recognize. The population I work with is mostly minority populations, and they love the Black Panther. They love Captain America; they love Batman. And using that, and having a kid running

> around and saying, "I'm Batman, and the Joker is my anxiety, and I'm going to sit there and fight the Joker." I love that. And I like to see that.

Kate agreed that superheroes are a tremendous asset:

> Superheroes are awesome. So awesome. Because they all have a backstory, and they all have some kind of loss in their backstory. And so whether it's telling a narrative through "If you could be any superhero, which one would you be?" and "Tell me about that. What do you have in common with Superman?" Superman lost his parents, too. He went to a new home, and he did all this stuff, really cool stuff. Or even dealing with nightmares. Bring in that superhero and save the day.

Kate went on to say that she finds storytelling "highly effective, and you can use those superheroes to do that storytelling."

Xander nodded in agreement with Kate and Gina on using superheroes as a form of play alongside trauma therapy. Tess added to the discussion, saying she prefers "play therapy" and "filial therapy"; however, play therapy has been more successful in working with children because they are less guarded than adults. Kids are freer, so she can let them take the lead. Overall, all the therapists agreed that play therapy intersecting with trauma-focused treatment is essential for a child who has experienced sexual trauma, even with the challenges of integrating either directive or nondirective play.

Theme 2: Parentification

The topics of parent buy-in and education emerged several times throughout the interview. The participants agreed that parents were often unaware of how the therapy process works, so psychoeducation would greatly benefit them. Kate shared, "Getting

that buy-in from parents" can be a challenge because of a lack of understanding. Kate stated that with "parent education and parent engagement, you're building trust and rapport, and a relationship with that parent, just as much as you are with that child to get that buy-in." She continued, "I like to start with parent education first and including the parent in there so that you can build that relationship with the whole family. Jade reiterated why parent buy-in is important:

> I guess one of the main dilemmas I've run into is what we talked about earlier, just getting the buy-in of the parents. I've had parents who will call after three or four sessions and be like, "Nothing's changed. My child's still the same. What you're doing isn't working. We want to see another therapist." Having to explain to the parents [that it] has to be a longer process than 3 weeks, and it's not an instant change. Your child did not become this way quickly. It's not going to leave very quickly. And that's one of the largest dilemmas is trying to make sure the parents understand what is play therapy. What does it look like? The timeline for it. So that they can then take off some of the pressure from you as a therapist, and the child, to see changes right away.
>
> Jade concluded, "The buy-in is the biggest thing holding [the parents] back."
>
> Tess shared, I actually just had a session like that last week. One of the parents looked at me and they're like, "Why haven't you fixed my child?" I'm like, "You all just came into the office. It doesn't work like that."

Kate added, "Like Jade said, the parent education, getting the parent buy-in, is important." She felt the need to educate parents on boundaries, as well. "You can't just

come drop off your 6-year-old. You can't do that. I need you here. And even having that conversation over and over and over again: 'Oh, I can't stay.' 'No, you have to stay.'"

Kate, Jade, Tess, and Elaine stressed that communication with the parents is essential to obtain buy-in, which is a vital component of a child's success in therapy. Participants also shared that parental psychoeducation is critical now more than ever due to how common telehealth has become because of COVID-19, and parents are often present during a session.

Theme 3: COVID-19 and Telehealth

Telehealth, the remote delivery of therapeutic and clinical services, has become increasingly popular due to the coronavirus pandemic. Telehealth is a form of telecommunication that allows the therapist and clients to meet remotely online in place of in-person sessions that may put them at risk of COVID-19. The participants talked about how telehealth challenged their work as therapists when incorporating play therapy into the session and parents' interference during a session. Gina said, "Due to COVID, we aren't able to, as play therapists, to have our clients in session be free to be themselves." She found it incredibly hard because parents want their kids to stay safe. "They want them not to catch COVID, but it's kind of hard trying to do the sand trays over the Internet." She reported that the pandemic "limits me to video therapy, which—I love video therapy, but sometimes the kids are like, 'I don't want you to read a book to me today. I want to be able to see you in person.'" Telehealth is often a struggle, because to children, "You're just that lady on the screen." The children feel like, "I want to be

able to see you and actually process my feelings in a different way," such as they have in face-to-face settings.

Kate stated, "Corona has definitely made it challenging doing child therapy and definitely play therapy. I have not figured that out." She went on to say,

> But that is something that I almost feel exhausted trying to figure out what to do, and that has definitely complicated things. Fortunately, a lot of mine are back to in-person, and they're comfortable coming in and doing things and finding very creative ways to keep things sanitized.

Elaine was eager to share her thoughts on COVID-19 and telehealth psychotherapy methods. She enthused, "I'm glad you brought up the telehealth and that COVID component to it because it's really made me stretch in techniques." She found that play therapy via telehealth can turn into filial therapy due to the parent being present. Elaine explained,

> I don't do family therapy, but because of COVID, I have a kid in their own house with a parent right next to them. And having to explain [to the parent], "Okay. It's okay that you don't have to keep correcting them every time they start playing with the toy" instead of answering my question that I asked. "It's okay; this is part of their process." And so I have been able to do it, not like strict filial therapy, but kind of increasing their understanding of that. Their kid is talking through what they're doing. So, I have been able to incorporate [filial therapy] a little bit more in those situations where the parent's in the room where we didn't do that before, and that's the interesting component.

Gina built on Elaine's comments, discussing how parents interrupt the session by trying to stop a child from playing or making a "mess" in an online telehealth session:

> I think I'll have to piggyback on the parent [topic]. I think, especially with teleplay therapy, the parent is sitting right there. The child feels like they can't express themselves or they can't let loose because their parent is going to constantly correct them, as you said, and they're going to constantly say, "Nope, pick that up; we're not going to have a mess," and things like that.

Tess, who is certified in telehealth, has a rule that parents cannot correct a child in the playroom during a session. Jade incorporates play using telehealth therapy. She related,

> Since we've been doing telehealth, there's been a lot of just drawing and giving them either like guided imagery or just a prompt or something to have them kind of do it on their end. So that way they're doing, and we're not just having to sit and stare at each other for the hour.

Kate illustrated how using telehealth has been a learning curve. She said, "I'll share a quick funny story, how nonaware I was of how telehealth would work at first, as probably a lot of us were because it was brand new to me." She continued,

> One of my clients said, "Oh, I can open up with art therapy and doing arts…I can just share my screen with you. This is how we do it." My client was teaching me how to screen-share and how to do these things. And he just opened up Paint, and he's drawing and doing his work, [and the client was like], "Here, you can see my screen now."

Kate concluded, “That was really cool.” Overall, participants shared their challenges and learning curves regarding telehealth amid COVID-19 and how they had learned new ways to ensure their clients get the best out of their psychotherapy session via online therapy.

Theme 4: Individual Therapy Compared with Group Therapy

Participants deemed individual sessions more successful in a clinical setting than in group sessions. There was an overwhelming consensus by both counselors and social workers about why one-on-one sessions are essential to a client who has experienced sexual abuse. Participants agreed that group sessions are helpful, but that group participation should happen further along the healing process when it may be more beneficial to the client. Tess shared, “Sometimes, dealing with trauma, I prefer one-on-one because I feel like sometimes kids aren’t going to open up around other kids.” However, she added, “Groups do work well with kids if they can find a common factor of why they’re in the group.” Jade agreed that starting with one-on-one is important because “it’s hard for kids to kind of open up around other kids.” She went on to say that due to trauma, the therapist and client must have a lot of “rapport-building,” especially during the “first six or seven sessions.” Those first sessions are critical to building trust before the therapist and client can dive “into anything that’s really heavy trauma-related.” In reference to groups, Jade said it was harder for the client “when there are other people around because then they have to build trust with the other people and not just with me as a therapist.”

Gina, who works in a school setting, shared, “Especially with kids that are sexually abused, I like to have individual sessions, but I’m unable to have the hour-long session because I’m in a school. So we’re limited to only 30 minutes, which is good.” She also found 30 minutes of trauma-informed practices ideal for working with pre-K and kindergarten children because their attention span is “15 to 30 minutes anyway, so I like to do individual sessions.”

Kate shared her appreciation of both group and individual therapy, saying, “I truly love groups. I love doing groups and individual work, as well.” She agreed with Jade regarding how individual sessions take precedence at first because of “building that trust and rapport,” as trust and rapport “give [clients] an anchor to going into the group” with the same clinician leading the group. Kate practices in a small town, which can become a challenge for groups. The client might know someone in the group, causing the client to become guarded during the group session.

Kate had also found the opposite when it comes to groups. In a sense, she said groups can become normalizing, especially when one group member is further along in their journey, who is very open and will “just let the flood gates open, and you don’t even have to facilitate the group.” Kate continued,

> They just take over; they just do it for you. And it’s so beautiful to see these little minds connecting and realizing, “Oh, there’s nothing wrong with me for thinking that way or having that thought or having this feeling that I’m having.” They’re so validating and normally normalizing for these children. And for teens, too. I really, thoroughly enjoy teen groups.

Kate discussed some of the challenges with groups, the first being "getting them in if they don't drive" because the clients are dependent upon their parents for transportation. She explained, "Teen groups have more success because a lot of them may drive themselves or come themselves, but for little kids, you have to rely on their parents to bring them, and that's a challenge." Kate sometimes struggles in "getting that buy-in from the parents," which is why parental education on psychotherapy is essential. She continued, "But, sure, groups are amazing. I love doing individual work, too, but the challenge is definitely just getting them in the door if they can't drive themselves." The participants' consensus was that one-on-one therapy is far more important to the client than group therapy; however, group therapy can be helpful, as well.

Theme 5: Trauma Response and Resiliency

Children who experience sexual assault display a trauma response, which often includes the inability to cope, feelings of helplessness, decreased self-esteem, and difficulty expressing proper emotions. Alleviating trauma response is possible via resiliency and appropriate psychotherapy treatment. Several participants discussed trauma response, screeners, and decreased symptoms and how they recognized when a client had become resilient.

Kate noted that "trauma hijacks the nervous system and that fight-or-flight; that freeze response comes in." She said kids might "freeze and that shame and self-blame comes." Sometimes a child can be very organized, sit in a session and just talk, and then she has "to realize that's indicative in itself of anxiety or even fear of exploring."

Kate discussed observing a child's shift toward resiliency. She said,

> There's nothing better than hearing from a past client, and they're like, "I just got accepted to LSU, and I'm on this team, and I'm doing that, and I'm doing this." And you see how resilient they are, and you see how they're still overcoming obstacles.

When this happens, Kate said, it shows that the trauma they experienced "did not hold them back." She went on,

> I think that's pretty awesome watching that play out, even long-term. Seeing how truly strong people can be or the ones that come and let you know, "Oh, I decided to major in psychology," or "decided to major in social work," or "decided to major in this." And just the impact that their own healing that they did within them, that empowerment that they encompassed, and now they want to use that to go help other people. That's pretty awesome.

Jade agreed with Kate:

> If a child comes in and they're sitting down so well, and they're just talking to you, then it's trying to figure out, "What is that? What part of the trauma response is that?" Because that's what it is: It's a trauma response.

Jade stressed the need to determine where the child was before delving into a session, a time when she would use expressive art. Jade expressed that trauma response can look like a change in behavior such as "a child who either isn't communicating that much to people, has been very withdrawn, just staying to themselves." She explained how she knews when the therapeutic process was working because the child, adolescent, or teen became:

> More outgoing, and they're communicating better. They're able to assert themselves and ask for what it is that they need and get those needs met. Or it could be someone who's having negative behavioral issues. And now they're beginning to use their words to express themselves and not having as many behavioral issues as they were prior.

Elaine said she used standardized TF-CBT assessments as a determining factor to track the process of trauma response and resiliency in a client. However, she would like to find evaluations that focus on strength and resilience.

Jade asserted that one of the best things about being a clinician is

"whenever you do see a child that you worked with, and now they are living a very productive life, and they're being active, and they're so grateful or thankful for the work that you've done." Jade elaborated, "They tell people about it, and they sing praises, which is always good to have positive reviews and hear people say positive things about the work that you've done." Jade shared a recent experience working with a kid who had faced sexual trauma and how now, after receiving therapy, the youth is "dealing with regular children issues or behavioral issues.…That is an improvement. That means they're no longer really working on the trauma. Now they're actually being an actual kid, and they're just being a rebellious child at this point." She expounded further by discussing how seeing the change in a child behaviorally, expressing and communicating more openly, and "having parents tell you they can see a difference in their child" indicates a child regaining normalcy and is an example of resiliency. She finished by saying, "That's the best."

Elaine discussed her process:

> With TF-CBT, we do standardized assessments, and so we can actually track progress and see that some things are better. But also, I think I'm hoping to do more with strengths and resilience. I haven't really found assessments that I want to be able to use with kids on that, because I think that's really important, being able to assess that. Because seeing it doesn't make it something you can show to somebody else, do you know what I mean? We know it happened, but we don't have any proof. But at the end of therapy, I always do a review of what kids learned, and when they are able to say, "This is something that was helpful; this is something I still use"; that's something that lets me know that they have taken what we've worked on and are able to use that moving forward.

Kate provided feedback on using standardized assessments to determine resiliency in a client, admitting, "I have a love-hate relationship with those things." She believes it is "great to have the concrete number or have the standardized testing or assessment screener measure" but wondered if the assessment truly measures "what is going on. What is the bigger picture?" She explained,

> A lot of times, especially with complex trauma, you'll see—and this has happened—some very low number in the assessments and the screeners, and then you'll do it again in maybe eight to 10 weeks or four to six weeks. And that number is way higher, but it's because they trust you now. And they're actually answering honestly. And you're like, "Oh my God, did I give this kid PTSD? Oh no. What happened? Or is it that they understand themselves better?"

Kate went on to say that exploring screeners are important, and she used “a lot of different ones, depending on what’s going on.” She discussed the need to examine the client outside of the assessment:

> Look into how are they perceiving their lives or even how are they perceiving problems. “What does this problem mean to you that’s coming up for you? What is the perception of what’s going on?” And as you see a shift in mood or a shift in these cognitive distortions of the view of themselves and the world around them, they will begin to perceive problems very differently. That is a really good indicator that they’re reaching that resiliency piece and some clinical significance in what’s going on in the therapeutic work.

Elaine discussed the practices at her agency:

> We use the child PTSD symptoms scale, the Children Psychological Process Scale. And so from the beginning to the end, and like Kate was saying, sometimes it does go up in the middle, but it tends to go down by the end. But looking at intrusive thoughts and hyperarousal and impairments in cognitions and mood, all those themes that are part of PTSD symptoms, almost all of our kids have very fewer, significantly less PTSD symptoms by the end. And so we do have those standardized assessments to be able to show that.

Kate added, “I love the child PTSD checklist. That one is one that I have. It’s more love than hate, but that one is utilized.” Kate also uses the PTSD checklist for DSM-5 (PCL-5), the skill assessment, and the trauma checklist. She noted the importance of “differential diagnosis” because

> Oftentimes, kids will have overlapping issues and being able to use discernment and going forward, doing that collaborative care with other professionals and ensuring that the right things are being treated at the appropriate time so that you can fully work through that trauma work and you can get to where there's a receptiveness to that, and the ability even to do it, cognitive ability to even do it."

Kate identified symptoms associated with trauma response: "Things like intrusive thoughts are a huge one. [Shame and] exploring that shame that's going on that affects the self-worth," including bedwetting, lashing out, and dishonesty, which she also deemed a "big one." She explained, "People in general, and not just kids, [lie to] avoid consequences or because we're ashamed of something" or because we "can't quite talk about that thing yet." Kate continued,

> I think if you start seeing increased honesty and open communication, then you're seeing less avoidance. And then the less avoidance, the more we're communicating; the more we're communicating, the less anxiety and depression. And then issues like bedwetting will eliminate, if not greatly improve. Again, there's differential diagnosis, always the medical pieces. Is there a medical issue for this? And we may see that because we know the history, we get the history that it's connected to the trauma that's happened, this trauma response, but being able to collaborate. And sometimes that can be really challenging with the communication piece with other professionals. So those are some of those symptoms of the desire to see the decrease.

Elaine also talked about "intrusive thoughts and hyperarousal and impairments in cognition and mood, all those themes that are part of PTSD symptoms" that can decrease through psychotherapy methods of TF-CBT and play therapy. Kate finished by sharing,

> I've worked with many younger children [who] have a really hard time asking for help: "I do it myself. I do it myself. I do it myself." And then they'll start a shift, and they'll start asking for help: "Can you help me do this?" And of course, letting them try to figure out those things, but they will refuse help, which again is a trauma response or, as Jade had mentioned, parentification earlier. There's a reason for everything that we do, but then children will start to ask and be willing to receive help in certain areas. I think that's a good indicator, too, that some healthy shifts are going on.

Theme 6: Vicarious Resilience and the Importance of Therapy

Some participants discussed how feelings could come up during a session and their experiences with vicarious trauma and vicarious resilience. They also spoke about why setting boundaries is essential to resiliency and maintaining a sense of self. Social workers and counselors noted that burnout can be detrimental to clinicians' work and the importance of having a personal therapist. Kate recalled a time when her feelings came up during play therapy:

> I hated sand tray because it was messy. I hated it. Oh, now I love it. It's my most favorite thing in the whole wide world. And kids love it, and I'm afraid of the mess. That was my stuff; I was bringing in the mess.

Kate acknowledged how her feelings could damage and prevent the clients from getting what they need out of their session. Her words were one example of why therapists must recognize their feelings and resolve them, even if that means seeing a therapist themselves.

As Xander explained, vicarious resilience helped him look at his life and his situations in a different light. The participant said,

> If there is one thing that my kids kind of show me every single day, is that if they can live through the terrible situations that they have been through, then it makes my comparatively not-so-terrible situation look pretty good. And I try not to take it to heart because, of course, we all have our own demons, but at the same time, some of these 5- and 6-year-olds that I work with deal with things that I haven't seen in my 30-plus years of life. So if they can deal with it, it definitely gives me a little bit of hope that I can do the same.

Elaine discussed how COVID-19 has impacted her work as a therapist, especially the resiliency factor:

> COVID has kind of made me learn a lot more about resilience than I had ever known previously. Of course, I've learned about vicarious trauma, and our office has done really great work on making sure we have ways to work through our own vicarious trauma. But, I've been doing lots of psycho ed stuff for myself on resilience and have been able to teach those skills to my kids, and teaching them makes me practice them, which makes me be able to remember them and use them. And so I think that's what has been really helpful when I can work with the

> parents and the kids in building up and their window of tolerance and learning how to access that, that I'm reinforcing it for myself and able to calm down when I'm feeling stressed and anxious and worried.

Kate shared how her clients taught her, unbeknownst to them, about life and the power of resiliency. She said, "I think I'll often have this surreal feeling of, 'Wow, this is the work I get to do.' It feels like, 'How am I the person doing this?'" Kate continued,

> I'm in this position to share this space with these individuals, these families, these children, whoever is in that room, and that has a lot to do with resiliency. But also, and I feel all the time, they teach me so much more than I think that I ever provide to them and that I could ever give to them, that I could ever share that space with them. And they teach me so much more about life and the world around us.

Kate asserted, "With that vicarious trauma, oh my goodness," it is important to ensure you are doing "your own therapy, doing your own work. And especially us being clinicians ourselves, it feels so vulnerable to go walk into another clinician's office and say, 'I'm a therapist.' Which makes them super uncomfortable, too." Kate found that getting a therapist is a good idea "because then they're working with you." She argued that therapists should embrace the vulnerability that comes along with knowing when they need a therapist themselves, "Because that's exactly what we're asking our clients to do, is to be vulnerable." She admitted, "It's scary to go in and talk about our own shadows and our own things that come up." Kate shared a personal example:

> One thing I’ve had to learn about myself is that, “When am I getting burned out? When am I experiencing my own vicarious trauma?” Well, it might be when my phone rings and I’m like, “Shit. No, it’s someone telling me a problem.” Or I don’t want to answer this phone, or I don’t want to go in to work that day. Just these really subtle things or, and just being transparent with myself and that, “Oh, I don’t want to be there.” And I know that I love this work that I do, then there’s something going on with me internally. I need to explore that. “Let me call my therapist.”

Kate also stressed that “trying different modalities yourself and experimenting and playing around” can help as well as remembering that “awareness is a key.” She talked about how if a therapist asks children “to be vulnerable and to explore the deepest parts of themselves,” that is intentional because there are always reasons the child is guarded and keeping things hidden. She continued, “We do the same stuff. We’re people just like them.” As she explained, “The resiliency piece is so important. I think that’s also the trauma part and the resiliency coincide through us doing our own work and just knowing, know thyself. ‘What’s going on with you?’” Kate shared, “One of my key indicators is usually when my phone rings, I cringe. I’m like, “No! Someone wants to tell me something.’ No.”

Jade expressed similar sentiments:

> Yeah, like Kate is saying, it’s so important to do your own work and have your own therapist because you’re processing at the same time that your clients are processing. And so you don’t want the session to turn into being you processing

your stuff in someone else's session instead of you doing the work by yourself. And so the resiliency piece is recognizing in that awareness of what's going on in yourself so that you can do the work. Because if you don't do your own work, you're not going to be able to do this work for a long time. You will burn out. I know, in the beginning, I did burn out when I was 2 years in. I had to take a very long break from counseling because I was just now beginning that process of doing my own work. And so trying to figure out what is that resiliency: What does that look like? So that I could do this work long term instead of just burning out and then deciding to go work with another population, when I knew this was population that I loved and wanted to work with.

Kate shared a similar experience with burnout:

Jade, I did the same thing early on and took a year and a half, two-year break. I went into a whole different career, with no intentions of ever going back. Like, "I can't do this." And I went and did hair for a year and a half, two years, and then it pulled me back. It pulled me back.

Xander reflected on his experiences with burnout:

I think for me personally, I had considered leaving the profession a couple of years after I started. But if there was one thing that, especially, my teenagers kind of repeatedly taught me…talking about the benefits of self-care and how some of these people are actively making their lives worse by not focusing on themselves and focusing on the feelings and the situations of others. And at some point, it kind of hit me like a brick: The same thing you're telling them to do is something

> you're not doing, and it really is leading to burnout. So, just kind of taking my own advice and basically having the kids [who] I thought I was kind of saving be the ones to kind of save me.

Elaine, too, agreed:

> Yeah. I've definitely felt like that, Xander, where I'm speaking all this, and I'm not practicing mindfulness at home, and I'm asking them to practice, and, "Okay, I'm going to commit to it again so that I can practice what I preach and show these kids that it really helps."

For Elaine, "COVID has made everything harder and practicing resilience, like I was saying earlier, has helped me help them, but I'm still struggling to make sure I'm doing it myself."

For Kate, going back into the field of trauma therapy had a lot to do with her "own self-exploration" and utilizing her "toolbox." Kate shared with the focus group one thing that has helped her build vicarious resiliency: practicing mindfulness at the end of a tough day or week and being mindful not to schedule all her trauma clients back-to-back. According to Kate,

> We all know that we have clients that have complex and significantly horrific trauma that has happened. And I had to learn the hard way of not scheduling all of them in one day. You're going to be completely drained and lacking yourself. Do not schedule them all on the same day. And every now and then, I'm like, "How did I do that? Oh, no."

Kate suggested one tool a therapist can use is "packing that stuff up before

you even leave for the day [or] once you get home and being able to energetically disconnect from that." She continued, "If you're a mindfulness-based practitioner and that's part of your modality of what you've included into the other parts of your work," then "being able to visualize and completely cut and disconnect that energetic connection to that week or that day is part of our toolbox, too." In doing so, she is "not continuously being drained with what's going on."

Kate explained that clinicians should use self-awareness by "being mindful if we are disengaging from the people that we love and the people that we want to be around. Are we isolating more?" She continued, "The same things we would ask for clients," we should ask ourselves and use our "own toolbox." She recommended, "Something that is helpful with the resiliency piece is being able to have my own container and to box that up." As a therapist, it is vital to be able to close the toolbox and "then turn around and be able to open it back up when we get back on Monday or when we go back on the next day or leave the hat at the door." She explained,

> It's so hard to do that some days, but we have to do it. And I think flexibility is key, too. That was hard for me, learning to be flexible, but I think I'm doing a much better job these days.

Kate noted finding self-awareness when she is in the resiliency zone:

> Like Elaine said, when you're practicing what you're preaching, and you're doing these things, it shows. And especially if you work with trauma, you're working with people with a superpower of a very strong intuition. They feel that. They feed off of what they're getting from you.

She continued,

> If we're not practicing it, on some level, they're going to know. They're going to pick up on whether or not you're just talking. If you're just going from a script, they're going to know because they're so receptive, and it truly is a superpower to have that ability to kind of read a room.

Kate shared, "I also find that when I am practicing what I'm preaching [and] I'm in that resiliency zone, I listen better, I hear better. I can reflect better, and my empathy isn't impacted." Jenn agreed that she, too, listens better when she is in the resiliency zone. Kate stressed the importance of vicarious resiliency:

> I think that when we're not in that zone and we're in more of the trauma response, vicarious trauma response, we're not listening to understand. We're kind of clock watching. We're stressed, we're in that zone of that's what we're focused on.

Kate finished talking about resiliency and stated , "I listen better. My empathy is stronger. My ability to understand is stronger, and the therapeutic connection" is more robust. "Isn't that really what therapy's about? People's basic human right is to feel connected, whether to themselves or to something larger than them or to a collective whole. You have that connection."

Theme 7: Boundaries and Resiliencies

Vicarious resilience and the importance of therapy for clinicians brought boundaries to the forefront of the discussion. Jade and Kate had similar views on the importance of boundaries and how resiliencies and boundaries go together. Jade shared,

> Boundaries are a big part. It is the part of building resiliency that is knowing where your boundaries are, and knowing how to set them, and knowing how to reinforce them when you need to, and that is a big part.

Jade talked about how setting boundaries means

> Being able to leave work at work and not think about it the entire weekend so that it's not taking over other parts of your life. It is figuring out how to do that and then not feel bad about it.

Further, Jade identified boundaries as knowing

> You can still have a life. You can still have joy. You can still do all these things that you want to do and not have to feel guilty because you're not constantly thinking about your clients or worrying about people who might be in a worse condition than you are.

Kate agreed, suggesting that therapists need "boundaries and not feeling guilty for setting those boundaries, no matter what the response is. And this is going back to the resiliency part and being mindful of your own vicarious trauma." Kate shared a personal experience about the importance of setting boundaries when she has a family to take care of:

> Something my therapist said to me is that, "Do you know how many therapists' kids I work with that come in here and talk about how they felt ignored and rejected, even though their parents were out saving the world and they were working with all these other kids?" …That hit me. I still get emotional hearing that. In that moment, I was like, "I really need to check my boundaries. Because

> [my kids] are my priority, and I can't be constantly focused on what's going on [at work]. I can be supportive, but I also have to be there for my family, too, and be present there. Gosh, yeah, Jade, you hit the nail on the head with that boundaries piece.

Theme 8: Dilemmas and Cultural Competency

Kate, Tess, and Elaine discussed cultural competency and how dilemmas arise that challenge trauma therapists' therapeutic methods concerning mindfulness-based techniques. Parents, culture, and religion play a significant part in why a therapist needs to be culturally aware and competent when working with child sexual survivors. Kate offered, "With self-regulation, the wording of things can be a dilemma and being very mindful of how we word things." Kate recalled, "Mentioning mindfulness or meditation" can make some parents "very uncomfortable." Instead, it might be better to use terms such as "self-regulation skills" or "calming the nervous system" to help the parents better understand. Using these terms will allow the therapist to ascertain how comfortable the parent is with these techniques. She found that some parents feel that mindfulness or meditation is "satanic or feel that that goes against their faith or their practices," which is an area where education may come in. Kate stressed that all therapists should be "mindful with words." Personally, she said, "I'll use the word 'mindfulness' or use just the word 'meditation,' or 'we're going to do some yoga movement today' and [the parents will say], 'Oh no, that's satanic.' And then I'm confused."

Tess joined the discussion and recalled,

> I had a parent do that. I had a parent [who], from the beginning, I hadn't even talked about mindfulness and meditation, and she was like, "If you're going to do any kind of yoga, I need you to not, because we don't believe in that." I was like, "Okay, sure." She saw my yoga mat. I had a yoga mat for kids to lie down for deep breathing. It wasn't even for yoga.

Kate contributed,

> That's culture. That's that cultural competency piece and that parent education. And again, self-determination. We can't force them to do anything that is on our agenda, but that's a dilemma in itself. Because you know how effective that can be, obtaining these skills in many different areas.

The skills used in mindfulness and yoga "can roll over," Kate said. Once a client learns to "soothe that nervous system" and "learn these self-regulation skills," those skills can "roll over into the classroom or their relationship with siblings or with the parents." However, Kate admitted, that's a "huge dilemma sometimes. …I know we're more subjective, but that is probably a Southern region thing…more so heavily here than maybe in other areas. But I've encountered it more times than I would like to."

Elaine interjected to say that she, too, experienced this dilemma but only once. Kate explained,

> It's been a couple of times, not a whole, whole lot, but more than I would like because it feels like you have to revamp the relationship again. And go back into it and rebuild that trust, too, because then they're super guarded.

She continued, "I've had one, a long time ago. I think one of the first times experiencing this. [The parent said] that we invoked Satan into her child by practicing controlled breathing." These experiences and examples could be a reason to consider parent psychotherapy or psychoeducation.

The social workers and the counselors agreed that cultural competency is an integral part of their practice. They discussed the benefits of being mindful of their clients' belief systems, culture, values, and religion. They all agreed that a therapist's job is to ensure the client receives the best practice even if it does not align with the therapist's planned agenda.

Unexpected Findings

During data collection, an unexpected finding was the counselors and social workers reported a lack of parent education and support involving mindfulness-based therapeutic methods. The social workers and counselors provided an in-depth discussion of parents' misconceptions of mindfulness-based therapy methods. The parents sometimes perceived deep breathing, yoga, grounding, guided meditation, or even using a yoga mat during therapy as infringing on their religious rights or even satanic.

Another unexpected finding was the challenges participants faced due to COVID-19, telehealth, learning curves involved in online sessions, and parents interrupting their children during an online session. The participants provided details and strategies on how they have faced these challenges amid the coronavirus pandemic and made the best of the situation.

Summary

This section began with discussions of the recruitment phase, data analysis process, validation techniques, participant demographics, and findings. The findings support the social workers' and counselors' experiences and perspectives when using TF-CBT and play therapy concurrently with CSA survivors. The six participants shared their experiences combining trauma-focused cognitive therapy through nondirective or directive play therapy in a psychotherapy session. Some therapists preferred a nondirective approach to play, whereas others discussed using both nondirective and directive play methods.

All six participants reported the significance of play therapy combined with trauma therapy, as play is a child's first language. Some participants professed that play is essential to trauma therapy when children cannot convey their feelings and emotions using words. Participants remarked that trauma hijacks the nervous system, resulting in the flight-or-fight response, anxiety, fear, and PTSD and reducing the brain's functionality. Trauma-focused CBT helps teach the child coping skills and cognitive restructuring. At the same time, play therapy in any form—including narrative writing, sand tray, drama, painting, or movement—is essential to helping the child regain control of the nervous system. Other techniques helping calm a child's nervous system and reducing mental health symptoms, stress, anxiety, PTSD, and fear included grounding, yoga, and mindfulness-based therapeutic techniques.

The therapists found that coping skills, including properly conveying emotions and feelings, reduced mental health symptoms, decreased negative behaviors, and

increased positive behaviors. Assessment tools helped determine resiliency in a child. A common belief was that vicarious resilience is essential for all therapists to maintain a positive client relationship; thus, all therapists should be mindful and remain in the resiliency zone.

All participants stressed the importance of parent education. Because parent buy-in is vital, parents should receive psychoeducation. According to the six participating therapists, psychoeducation should include key terms used in a therapy session, what different therapy techniques included, an outlook on what therapy for their child could look like, and how long it might take to heal and recover from child sexual abuse.

The majority of the participants discussed how COVID-19 had challenged them when incorporating play into a session via telehealth and having parents interrupt their session. The participants were able to remediate these challenges by learning alternative methods to play via a computer and educating the parents on appropriate behavior when a child is in session. All therapists agreed that a client can successfully receive TF-CBT and play therapy through telehealth.

Social workers and counselors reported that treating clients who have been sexually abused can result in therapist burnout. Fifty percent of the participants discussed their experiences with burnout. All participants agreed that engaging a personal therapist and practicing self-care and mindfulness are essential to do their work.

The therapists also emphasized being mindful of parents' and clients' culture, religion, and belief system. Participants have faced dilemmas based on parents' assertions that mindfulness-based therapy techniques are against their religion or are satanic. Thus,

educating parents on mindfulness-based techniques to help them better understand how mindfulness-based practices work was essential to good practice. Participants noted that cultural competency ensures they meet the client where they are and use methods that are not harmful to the client or the client's belief system, religion, or morals.

Section 4 presents how this study's findings applied to social workers' and counselors' professional practice. The topics discussed include professional ethics in social work, social change recommendations, and clinical social work practice e. I also present the dissemination of the findings.

Section 4: Application to Professional Practice and Implications for Social Change

Introduction

The purpose of this study was to understand social workers' and counselors' experiences and perspectives when using the intersectionality of TF-CBT and play therapy with survivors of CSA. I employed a qualitative research design with a homogenous sample of social workers and counselors with similar work backgrounds in trauma and play therapy. Conducting an online focus group allowed me to collect in-depth data from the participants (see Onwuegbuzie et al., 2009; Ravitch & Carl, 2016; Rubin & Rubin, 2012).

Exploring social workers' and counselors' experiences and perceptions allowed for an in-depth understanding of how psychotherapy methods for sexually abused children can influence social work and counseling services through play in a trauma therapy session. The experiences shared by the participants contribute to ongoing social change through education and increased awareness of combining TF-CBT and play therapy in professional practice. In addition, the information the participants provided on psychotherapy methods that help increase resiliency in children can be used in school settings, professional trainings, and at agencies to increase positive outcomes in CSA survivors and maintain continuous social change.

Among the findings was that trauma hijacks the nervous system, resulting in the brain shutting down as a means of protection and increasing mental health symptoms, such as PTSD, anxiety, and depression. Findings suggested that adopting evidence-based practice using play in trauma therapy allowed the child's brain and nervous system to

calm, permitting the client to stay present. In staying present, the client can relax, clear the mind and body, breathe, and reduce fear and anxiety, opening the pathway to healing and resiliency. Therefore, the research question was answered.

In this study, I also explored participating social workers' and counselors' experiences with trauma response, vicarious trauma, resiliency, vicarious resiliency, individual and group therapy, and boundaries. I discovered ways that participants managed burnout and boundaries in a therapeutic setting. Other topics discussed throughout the study included parents, COVID-19, telehealth, dilemmas, and cultural competency.

This study's findings contribute to knowledge in the social work field by increasing the understanding of psychotherapy methods with children who have experienced sexual abuse. Furthermore, the findings emphasize the importance of parent psychoeducation and why mindfulness-based play therapy techniques are essential to trauma therapy. This study also informs social work practice by addressing the need to decrease burnout and why self-care is crucial to trauma therapists.

This study also provides an in-depth look at COVID-19 telehealth. The participants commented that the coronavirus pandemic has increased the number of online resources and video communications that can be used by clients and therapists. Participants shared how trauma therapists can adjust to the change in therapy services and continue use trauma-focused therapy and play simultaneously online. Furthermore, this study adds to the existing knowledge in social work supported by Killian et al., (2017) that trauma therapists should increase self-care, maintain clear boundaries and limits,

practice mindfulness, seek out therapy services for themselves, apply self-awareness daily, and stay in the resiliency zone to decrease burnout.

Application to Professional Ethics in Social Work Practice

The NASW's (2017) set of core values for evaluation and research related to this research by including the following: service, social justice, dignity and worth of the person, the importance of human relationships, integrity, and competence. The study's findings inform the core values of social work through an in-depth understanding of social workers' and counselors' lived experiences. Participants demonstrated their responsibility to serve their clients by providing evidence-based psychotherapy. The social workers and counselors practiced and confirmed the importance of human relationships and the dignity and worth of a person by building trust and rapport with their clients and validating the children's experiences and feelings. They reported continually advocating for social justice, incorporating psychotherapy methods within their scope of practice, educating themselves on best practices, and using methods that ensure cultural competency as set forth by the NASW Code of Ethics.

This study complied with the NASW's (2017) Code of Ethics on evaluations and research by contributing to social work research and adding existing knowledge to social work. The information gathered in this study also contributes emerging and current knowledge to the field of social work. An example of emerging and current knowledge is the increase of telehealth therapy services due to the coronavirus pandemic.

In conducting this research study, I adhered to all ethical guidelines as set forth by the NASW (2017) and Walden University's IRB by ensuring participants' confidentiality

throughout data collection and analysis. Participant protection began with them electronically signing an informed consent form, which provided information on the study's nature and the extent and duration of the focus group interview in compliance with the NASW guidelines. Participants were also aware of the risk and benefits of participating in the research study.

The aim of this study was to understand social workers' and counselors' experiences when providing services to children who had been sexually abused. The goal was to increase knowledge in the social work profession regarding trauma-informed social workers' and counselors' psychotherapy methods for treating children who have experienced sexual trauma. An unintended achievement was addressing the challenges of teletherapy amid a pandemic, parent education, and self-care.

Recommendations for Social Work Practice

Based on this study's findings, I recommend two action steps for trauma-informed clinical practitioners in the areas of practice, research, and policy in working with child survivors of sexual assault. The first recommended step is to provide trauma-informed social workers and counselors with training and education on parent psychoeducation specific to mindfulness-based play therapy techniques. Psychoeducation on mindfulness-based play would be useful to improve parents' knowledge to obtain their buy-in. Agencies that work with CSA survivors should offer this psychoeducation to their trauma-informed therapists. Following training, the trauma-informed therapist would share mindfulness-based play psychoeducation with the parent or guardian before the child's first therapy session. Also, trauma-informed therapists may benefit from

continuing education opportunities, a part of licensure requirements, and educational training focused on parent education and why mindfulness-based interventions are essential for child trauma survivors.

The second recommended action step would be for organizations and agencies to understand the importance of ensuring that their social workers and counselors practice self-care. Trauma-informed social workers and counselors are at a high risk of experiencing vicarious trauma and burnout due to their workload and the population they serve (Killian et al., 2017). During the focus group interview, one participant mentioned that agency culture can contribute to therapist burnout by assigning caseloads with high numbers of trauma survivors. Therefore**,** agencies being mindful of their trauma therapists' workload and well-being may help decrease burnout by providing a nonjudgmental zone for the therapists to express their concerns, feelings, and emotions triggered by their work with trauma survivors without fear of judgment or job retaliation. Agency support could be via weekly supervision or weekly staffings.

I am a social worker who works with parents and children and I found that, parent education is essential to evidence-based practice and it should be a part of continuing education. I will develop a discussion topic regarding parentification and mindfulness-based play and share it with social workers and counselors via a live video discussion on recommended ways to remedy parentification and increase parent buy-in. Also, the experiences with burnout shared by the trauma-informed therapists who participated in this study may help create a conversation on the importance of self-care, mindfulness, and personal therapy to increase vicarious resiliency and decrease burnout. The topic

shared will also incorporate why implementing these strategies in social workers' and counselors' lives and practice is just as important as clients' work.

Transferability

One component that measures a study's trustworthiness is transferability (Stahl & King, 2020). Transferability is limited in an action research that uses a small number of participants. This study had six participants; therefore, I used triangulation, peer debriefing, member checking, reflexive journaling, and two coding phases to ensure trustworthiness aligned with Stahl and King (2020) on transferability in trustworthiness. The transferability of this study's findings based in South Louisiana are not confined by the small number of participants because the patterns and descriptions in the themes identified may impact social workers and counselors in other states and countries, thus expanding knowledge through the study's findings Data collected from this study provided in-depth information on the integration of trauma therapy and play therapy, parentification, COVID-19 and telehealth, individual and group therapy, trauma response, and resiliency among survivors. Also collected were data regarding therapists' experiences with vicarious resilience, personal treatment, boundaries, dilemmas, and cultural competency. The experiences shared by counselors and social workers may not extend beyond their agencies and practices. This comprehensive study focusing on play therapy and TF-CBT with CSA survivors may be applicable across all settings where trauma therapists work with trauma survivors. In addition, virtual play therapy and trauma psychotherapy via telehealth would support transferability regarding experiences and challenges with incorporating play virtually with trauma survivors amid a pandemic.

The information and knowledge gained from the study's social workers may be useful to support child survivors of trauma and address the challenges discussed in this research study.

Usefulness of the Study

Application of the information gathered from this study can promote social change, provide continuing education to social workers and counselors, and help increase social workers' and counselors' job effectiveness. New and emerging information regarding COVID-19 and telehealth will be useful in building rapport and client relationships through nonface-to-face therapy. The information presented can also inspire social workers and counselors to decrease burnout by having their own therapist, practicing mindfulness, and staying in the resiliency zone.

Limitations

A limitation of the study was the small number of social workers who participated in the focus group. Two participants were social workers, and the other four participants were counselors, thus decreasing the input from social workers. Another limitation was that only one participant identified as a male, reflecting minimal male input. The final limitation was that participants practiced exclusively in Louisiana's southern region. Social workers and counselors practicing in North, East, and West, Louisiana or , elsewhere in the United States of America may have different experiences and perspectives.

Recommendations for Further Research

A recommendation for future research in the field of social work is play therapy using teletherapy with children who have experienced trauma, providing an in-depth look at how telehealth and COVID-19 have changed the face of play therapy. Another recommendation would be additional research on social workers and their perceptions and experiences using trust-based relational therapy with children who have behavioral problems. The experiences and perceptions of social workers who use trust-based relational interventions may help decrease behavioral problems often seen in children who have experienced trauma through the foundation of trust and good client-therapist rapport. This recommendation is based on participating social workers' and counselors' experiences that building trust and rapport with children who have experienced trauma is vital to any type of trauma therapy.

As a social worker who works directly with children with sexual trauma and behavioral problems, I found that the study reinforced why evidence-based practices are essential to social workers providing child trauma survivors psychotherapy. The study also indicated the need for continuing education on effective trauma therapy methods and why they are vital to social workers' training and instruction. In addition, I will continue to work with social workers and counselors to bring awareness to psychotherapy methods and the treatment needs of children who have experienced trauma. This work will entail facilitating discussions and conversations that focus on the best practice methods to serve children who have experienced trauma.

Dissemination of Findings

Dissemination of this study's findings will be to the participants and audiences that can directly benefit from this study. These audiences include community stakeholders, local and national child advocacy agencies, national alliances and associations, and local school social workers and counselors. The findings may encourage shared experiences among social workers and counselors who work with child trauma survivors, increasing the use of play therapy and TF-CBT across therapeutic settings. The dissemination of the findings may encourage licensed therapists to create a dialogue on trauma therapy methods, mindfulness-based play, virtual therapy within agencies, schools, and private practices, and the importance of trauma therapists being in the resiliency zone to best meet their client's needs Disseminating the finding to agencies, alliances, and associations will increase knowledge among social work networks, such as Louisiana's Children Cabinet Advisory Board, Louisiana Association for Play Therapy, the National Alliance on Mental Health, the NASW-Louisiana chapter, the National Advisory Committee on the Sex Trafficking of Children and Youth in the United States, the National Child Traumatic Stress Network, child advocacy centers in Louisiana and the United States, local social work and counselor organizations and social media groups and forums. The study's findings show the importance of combining play therapy with TF-CBT and promote resiliency in children who have experienced sexual abuse, thus creating the opportunity to develop professional development trainings and webinars.

Implications for Social Change

Positive social change allows for improving both human and social conditions (Walden University, 2017). This study's findings have implications for positive and continued social change at the micro, meso, and macro levels. Implications for change at a micro level include social workers and counselors providing client-centered trauma psychotherapy services. Additionally, social workers and counselors can offer parents and caregivers psychoeducation regarding trauma therapy methods that best benefit their children on a micro level.

Implications for social change on a meso level include educating local organizations, schools, and agencies in South Louisiana. Social workers can instruct these groups on best practices, policies, and procedures that directly affect child sexual survivors' psychotherapy services in these settings. The study can also inform these agencies, organizations, and schools on evidence-based interventions and practices by working directly with the organizations to ensure that clients who have experienced trauma receive the best services and procedures.

On a macro level, social workers who hold leadership positions in agencies and local and national organizations and alliances can advocate for continuing education and professional development on trauma service delivery and parent education. The clients can benefit directly through the expanded services offered to social workers and counselors on trauma service delivery and parent education. The client will experience positive social change via service delivery within the organization or agency by receiving therapeutic service through the trickle-down effect of comprehensive trauma treatment.

Summary

Children who experience sexual traumas can develop symptoms related to somatization, PTSD, physical illness, personality disorder, anxiety, depression, irregular sleeping patterns, and stress due to their brain and body trauma's response. Six licensed social workers and counselors shared how they provide TF-CBT and play therapy concurrently to children who have experienced traumatic sexual experiences that have disrupted their normal childhood and developmental processes. Social workers and counselors who participated in this research shared their experiences with vicarious trauma and resilience about their roles as trauma therapists and their challenges with boundaries and burnout. The trauma therapists articulated their thoughts and feelings on therapeutic dilemmas related to mindfulness-based play and cultural competency. The participants also discussed the importance of parent education, COVID-19, teletherapy, and what trauma response and resiliency look like for a child who has experienced sexual trauma. The findings from this study can bring about positive social change for social workers, counselors, and CSA survivors.

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Appendix A: Invitation Email Template

Dear [*Insert name/agency here*]:

My name is Shayla Polk, and I am a Doctor of Social Work student from the Social Work and Human Service department at Walden University. As a student researcher, I am writing to invite you to participate in my academic research in pursuit of an advanced degree. My research study is entitled "Exploration of Combined Trauma and Play Therapy With Child Sexual Assault Survivors."

The purpose of this study is to explore the experiences and perspectives of trauma-informed licensed social workers and counselors who use a combined approach to trauma-focused cognitive behavioral therapy and play therapy in treatment with children who were sexually abused and aid in the understanding of factors that increase resiliency in CSA survivors.

Eligibility requirements for this study are as follows:

- Licensed social workers defined as a LMSW or Licensed Clinical Social Worker (LCSW) licensed by the LABSW) having been in practice and compliance with the LABSW for a minimum of 2 years.
- Licensed counselors defined as a LPC or a PLPC licensed by the LPCB of Louisiana having been in practice and compliance with the LPCB for a minimum of 2 years.
- Currently, practice a combined approach to therapy with CSA survivors using both trauma-focused cognitive behavioral therapy and play therapy.

I obtained your contact information from [*will describe source here*].

If you are eligible to be in this study and if you decide to participate in this study, you will be asked to sign a consent form and participate in a 2-hour audio-recorded focus group interview with six to eight other individuals present. The research interview may be scheduled via a video conference or phone interview, taking into consideration that some participants may have limited internet or equipment access.

The audio recorded interview will be transcribed verbatim and then used to report the research study findings. No compensation will be provided for this study.

Remember, this study is voluntary. You are free to accept or turn down the invitation. If you decide to be in the study now, you can still change your mind later. You may also stop at any time during the interview.

IRB Approved: 07-02-21-0722256.

Thank you very much,

Shayla Polk, LMSW

Walden University Doctor of Social Work Candidate

Appendix B: Invitation Flyer

My name is Shayla Polk, and I am a Doctor of Social Work student from the Social Work and Human Service department at Walden University. As a student researcher, I am inviting you to participate in my academic research in pursuit of an advanced degree. My research study is entitled "Exploration of Combined Trauma and Play Therapy With Child Sexual Assault Survivors."

ARE YOU a licensed SOCIAL WORKER or COUNSELOR in the state of Louisiana?

Are you interested in participating in a research study?

Eligibility Requirements:

- **Licensed social workers defined as Licensed Master's Social Worker (LMSW) or a Licensed Clinical Social Worker (LCSW) licensed by the Louisiana State Board of Social Workers (LABSW) and have been in practice and compliance with the LABSW for a minimum of two years.**
- **Licensed counselors defined as Licensed Professional Counselor (LPC) or Provisional Licensed Professional Counselor (PLPC) licensed by Licensed Professional Counselors Board (LPCB) of Louisiana and have been in practice and compliance with the LPCB for a minimum of two years.**
- **Must currently practice a combined approach to therapy with child sexual assault survivors using both trauma-focused cognitive behavioral therapy and play therapy**

- **Volunteer ONLY. To participate in this study, you will be asked to sign a consent form and participate in a 2-hour audio-recorded focus group interview with six to eight other individuals present. The research interview may be scheduled via a video conference or phone interview, taking into consideration that some participants may have limited internet or equipment access.**
- **Consent FORM IS REQUIRED.**
- **There will be no compensation for this study.**

IRB Approved: 07-02-21-0722256

Appendix C: Semistructured Interview Guide

Research Question

What are the trauma-informed licensed social workers' and counselors' experiences and perspectives when combining trauma-focused cognitive behavioral therapy and play therapy in a psychotherapy session with child sexual assault survivors?

Purpose

The purpose of this study is to explore the experiences and perspectives of trauma-informed licensed social workers and counselors who used a combined approach to trauma-focused cognitive behavioral therapy and play therapy in treatment with children who were sexually abused. From fulfilling this purpose, the findings will help to understand the factors that increase resiliency in child sexual assault survivors from the social workers and counseling perspectives and experiences.

Methods

- Action research: Qualitative (Phenomenology)
- Sample: Six to eight social workers/counselors
- Focus group: One for 2 hours
- Recorded and transcribed verbatim
- Analysis
    - Coding: (open and descriptive), categories, and themes
- Rigor
- Research ethics
- Results: What did you find

- Implications for social work practice: Hope for what change/impact findings have on social work practice, policy, and profession

Questions

1. Identify your role: Are you a licensed social worker or licensed counselor?
2. Describe your perspectives on combining trauma-focused cognitive behavioral therapy and play therapy as an intervention with child sexual assault survivors.
3. Describe your rationale for adding play therapy to trauma-focused cognitive behavioral therapy.
4. Describe how you utilize the intersectionality of trauma-focused cognitive behavioral therapy and play therapy in a clinical setting with child sexual assault survivors.
    a. What do you perceive as most effective therapeutically? For example, how do you prefer using this combined therapeutic method
        - one-on-one therapy, group therapy, or both.
    b. Why do you perceive it to be most effective?
5. In your experience, what is the most effective play therapy techniques to use in combination with trauma-focused cognitive behavioral therapy? For example,
    - narrative play, sand tray, sensory toys, drawing, painting, etc.
6. Vicarious trauma is experienced by trauma therapists due to the empathetic bond created between the client and the therapists (Pack, 2013), and vicarious resilience is established when trauma therapists identify vicarious trauma.

Vicarious resilience is built through observing and participating in the therapeutic process with the client (Hernandez-Wolfe et al., 2015). What is your perception on vicarious resilience as a result of using play therapy and trauma-focused cognitive behavioral therapy with child sexual assault survivors?

7. In what ways have your experiences with vicarious resilience aided in furthering your use of both play therapy and trauma-focused cognitive behavioral therapy with survivors?
8. In your experience, how has vicarious resilience impacted your clients positively or negatively?
9. Describe your experience in seeing increased resiliency in child sexual assault survivors following successful completion of therapy when using combined trauma-focused cognitive behavioral therapy and play therapy.
10. In your experiences, how has combining trauma-focused cognitive behavioral therapy and play therapy helped to decrease mental and physical symptoms associated with child sexual abuse?
    a. Describe ways you came to this conclusion.
11. In your experience, did you run into any dilemmas when applying play therapy to trauma-focused cognitive behavioral therapy with child sexual assault survivors?
12. Describe your dilemmas and how they were solved.