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Influence of Clinical Supervision on Licensed Clinical Social Workers' Confidence in Implementing Trauma-Focused Cognitive Behavioral Therapy

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Abstract

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MSW, Western Carolina University, 2011

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Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Social Work

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Abstract

Licensed clinical social workers (LCSWs) require clinical supervision when they are new to the field or new to a treatment method. The supervision is meant to guide the LCSWs as they learn new skills and build confidence. The purpose of this basic qualitative study was to understand how LCSWs described the impact clinical supervision had on their confidence in implementing trauma-focused cognitive behavioral therapy (TF-CBT) with youths in a North Carolina intensive in-home program. Social cognitive theory was the framework for this study. Semistructured interviews were completed with 10 participants. Thematic coding was used to identify themes. All participants reported they were confident in their understanding of TF-CBT concepts. However, all participants reported low confidence in implementing TF-CBT interventions and addressing barriers to treatment and had low confidence that interventions would alleviate symptoms. Four themes indicated the impact of supervision on LCSWs' confidence: insufficient time, low support, fear, and feeling unprepared. Findings may be used by clinical supervisors, agencies, and researchers in clinical social work supervision for positive social change to recognize the difference between understanding material taught and implementing it in practice, which may enhance training methods.

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Dedication

This capstone is dedicated to my beloved dog, Delilah. She was my constant companion during my Master's of Social Work program, the beginning of my career as a licensed clinical social worker, and my doctoral program. She passed away during the creation of this work.

Acknowledgments

I thank my professors and colleagues who have supported my development as a clinician. I also thank my grad school buddy, Sonja. We emotionally supported each other during classes and the capstone project.

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Section 1: Foundation of the Study and Literature Review

Youth trauma resulting from childhood maltreatment is a serious social problem in the United States, affecting 9.1 victims per 1,000 children annually (National Child Abuse and Neglect Data System, 2019). Without treatment, the trauma resulting from childhood maltreatment can have long-term consequences on a youth's mental health and social functioning into adulthood (Cecil et al., 2017). The most studied intervention model used to treat childhood maltreatment is trauma-focused cognitive behavioral therapy (TF-CBT; Nader, 2020). Licensed clinical social workers (LCSWs) new to providing TF-CBT require clinical supervision to implement the model with youths experiencing trauma symptoms (Pullman et al., 2018). The purpose of the current basic qualitative study was to describe the impact clinical supervision had on LCSWs' feelings of confidence in implementing TF-CBT with youths in a North Carolina intensive in-home (IIH) program.

Although there have been several scholarly debates over the benefits and best practices for providing clinical social work supervision, researchers agreed the relationship between the supervisor and supervisee has the most significant impact on confidence and job performance (Alfonsson et al. 2018; Kühne et al. 2019; Lucid et al. 2018; Watkins, 2019). Dan (2017) stated the relationship between the clinical supervisor and supervisee should mirror the relationship between the supervisee and their clients. Ormhaug and Jenson (2018) noted the therapeutic relationship is crucial when working with youths in TF-CBT. Understanding whether the relationship developed during

clinical supervision increases the supervisee's confidence in implementing treatment with a client is an essential first step in assessing clinical supervision in TF-CBT.

In this basic qualitative study, I sought to understand the impact clinical supervision had on the supervisee's confidence to implement TF-CBT with youths in a North Carolina IIH program. Basic qualitative research is conducted to understand the way people interpret their experiences and ascribe meaning to those experiences (Patton, 2015). I gathered firsthand information from LCSWs receiving clinical supervision in TF-CBT while working in the IIH program. The participants were interviewed face-to-face over Microsoft Teams using a semistructured interview protocol (see Appendix).

The purpose of the study was to understand the clinical supervision needs of LCSWs and the impact supervision had on their feelings of confidence in their ability to implement TF-CBT to youths in a North Carolina IIH program. This study addressed a social work practice problem of youths dropping out of TF-CBT before completing the program. LCSWs receiving supervision in TF-CBT were asked to provide information about their experiences and the impact supervision had on their ability to provide TF-CBT confidently. Data were collected through semistructured interviews and analyzed using descriptive coding. The study was intended to increase understanding of the impact clinical supervision has on the confidence of LCSWs. The National Association of Social Workers (NASW, 2021) code of ethics guided this study, ensuring that ethical research practices were upheld. The study may provide an increased understanding of the supervision needs of LCSWs receiving TF-CBT supervision within IIH programs. I used social cognitive theory as the theoretical framework.

Social cognitive theory provided a lens for understanding observational learning, beliefs that people can learn, and the ability to apply the concepts people learn through observation to TF-CBT supervision. The findings of this study may aid clinical supervisors in improving TF-CBT supervision, the understanding of supervision needs of LCSWs, and the LCSW's ability to implement the TF-CBT model effectively. Improving the supervision LCSWs receive may improve job performance and the quality of services LCSWs provide to youths with trauma symptoms in a North Carolina IIH program.

This basic qualitative study was divided into four sections. Section 1 covers the social work practice problem, the purpose of the study, and the research questions. This is followed by a review of the nature of the doctoral study, the significance of the study for social work practice, and the theoretical framework supporting the study. Social work values and ethics are explored, an academic literature review is provided to understand the social work problem, and a summary completes the first section. The second section provides an overview of the research design and mythology. Data analysis, ethical procedures, and summary conclude Section 2. Section 3 includes a description of the data analysis techniques, findings, and summary. Finally, Section 4 delineates this study's application for professional ethics in social work practice, recommendations for social work practice, implications for social change, and a final summary.

Problem Statement

TF-CBT is an evidence-based practice developed to address the trauma symptoms of youths ages 5 to 17 (Nader, 2020). TF-CBT is the most effective treatment model used to decrease trauma symptoms in children (Dorsey, McLaughlin, et al., 2017). However,

inadequate supervision provided to LCSWs is correlated with high treatment dropout rates from TF-CBT (Dorsey, McLaughlin, et al., 2017). Additionally, therapist and agency factors affecting TF-CBT dropout are perceived agency support of TF-CBT, therapist buy-in with the treatment model, and training needs (Dorsey, McLaughlin, et al., 2017). On average, 47% of youths drop out of the TF-CBT treatment model (Barnett et al., 2019). Although studies showed there are many youth and family risk factors that predict dropout from TF-CBT (e.g., poverty, transportation, and access to care), social workers must eliminate poor supervision as a practice barrier to completing trauma treatment with youths (NASW, 2019; Ormhaug & Jenson, 2018; Yasinski et al., 2018).

The clinical supervision LCSWs receive while providing TF-CBT is critical to preventing treatment dropout (Lucid et al., 2018). Studies have shown LCSWs providing TF-CBT need clinical supervision that focuses on case conceptualization, fidelity monitoring, and practicing interventions to feel confident implementing the model (Dorsey, McLaughlin, et al., 2017; Lucid et al., 2018, Pullmann et al., 2018). However, the majority of weekly clinical supervision in children's mental health focuses on administrative tasks with limited time dedicated to a single case (Dorsey, McLaughlin, et al., 2017). Clinical supervision that limits the amount of time spent on single case conceptualization can lead to missed opportunities in treatment and deficits in the supervisee's ability to implement the model (Dorsey, McLaughlin, et al., 2017). LCSWs need clinical supervision that allocates time to addressing challenges in specific cases and interventions to implement TF-CBT effectively (Pullmann et al., 2018). When LCSWs do not receive clinical supervision that supports feeling confident in their ability to apply the

TF-CBT model interventions, they cannot provide effective trauma treatment to youth (Dorsey, McLaughlin, et al., 2017). Current research has documented clinical supervision's effect on supervisee confidence by focusing on the supervisor tasks needed to increase job performance (see Alfonsson et al. 2018; Kühne et al. 2019; Levenson, 2017); Lucid et al. 2018; Watkins, 2019). The supervisee's perspective and the relationship with their supervisor were lacking from recent research on clinical supervision. I sought to understand the supervision needs of social workers providing TF-CBT to youths in a North Carolina IIH program.

Purpose Statement and Research Question

The purpose of this basic qualitative study was to understand how LCSWs describe the impact clinical supervision had on their feelings of confidence in their ability to implement TF-CBT with youths in a North Carolina IIH program. The IIH program provides services to youths ages 4 to 21 for 4 to 6 months to decrease internalized (depression and anxiety) and externalized (aggression and defiance) behavioral issues in the home, school, and community (Huhr & Wulczyn, 2019). A qualitative inquiry was conducted to gather data from interviews with LCSWs providing TF-CBT to youths at the agency, while receiving clinical supervision in the TF-CBT model from the agency. The semistructured interviews with LCSWs focused on their description of the impact clinical supervision had on their confidence to implement interventions in the TF-CBT model to improve the quality of trauma treatment provided to vulnerable youths in a North Carolina IIH program.

Clinical supervision is required to practice as a clinical social worker. Although researchers agreed that clinical supervision impacts confidence and job performance (Alfonsson et al. 2018; Kühne et al. 2019; Lucid et al. 2018; Watkins, 2019), there is little research on topics and processes that must be included in clinical supervision (Watkins, 2019). The North Carolina Social Work Licensure Supervisor Training (2019) stated licensure supervisors would likely train future LCSWs how their licensure supervisors trained them. Without research-based practices, this guild training system can prevent the social work field's clinical growth and impact clinical care provided to clients (Watkins, 2019).

The current study added to existing knowledge about clinical social work supervision by focusing on clinical supervision's impact on the LCSW's confidence while implementing TF-CBT with youths. Clinical supervision in TF-CBT was chosen because the TF-CBT model had been well studied. Researchers had noted high dropout rates in TF-CBT and had studied the factors leading to high dropout rates for TF-CBT (see Barnett et al., 2019). The factors affecting TF-CBT dropout rates had been studied in youths, families, and individual therapists (see Cohen et al., 2018; Dorsey, McLaughlin, et al., 2017; Lucid et al., 2018; Steinberg et al., 2019; Wamser-Nanney, 2020). The field of social work must remove inadequate supervision as a factor affecting dropout rates from TF-CBT (NASW, 2019; Ormhaug & Jenson, 2018; Yasinski et al., 2018). Supervision can address therapist-controlled factors such as low therapeutic alliance (Ormhaug & Jenson, 2018), in-session avoidance (Yasinski et al., 2018), low model fidelity (Dorsey, McLaughlin, et al., 2017), poor session structure (Ovenstad et al., 2020),

and low therapist responsiveness (Ovenstad et al., 2020). Youth and family factors affecting treatment dropout may decrease if the therapist factors are mitigated (Yasinski et al., 2018). The current study was guided by the following research question: How do LCSWs describe the impact of supervision on their feelings of confidence in their ability to implement TF-CBT with youths in a North Carolina IIH program?

Definitions of Key Terms, Concepts, or Constructs

Definitions of key terms, concepts, and constructs are provided to increase the reader's understanding of terms used in this study.

Clinical supervision: Child mental health agencies offer multiple types of supervision to their employees under the umbrella of clinical supervision. Clinical supervision depends on who is providing the supervision and what topics are discussed. Topics covered can include administrative tasks (paperwork and agency policies), clinical models, case-specific discussions, crisis interventions, and career development (Alfonsson et al., 2018; Forshaw et al., 2019; Rast et al., 2017). These types of supervision are often noted as clinical supervision (Vandett & Gosselin, 2019). I used the term to indicate the formal professional relationship used to train and develop social workers into clinicians (see O'Donoghue et al., 2018).

IIH program: The IHH program is an in-home crisis intervention service for youths and families to prevent out-of-home placements (Huhr & Wulczyn, 2019). The IIH program uses several evidence-based practices such as adolescent community reinforcement approach, community advocacy project, collaborative problem solving, TF-CBT, CBT, and motivational interviewing (Huhr & Wulczyn, 2019).

Large multiservice organization (LMSO): The LMSO operates in 94 locations in 23 states (Director of Clinical Services, personal communication, January 25, 2021). The LMSO offers IHH services, multisystemic therapy, transitional living programs, residential treatment programs, foster care, adoption, and specialized crisis services (Peatross & McNamera, 2019).

TF-CBT: TF-CBT is a seven-component therapeutic treatment model used to address child and adolescent trauma symptoms (Cohen et al., 2012).

Youth: The World Health Organization (2021) defined adolescents as individuals between the ages of 10 and 19 years, youths as individuals between the ages of 15 and 24 years, and young people as individuals between the ages of 10 and 24 years. The IIH program uses the term youth to represent its treatment population, which is between 4 and 21 years old (Huhr & Wulczyn, 2019). The study participants work for the LMSO and are accustomed to using the term youth to represent the treatment population. Therefore, the term youth was used throughout this study to denote the treatment population of the LMSO.

Nature of the Doctoral Project

A basic qualitative research design was used to collect qualitative data through the purposive sampling of social workers providing TF-CBT while working in the North Carolina IIH program. The individual semistructured interviews allowed the participants to describe the impact clinical supervision had on their feelings of confidence in their ability to implement TF-CBT with youths in the North Carolina IIH program. Semistructured interviews are used by researchers to obtain insider information,

experiences, and privileged insight (Rubin & Rubin, 2012). Individual interviews protect the participants' identity and ensure the participants can comfortably share confidential information with researchers.

The semistructured interviews lasted between 55 and 80 minutes. The social workers were asked to provide insight into the impact clinical supervision had on their confidence while implementing the TF-CBT model with youths in the IIH program. A list of social workers receiving TF-CBT supervision was obtained from the North Carolina clinical director. Next, with permission of the LMSO, Walden University's email system was used to invite potential participants to the study individually. The participants were asked to reply to the email if they were interested in participating in the study. For inclusion in the study, the social worker had to be working with youths in the IIH program while receiving clinical supervision in TF-CBT.

The format for the semistructured interview was face-to-face with Microsoft Teams. Microsoft Teams is an online meeting platform that provided a safe and confidential environment to conduct face-to-face interviews during the COVID-19 pandemic. With the participant's permission from an informed consent form, the interview was recorded and transcribed verbatim for data analysis. The data were coded and categorized into themes guided by social cognitive theory. The resulting themes answered the research question by describing the impact clinical supervision had on the LCSWs' feelings of confidence in their ability to implement TF-CBT with youths in a North Carolina IIH program. All materials were kept in a locked cabinet in my locked home office to protect participant confidentiality.

Significance of Study

Understanding how clinical supervision affects the confidence LCSWs have in their ability to implement interventions in TF-CBT may support improvements in the LMSO supervision practices. Additionally, an increased understanding of the clinical supervision needs of LCSWs may demonstrate how clinical supervision can help or hinder the implementation of the TF-CBT model within an agency and add to existing research on clinical supervision in TF-CBT. The findings of this study may aid TF-CBT supervisors in improving clinical supervision, the understanding of supervision needs of LCSWs, and the LCSW's ability to implement the TF-CBT model confidently. The quality of services LCSWs provide to youths with trauma symptoms may be improved by sharing the findings of this study with a North Carolina IIH program. This research may promote better understanding of the feelings of confidence LCSWs have in their ability to implement TF-CBT interventions to inform clinical supervision practices in a North Carolina IIH program, thereby supporting improved outcomes for youths experiencing trauma symptoms (King et al., 2019; Lucid et al., 2018; Pullmann et al., 2018). Improving the quality of services LCSWs provide to youths with trauma symptoms in a North Carolina IIH program may assist the agency in providing services that decrease risk factors for the youths, families, and community.

LMSOs that provide mental health therapy to youths and families often address trauma symptoms and can enact positive social change. Understanding the supervision LCSWs need while providing TF-CBT may enhance treatment delivery because the gains in treatment are more sustainable if the trauma symptoms are addressed (Wamser-

Nanney, 2020). Addressing trauma symptoms supports children and families living sustainably in the community without child welfare and juvenile justice interventions (Nader, 2020). Additionally, addressing trauma symptoms before adulthood prevents the adverse outcomes associated with trauma, such as substance use, poverty, lack of educational attainment, and adult health issues (Wamser-Nanney, 2020). Finally, treating youth trauma symptoms strengthens the family's ability to keep children safe, supported, and healthy (Cohen et al., 2018). When children grow up in supportive, safe environments, they become adults who are assets to their community.

Theoretical Framework

The theoretical framework for this study was social cognitive theory. Social cognitive theory describes observational learning, people's beliefs that they can learn, and the ability to apply the concepts learned through observation (Bandura, 1998). Bandura (2014) stated that individuals learn from within their social context, environment, and interactions with others. The reciprocal causation model organizes the behavior, person, and environment (Bandura, 2014). The interactions between behaviors, personal factors, and the environment influence learning at varying degrees depending on the situation (Bandura, 2014). Additionally, social cognitive theory notes that previous experiences influence future behaviors and explain why people behave the way they do (Bandura, 2014).

Self-efficacy is a key concept in social cognitive theory. Self-efficacy is an individual's beliefs or confidence in performing behaviors necessary to achieve a specific outcome (Bandura, 1998). Self-efficacy beliefs influence the goals people set for

themselves, the energy people put into achieving their goals, and the likelihood that their performance will be sufficient to achieve their goals (Bandura, 1998). Self-efficacy explains why people who have never done a task feel confident that they can learn the task and be successful. According to Bandura (2014), high self-efficacy allows people to persevere and remain confident in their abilities even when things are not going as expected. People with low self-efficacy do not have confidence in their ability to be successful. Although people with high self-efficacy are likely to redouble their efforts when unsuccessful, people with low self-efficacy give up quickly and see difficult tasks as challenges that should be avoided (Bandura, 2014). In clinical social work, self-efficacy could refer to the social worker's capability to perform required tasks to advance the treatment of their client.

I used social cognitive theory to inform how supervision impacts the LCSWs feelings of confidence in applying TF-CBT. According to Lucid et al. (2018), TF-CBT supervision needs to be grounded in an understanding of trauma, trauma-informed care practices, a robust relationship between the supervisor and supervisee, and strong support for TF-CBT from the agency. This basic qualitative inquiry framed by social cognitive theory was conducted to explore the personal experiences of LCSWs while interacting with their TF-CBT supervisor and the impact these experiences and interactions had on their confidence. Social cognitive theory was used to examine the agency environment because the LCSWs receive supervision in the TF-CBT model within the IIH program. Concepts explored included detailed accounts of how LCSWs use TF-CBT supervision,

the relationship with their TF-CBT clinical supervisor, and how supervision affects their confidence in implementing the interventions.

Values and Ethics

The NASW (2021) code of ethics outlines values, principles, and standards that guide social work practice. The NASW values of service and competence were related to the social problem of ensuring supervision provided to LCSWs prepares them to treat the trauma symptoms of youths confidently. The value of service was associated with the ethical principle of helping people in need and advocating to address social problems (see NASW, 2021). LCSWs who treat the trauma symptoms of youths are expected to use their knowledge, values, and skills to help the youths. The value of competence was associated with the ethical principle of social workers operating within their expertise and continuing to gain knowledge to enhance their social work practice (see NASW, 2021). LCSWs receiving supervision in TF-CBT build on their academic knowledge and improve their clinical skills to treat trauma symptoms in youths.

Standard 1.04(b) of the NASW code of ethics indicates that when social workers provide services or interventions that are new to them, they should receive the appropriate education, training, consultation, and supervision needed to carry out these new interventions (NASW, 2021). The TF-CBT therapist certification program requires 2-day training, passing an exam, completing TF-CBT with three youths, and attending 12 consultation calls (TF-CBT Therapist Certification Program, 2021). The LMSO in North Carolina has a TF-CBT nationally certified supervisor who provides training and consultation calls (Director of Clinical Services, personal communication, January 25,

2021). However, there is no exam and no set number of consultation calls, and completion of TF-CBT with four youths concludes the LMSO training in TF-CBT (Director of Clinical Services, personal communication, January 25, 2021). LCSWs who are LMSO trained in TF-CBT are not recognized as nationally TF-CBT certified therapists. LCSWs who are LMSO trained in TF-CBT can provide TF-CBT to youths within LMSO programs. However, LMSO-trained LCSWs must complete the TF-CBT therapist certification program to provide TF-CBT outside the LMSO and be nationally certified. Standard 1.04(b) does not state social workers need to be certified to provide interventions, only that social workers need to receive education, training, consultation, and supervision to provide interventions (NASW, 2021). LCSWs who are LMSO trained to provide TF-CBT are in alignment with the NASW ethical standards.

The purpose of this study was to understand the impact clinical supervision has on the LCSWs' confidence to implement TF-CBT with youths in a North Carolina IIH program. The study was aligned with the LMSO's value of "we are each responsible for providing the highest level of service to our customers," and the LMSO mission "helps children and families live successfully" (Youth Villages, 2021). The current study supported the values and principles of the NASW and LMSO by adding to the social work body of knowledge related to clinical supervision and the body of knowledge related to supervision in TF-CBT.

Review of the Professional and Academic Literature

The literature review was completed over 1 year using Walden University's library and the LMSO research department. The databases used were Thoreau

multidatabase search, SAGE Journals, APA PsycInfo, MEDLINE with full text, APA PsycExtra, SocINDEX with full text, and Social Work Abstracts. Peer-reviewed journal articles and abstracts were reviewed as part of the professional and academic literature. Key search words included *supervision*, *clinical supervision*, *supervisory*, *supervising*, *supervisor*, *trauma-focused cognitive behavioral therapy or TF-CBT*, *evidence-based treatment or EBT*, *community mental health*, *implementation*, *implementation strategies*, *children's mental health*, and *adolescent's mental health*.

IIH Program in North Carolina

The IIH program began in the late 1990s as part of a contract with the Tennessee Department of Children Services (Peatross & McNamara, 2019). The IIH program aims to reduce the number of youths in the foster care system and costly long-term out-of-home placements for youth (Director of Clinical Services, personal communication, January 25, 2021). The IIH program provides youths and families with intensive, evidence-based services to reduce the risk of entry into foster care and reduce time spent in foster care (Huhr & Wulczyn, 2019). In 2013, the LMSO expanded the IIH program into North Carolina with the same goal to decrease the number of youths needing out-of-home placements (Director of Clinical Services, personal communication, January 25, 2021).

When a family is referred to the North Carolina IIH program, the youth receive a comprehensive clinical assessment to determine eligibility for the IIH program, assess referral behaviors, and assess mental health diagnoses (Placement Team Lead, personal communication, January 20, 2021). Once approved for services, the family is assigned an

IIH specialist (Placement Team Lead, personal communication, January 20, 2021). The IIH specialist works with the youth and family to address safety issues in the home (e.g., unlocked weapons/firearms, poor supervision practices, suicidality, nonsuicidal self-injurious behavior), decrease risk factors (e.g., truancy, legal involvement, child protective services involvement, abuse, neglect, basic needs concerns), and teach the families how to solve problems (e.g., collaborative problem solving; Clinical Services Program Manager, personal communication, January 18, 2021). The specialist uses evidence-based practices such as collaborative problem solving, adolescent community reinforcement approach, TF-CBT, and motivational interviewing (Clinical Services Program Manager, personal communication, January 18, 2021).

The program uses small caseloads of four to five families seen three or more times a week and continuous emergency on-call support (Clinical Services Program Manager, personal communication, January 18, 2021). The IIH staff members receive weekly group supervision with their direct supervisor, weekly individual staff development meetings with their direct supervisor, and weekly supervision from a licensed program expert in the model (Director of Clinical Services, personal communication, January 25, 2021). Additionally, IIH staff members receive biweekly supervision in the evidence-based practice models, and merit-based parameters are used to determine graduation from supervision (Director of Clinical Services, personal communication, January 25, 2021). Program fidelity is monitored annually by gathering information from youths, parents, staff, leadership, case record reviews, and postdischarge outcomes (Director of Clinical Services, personal communication, January

25, 2021). Postdischarge outcomes are collected at 3 months, 6 months, 1 year, and 2 years (Director of Clinical Services, personal communication, January 25, 2021).

TF-CBT

According to the National Institute for Health and Care Excellence (2018), the recommended treatment for youths experiencing post-traumatic stress disorder (PTSD) symptoms is cognitive behavioral therapy with a trauma focus. TF-CBT was developed by Dr. Anthony Mannarino, Dr. Judith Cohen, and Dr. Esther Deblinger to address the negative impacts of trauma in youths age 5 to 17 (Cohen et al., 2012). TF-CBT is a gradual exposure model of treatment that encourages youths to process distressing trauma-related reminders and memories, intending to decrease PTSD symptoms (Cohen et al., 2012). The model incorporates the caregivers as the youth completes seven treatment components: psychoeducation, relaxation, cognitive coping, affective expression, trauma narrative, in-vivo exposure, and enhancing safety skills (Cohen et al., 2012). These components are taught in a logical sequence, resulting in skills taught in one component building on skills taught in the previous components.

TF-CBT is the most studied evidence-based practice used to address child and adolescent trauma exposure, and has been shown to reduce the symptoms of PTSD, depression, anxiety, and externalizing behaviors (Cohen et al., 2018; Dorsey, McLaughlin, et al., 2017). TF-CBT has been shown to be effective in ethnically diverse populations, diverse traumatic experiences (e.g., exposure to war, natural disasters, sexual abuse, physical abuse, neglect, foster care, refugees, domestic violence, traumatic grief), and genders (Dorsey, McLaughlin, et al., 2017; Jenson et al., 2017). The model is

adaptable for the different cultural populations. Jenson et al. (2017) found that the most common cultural adaptations were related to language (e.g., culturally relevant vocabulary) and incorporating the family's cultural traditions.

The TF-CBT model has been adapted for populations with limited access to therapy. In the Democratic Republic of the Congo, randomized clinical trials demonstrated that group TF-CBT effectively reduced trauma symptoms of underage sex workers (McMullen et al., 2013). In Zambia, lay counselors provide TF-CBT to youths experiencing traumatic grief from losing a caregiver due to AIDS (Murray et al., 2013). TF-CBT was adapted to accommodate therapy in the urban school environment for youths experiencing traumatic and disenfranchised grief (Dutil, 2019). The TF-CBT model's adaptability allowed youth populations to access the mental health care they may not have received without adaptations.

Despite overwhelming evidence for TF-CBT's benefits, researchers estimated the number of youths who qualify to receive TF-CBT and complete treatment between 1% and 3% (Barnett et al., 2019). Researchers have explored multiple client, family, and clinician factors contributing to TF-CBT's low completion rates. However, recent research has focused on organizational and supervision factors leading to TF-CBT's low completion rates (Dorsey, McLaughlin, et al., 2017). Pullmann et al. (2018) found that implementing evidence-based practices is often slow in community mental health agencies resulting in poor service delivery quality. In a quantitative study addressing the implementation and clinical outcomes of a trauma grant in New Hampshire, Barnett et al. (2019) found that clinical outcomes for youths who completed treatment (59% reported a

reduction of PTSD symptoms) were similar to clinical results achieved in research settings. However, only 24% of clinicians (n = 292) adhered to the implementation protocols, and 44% of youths (n = 363) dropped out of treatment before completion. According to Barnett et al., the primary implementation strategy organizations should focus on while implementing TF-CBT in community mental health is clinical supervision.

Although TF-CBT has been shown to be efficacious (see Dorsey, McLaughlin, et al., 2017), children infrequently receive these treatments for trauma symptoms due to a research-to-practice gap. Steinberg et al. (2019) stated that the gap between statistically significant change in research and clinically significant change in social work practice has led to researchers studying outcome data to incorporate clinical tools into research. These clinical tools (e.g., quantitative standardized clinical instruments and qualitative clinician-rated indicators) were not meant to be used in outcome studies; therefore, study measurements on TF-CBT are often inaccurate (Steinberg et al., 2019). King et al. (2019) also identified poor research practices and data manipulation that yielded false positives as a rationale for the research-to-practice gap. Barnett et al. (2019) stated the research-to-practice gap highlights the research setting's controlled nature and the need to mimic the research setting by incorporating implementation strategies to minimize the gap between research results and clinical practice, such as a learning collaborative, expert consultation, and training clinicians.

Clinical Social Work Supervision

In social work, clinical supervision is meant to bridge the gap between school education and the reality of social work practice (Dan, 2017). According to Hafford-Letchfield and Engelbrecht (2018), clinical social work supervision can be described as the "pivot upon which the integrity and excellence of social work practice can be maintained" (p. 329). Although clinical social work supervision has evolved and been influenced by theories, organizational structures, stakeholders, and financing sources, clinical supervision's primary function is to act as a gatekeeper for the profession (Dan, 2017). As the gatekeeper, the clinical supervisor is the final check for the social work profession, preventing those who should not be therapists from obtaining licensure (Dan, 2017). Clinical social work supervision is essential to teach and maintain the standards of social work practice.

Clinical supervision serves three primary functions for the supervisee: administrative, educational, and supportive (Dan, 2017). The clinical supervisor imparts their knowledge to their supervisee, thereby affecting services rendered by the supervisee (Dan, 2017). Research has demonstrated that supervisees find clinical supervision helpful in their development as social workers (Alfonsson et al., 2018; Forshaw et al., 2019; Rast et al., 2017). However, researchers have struggled to understand how clinical supervision affects direct social work practice and impacts services (Pott, 2018; Simpson-Southward et al., 2017; Snowdon et al., 2017).

Other helping professions use clinical supervision to teach and maintain their profession's standards. Vandette and Gosselin (2019) examined clinical supervision

practice in professional psychology, social work, nursing, and medicine. Although these professions use clinical supervision as their primary process to transfer knowledge from senior to junior practitioners, every profession struggles to identify minimum standards for adequate supervision (Vandett & Gosselin, 2019).

Watkins (2019) conducted a review of 25 years of clinical supervision research and found although there have been gains in understanding clinical supervision, the studies have often had small sample sizes, overreliance on self-report measures, a limited number of valid supervision measures, ex post facto designs, little attention to client outcomes, and lack of longitudinal data. Another review of frameworks for best practices used in social work supervision indicated that clinical supervision is relativity uniform worldwide (Unguru & Sandu, 2018). In line with Dan (2017), Unguru and Sandu (2018) found social work clinical supervision worldwide focuses on administrative management, personal support, and education. The clinical social work supervision framework of education, emotional support, and administrative functions (Dan, 2017; Unguru & Sandu, 2018; Watkins, 2019) suggested a connection between supervision and direct social work practice.

Bostock et al. (2019) conducted a mixed-methods study examining the difference adequate clinical supervision had on the supervisee's practice and client outcomes, finding a statistically significant relationship between adequate supervision and the overall quality of direct practice. Adequate supervision was defined as the supervisor's ability to offer support and encouragement during the learning process, model ethical principles, and address the strengths and challenges the supervisee is experiencing.

Additionally, adequate supervision was linked with the purposeful child-focused interventions that impact client outcomes. This study was significant because it demonstrated a causal link between supervision and direct practice outcomes with clients.

Perhaps the most challenging aspect of studying clinical social work supervision has been the lack of evidence to support the effectiveness or ineffectiveness. Scholars have attempted to develop frameworks and theories to delineate clinical social work supervision (O'Donoghue et al., 2018; Wilkins, 2019). O'Donoghue et al. (2018) proposed an evidence-informed model of social work supervision that targets the construction or understanding of supervision (e.g., supervisors focusing supervision on education, support, and practice rather than administrative matters), supervision of the practitioner (e.g., supervisors providing social-emotional support as well as support with work and professional development), supervision relationship/ alliance (e.g., building a secure relationship in which the supervisee feels safe and participates fully), interactional process (e.g., structuring supervision sessions to mirror the social work helping process), and supervision of practice (e.g., assessing best outcomes for clients). Wilkins (2019) proposed that the purpose of clinical supervision is to promote a rights-based approach to social justice to alleviate social inequality. Additionally, Watkins stated it was impossible to develop an evidence-informed social work supervision model based on recent studies that were poorly designed. This scholarly discourse suggested notable gaps in understanding clinical social work supervision and how supervision is helpful to social workers in direct practice.

According to a review of 25 years of clinical supervision research, the jury is still out on whether clinical supervision does anything to support the therapist's growth (Watkins, 2019). Watkins (2019) concluded supervisors and supervisees desire to believe in the power of supervision, but these convictions do not translate to empirical findings due to problems in research designs. According to Watkins, clinical social work supervision needs to incorporate evidence-based practices, develop research addressing shortcomings, and provide empirical findings to support clinical supervision's positive application.

Workplace-Based Supervision

Community mental health agencies often combine clinical supervision, oversight for administrative issues, professional development, and emotional support into a once-a-week or biweekly supervision session (Pullmann et al., 2018). In a quantitative study, Dorsey, McLaughlin, et al. (2017) found that workplace-based supervision generally occurs weekly for 1 hour or bi-weekly for 31 hours. On average, the clinicians had caseloads of 30.9 youths, and 20% of the time was focused on nonclinical functions such as administrative needs, paperwork, and personal support for clinicians. The clinicians and supervisors reported wanting more time to focus on case conceptualization and interventions to meet the clinician's supervision needs.

Acknowledging the multiple duties workplace-based supervision fulfills, current research on implementing evidence-based practices such as TF-CBT recommends agencies obtain expert consultation (King et al., 2019). Pullmann et al. (2018) stated when clinicians are provided expert consultations following training; they have greater

treatment adoption and competency in the evidence-based practice. The more frequent the expert consultation, the greater the competency (Pullmann et al., 2018). King et al. (2019) found that group expert consultation was mostly equivalent to or better than individual expert consultation. These studies indicated that if an agency wants to increase its use of evidence-based practices, it should use expert consultation.

Supervision in Trauma-Focused Cognitive Behavioral Therapy

Evidence-based practices, such as TF-CBT, require a high intensity of supervision coverage to ensure clinicians progress through the model with their clients within the recommended treatment duration of 12 to 18 sessions (Lucid et al., 2018). In community mental health agencies, this supervision can be completed by an external expert or the clinician's supervisor (Dorsey et al., 2018). A quantitative study by Lucid et al. (2018) found clinicians who receive external expert supervision in TF-CBT were more likely to use TF-CBT with high fidelity to the model, intensity of coverage, and client completion. Unfortunately, Dorsey, McLaughlin, et al.(2017) found that agencies overwhelmingly label the cost of implementing evidence-based practices as a barrier to starting TF-CBT regardless of whether they have someone to provide supervision internally.

In a quantitative study, Pullmann et al. (2018) explored the predictors of supervisory thoroughness of TF-CBT in community workplace-based supervision and found that supervision occurs with greater fidelity and intensity in organizations that expect, support, and reward the use of evidence-based practices. Pullmann et al. (2018) noted that the trauma narrative, in vivo exposure, and assessment are the most critical areas in TF-CBT that require more support from the supervisor. The more knowledgeable

the supervisor was in TF-CBT, the greater the intensity of supervision in these crucial areas (Pullmann et al., 2018). These findings aligned with Dorsey et al. (2018). The researchers coded workplace-based supervision sessions provided during a state-funded TF-CBT initiative and found wide variations in the coverage of TF-CBT principles and practice interventions (Dorsey et al., 2018). Even more concerning than the coverage of TF-CBT principles and practice interventions was the low intensity of supervision provided during the trauma narrative, in vivo exposure, and assessment portions (Dorsey et al., 2018). The low intensity of coverage negatively impacted the model's fidelity and provided insufficient support to the junior clinicians implementing the model (Dorsey et al., 2018). Whereas 82% of supervision sessions discussed the trauma narrative and in vivo exposure, only 17 % of supervision sessions covered these elements with high intensity (Dorsey et al., 2018). Whereas 55% of supervision sessions discussed assessment, only 5% discussed assessment with high intensity (Dorsey et al., 2018). These results were consistent with a quantitative study where Lucid et al. (2018) examined TF-CBT implementation in a community mental health agency. The clinicians reported moderate coverage of TF-CBT principles and practice interventions (Lucid et al., 2018). The clinicians reported their supervisor rarely role-played interventions and infrequently reviewed progress through the treatment model (Lucid et al., 2018). These results indicated that organizations that want to implement TF-CBT need policies that support, expect, reward, and focus on fidelity to the model to ensure successful implementation.

In a recent literature review of 34 studies, Finch et al. (2020) summarized the clinician factors, client factors, organization factors, and implementation factors that affect the use of TF-CBT to address youth PTSD symptoms. The most commonly identified barriers to utilizing TF-CBT were the lack of training, insufficient knowledge of approaching trauma, and lack of confidence in using TF-CBT (Finch et al., 2020). Finch et al. recommended continuous training to address the clinician's beliefs, attitudes, and confidence in the TF-CBT model. Organizational difficulties also prevent TF-CBT implementation with youths by limiting access to training or resources and leading to inadequate clinical supervision (Finch et al., 2020). These results highlighted the need for organizations to support training needs and provide supportive clinical supervision to ensure clinicians feel confident in implementing TF-CBT.

Supervision of TF-CBT in the North Carolina IIH Program

The LMSO uses group consultation to provide clinical supervision of the TF-CBT model in the North Carolina IIH program (clinical manager, personal communication, December 7, 2020). Clinical supervision of the TF-CBT model is provided twice a month over a telephone conference line (clinical manager, personal communication, December 7, 2020). There are approximately ten participants in the telephone conference call, which lasts about one hour (clinical manager, personal communication, December 7, 2020). The LCSWs receive supervision from an internal agency expert in TF-CBT (clinical manager, personal communication, December 7, 2020). The group consultation style is in line with that of Dorsey, McLaughlin, et al. (2017), who suggested that organizations that want to increase the time allocated to case conceptualization and interventions should be creative,

such as by using all staff meetings to address the administrative and paperwork concerns, conducting group supervision sessions to focus on case conceptualization and interventions, restructuring to have non-clinical supervisors address administrative concerns, arranging for peer-to-peer TF-CBT consultation, or having supervisors closely supervise a small number of cases on a caseload to provide experiential learning that the supervisee can generalize to their other youths.

Increased Confidence as a Result of Clinical Supervision

The benefits of clinical supervision in the TF-CBT model and the impact supervision has on the social worker's confidence have been areas of limited coverage in research. While Watkins (2019) argued there is little empirical evidence that supervision supports therapist growth, Watkins acknowledge the self-fulfilling prophecy by noting that the supervisors and supervisees believe the process works; therefore, clinical supervision works. According to Watkins (2019), supervisees reported enhanced self-awareness, self-efficacy, and clinical skill acquisition despite limited research supporting skill transfer and the impact supervision has on client outcomes. Alfonsson et al. (2018) partially agreed with Watkins (2019), noting clinical supervision impacts social workers' confidence and positive job performance, but they highlighted that there is no correlation between client outcomes and confidence.

Kühne et al. (2019) and Lucid et al. (2018) presented specific tasks the supervisor can do to increase social workers' confidence. According to Kühne et al. (2019), when the supervision involved case discussions and intervention feedback, supervisees reported clinical supervision helped them feel confident and acquire therapeutic skills. Lucid et al.

(2018) similarly found clinicians receiving specific constructive feedback from their workplace-based supervisors and that this feedback increased their confidence in using TF-CBT.

Summary

Clinical supervision is ubiquitous in the helping professions and is required for a social worker to become an LCSW. Clinical supervision is also required before social workers can implement TF-CBT independently. The purpose of supervision is to pass knowledge from a senior to a junior practitioner. While this practice of imparting knowledge is meant to protect and enhance the profession, there is little evidence that supervision positively affects the social worker's confidence while implementing treatment with clients. Current research on clinical supervision's effects on confidence has focused on the tasks performed by the supervisor to improve the supervisee's job performance (Alfonsson et al., 2018; Kühne et al., 2019; Lucid et al., 2018; Watkins, 2019). Consideration of the supervisee's perspective and the relationship with their supervisor has been lacking from current research on confidence. The purpose of this basic qualitative study was to understand how LCSWs describe the impact supervision has on their feelings of confidence in their ability to implement TF-CBT with youths within the North Carolina IIH program.

For this basic qualitative study, firsthand qualitative data was collected from a purposive sample of LCSWs working in the IIH program while receiving clinical supervision in TF-CBT. The study was conducted using social cognitive theory as a framework to understand a social worker's learning process through observational

learning, their belief that they can learn, and their ability to apply the concepts they learn through observation (Bandura, 1998). The participants were asked to participate in individual semistructured interviews about their experiences related to clinical supervision in TF-CBT. The study provided qualitative data to enhance the understanding of how supervisors can support LCSWs receiving clinical supervision in TF-CBT. The NASW Code of Ethics (2021) provides the values, principles, and standards social workers use to conduct themselves while working with vulnerable populations as well as the framework for the ethical standards used in the research process.

The literature review addressed the need to understand clinical social work supervision and its impact on the social workers' ability to provide services. The literature review also addressed the research challenges that make this a limitedly studied research area. Evidence-based practices were proposed to add structure and uniformity to supervision (Watkins, 2019; O'Donoghue et al., 2018). However, creating evidence-based practices without understanding the role supervision plays in molding a social worker into a confident practitioner is an ill-fated venture likely to result in haphazard practice models.

In this basic qualitative study, semistructured interviews with LCSWs were used to describe the impact supervision had on their confidence to implement interventions in the TF-CBT model to improve the quality of the trauma treatment provided to vulnerable youths within the North Carolina IIH program. This study added to the limited body of research about clinical supervision in TF-CBT and its impact on the confidence of LCSWs to complete interventions with youths.

Section 2: Research Design and Data Collection

Clinical social work supervision impacts a social worker's ability to implement treatment models. Dorsey, McLaughlin, et al. (2017) indicated therapists providing treatment for youth mental health are new to the field, often holding provisional licenses or being newly licensed. Inexperienced therapists who are not receiving supervision that supports their development in youth mental health results in poor outcomes for youths and families (Lucid et al., 2018).

I used a basic qualitative design and purposive sampling to identify social workers who provide TF-CBT to youths in a North Carolina IIH program. In individual semistructured interviews, the participants described their perceptions and experiences while receiving clinical supervision for the TF-CBT model. The interviews were recorded using two audio recording devices for data collection purposes. The recordings were transcribed verbatim for analysis. A reflexive journal was used to record notes throughout the interview and analysis process. The journal helped me ensure ethical standards and trustworthiness. The data were analyzed using deductive and inductive techniques. Section 2 includes descriptions of the design and a review of the research methodology, data collection method, and data analysis plan. Section 2 also includes a description of ethical research practices used in the study.

Research Design

The purpose of this basic qualitative study was to understand how LCSWs describe the impact clinical supervision had on their feelings of confidence in their ability to implement TF-CBT to youths in a North Carolina IIH program. The research question

was the following: How do LCSWs describe the impact of clinical supervision on their feelings of confidence in their ability to implement TF-CBT to youths in a North Carolina IIH program? Basic qualitative research is conducted to understand the way people interpret their experiences and ascribe meaning to those experiences (Patton, 2015). LCSWs receiving clinical supervision while providing TFCBT to youths were a valuable resource because they had direct knowledge of current practices and procedures used in supervision. A sample of LCSWs receiving clinical supervision in TF-CBT in a North Carolina IIH program provided information about how clinical supervision affected their confidence while implementing TF-CBT.

A qualitative approach was used for this study. Lincoln and Guba (2013) argued that qualitative research is the best method to capture a description of experiences by exploring various factors, observed and unobserved intentions, actions, internal meaning, external consequences, and options considered but not taken. According to Rubin and Rubin (2012), qualitative researchers obtain data in various ways: interviews, direct observation, statements of personal experiences, documents, photographs, or recordings (audio or video). I used audio/video conference via Microsoft Teams to conduct face-to-face semistructured interviews with the participants during the COVID-19 pandemic. Semistructured interviews are sources for obtaining insider information, experiences, and privileged insight (Rubin & Rubin, 2012).

LCSWs working in the IIH program while receiving clinical supervision in TF-CBT volunteered to participate in this basic qualitative study using semistructured interviews. The participants had valuable firsthand knowledge of the impact clinical

supervision in TF-CBT had on their confidence to implement TF-CBT with youths. According to Patton (2015), basic qualitative research is conducted to understand the way people interpret their experiences and ascribe meaning to those experiences. Social cognitive theory, which addresses how previous experiences in a social context shape and reinforce behavior in the future (Bandura, 2014), was used to frame the study. The individual interviews produced the data to explain how clinical TF-CBT supervision impacted the LCSWs' confidence. The interviews were conducted individually to ensure the participants' confidentiality and open communication.

Methodology

LCSWs working in a North Carolina IIH program were asked to provide information about how TF-CBT supervision affected their confidence in providing TF-CBT to youths. The company network was used to contact potential participants. An email explaining the project was sent individually to potential participants. The potential participants were contacted separately to arrange an appointment over Microsoft Teams. Ten participants participated in this study and represented one third of the total population. According to Opdenakker (2006), face-to-face interviews provide information about body language, voice tone, and social cues. Microsoft Teams was used to conduct interviews due to the COVID-19 pandemic. A face-to-face interview is direct with no delay in responses; however, the interviewer can affect the participant causing them to change their answers (Opdenakker, 2006). I controlled for the interviewer effect by using a semistructured interview protocol (see Appendix). The semistructured interviews were recorded and analyzed using open coding to identify themes. LCSWs

participating in the study provided firsthand knowledge of how supervision had affected their confidence while providing TF-CBT to youths, thereby enhancing current clinical social work supervision knowledge.

Prospective Data

I used a nonprobability sampling to recruit volunteers. The nonprobability sample identified LCSWs receiving supervision for TF-CBT in a North Carolina IIH program. Ravitch and Carl (2016) noted researchers using nonprobability sampling might experience sampling bias. Sampling bias may have been present in the current study because professionals holding licenses other than LCSW were excluded. The interviewed participants constituted a homogeneous purposive sample, a type of purposeful sampling that is ideal for studying a phenomenon in a selected group (see Patton, 2015). I was mindful of my potential bias from working in the agency. At the time of the study, I was not working in the IIH program and was not working in the North Carolina offices. The individual interviews with LCSWs were the only data source for this study.

Participants

I recruited LCSWs by obtaining a list of LCSWs receiving supervision in TF-CBT at the LMSO. The LCSWs were individually emailed a description of the research project, informed consent, and my contact information. All communication with participants and potential participants occurred individually over Walden University's email system. The participants were LCSWs receiving internal agency supervision in TF-CBT while working in a North Carolina IIH program. This study had 10 research participants representing one third of the total population. The interviews with the

participants were the only data source for this study. Purposive sample was necessary to gather the individual experiences of the LCSWs receiving supervision. Alfonsson et al. (2018) noted that supervisees report clinical supervision affecting their feeling of confidence and job performance. Similarly, Kühne et al. (2019) noted that supervisees report clinical supervision affects their feeling of competence and building therapeutic skills. Therefore, the LCSWs receiving clinical supervision in TF-CBT were the best source to provide information about how clinical supervision affected their confidence in their ability to implement the TF-CBT model with youths.

In qualitative research, the goal is thematic saturation in which little new information is obtained after a certain amount of data collection (Weller et al., 2018). Weller et al. (2018) expanded the traditional definition of thematic saturation to include the quality of the data. Weller et al. argued that probing using open-ended questioning increases sample efficiency by allowing the researcher to focus on the most salient items for thematic saturation. I interviewed 10 participants for the current study to reach thematic saturation. These participants represented one third of the population receiving TF-CBT supervision while working in the IIH program. Including 10 participants is ideal for probing using open-ended questions (Weller et al., 2018).

The interviews in the current study were semistructured and conducted individually to ensure the confidentiality of the participants. The interviews lasted between 55 and 80 minutes. I used knowledge of the population and treatment model to provide prompts and elicit complete responses to the questions. After data analysis, the

participants were contacted individually to provide feedback on the resulting themes. Four participants provided feedback on the results.

Instrumentation

The instrument was a self-designed semistructured interview protocol created from my experience, the literature review, and the theoretical lens (see Appendix). The interview questions were aligned with the research question, purpose, and problem. According to Patton (2015), researchers should formulate questions in qualitative research that fit the context of the purpose and problem. I used open-ended questions to engage participants in a dialogue, thereby producing greater insight and engagement with the data. The interviews were conducted via Microsoft Teams to ensure safety during the COVID-19 pandemic. The interviews were completed individually to protect the confidentiality of the participants. The protocol ensured the participants felt safe in providing candid answers about the clinical supervision they received and how it impacted their feeling of confidence while providing TF-CBT. The interview questions focused on the LCSWs' experiences while receiving clinical supervision in TF-CBT. The responses of the LCSWs produced a data set on how clinical supervision in TF-CBT affected their feeling of confidence. I did not use existing data or measurement instruments.

Data Analysis

The participant's answers to the open-ended interview questions were used for data collection. I manually transcribed verbatim the recorded interviews using Microsoft Word. The transcripts were read for content analysis. The transcripts were then coded

using the descriptive coding method following an inductive analysis approach. The participants were contacted individually to provide feedback on the analysis, and four participants provided feedback. According to Patton (2015), the key elements of inductive analysis are organizing data, reviewing data, creating initial codes, creating categories for codes, combining or revising codes, and identifying themes.

The data were organized using Microsoft Excel and Word. Hand coding consisted of using quotes from the transcribed interviews and entering these quotes into an Excel spreadsheet. The initial codes represented quotes from the interviews. A second round of coding was conducted, followed by categorization. According to Rubin and Rubin (2012), codes should reflect the overall understanding of the research problem. I focused on the general meaning of the quotes while creating codes. Similarly, coded data that shared some characteristics were grouped into categories. Qualitative researchers expect 80–100 codes and 20–30 categories (Patton, 2015). According to Rubin and Rubin (2021), qualitative researchers compare categories to discern possible relationships. Once the codes were categorized, overall themes emerged that answered the research question.

I used a reflexive journal to maintain credibility, validity, and reliability. Halcomb and Davidson (2006) suggested recording the interview while taking notes, then journaling and checking notes against the recording. The reflexive journal also allowed me to be mindful of potential biases as well as internal and external threats, thereby increasing the trustworthiness of the findings (see Patton, 2015). I recorded the interviews and took reference notes on touring questions to use later in the interview. After each interview, I used the reflexive journal to document interview impressions, key

information obtained from the participant, and thoughts about the information obtained during the interview. I also noted how the participant learned best. The reflexive journal was used while writing the research findings to maintain objectivity (see Halcomb & Davidson, 2006).

Ethical Considerations

In accordance with the established guidelines of Walden University's Institutional Review Board (IRB; Approval No. 02-03-22-0977967), confidentiality was maintained during the interview, data analysis, and storage of research materials. I obtained a list of LCSWs receiving TF-CBT supervision from the LMSO. The LCSWs were individually emailed an invitation to participate in the study and were provided a copy of the informed consent form. All communication with potential participants and participants was conducted individually to protect their confidentiality. The interviews were arranged at times that were convenient for the participants. The interviews were conducted over audio/video conference using Microsoft Teams due to the COVID-19 pandemic. The interviews were recorded using Microsoft Teams, and an audio recorder was used as a backup. The audio recordings were stored on a password-protected computer. Once the interviews were transcribed and checked by me, the recordings were erased. The transcripts were stored on a password-protected computer. The transcripts will be erased after 5 years, and the transcripts do not have any identifiable participant information. All research materials, the audio recorder, and the computer are locked in a filing cabinet in my locked home office. There was no identifiable participant information in any reports.

Summary

I used a homogenous purposive sample of LCSWs receiving clinical supervision in the TF-CBT model while working in a North Carolina IIH program. The LCSWs participated in a recorded audio/video conference via Microsoft Teams to describe how clinical supervision in TF-CBT affected their confidence in implementing TF-CBT with youths. These recordings were transcribed verbatim, and the participants were allowed to review the transcripts for accuracy. The data were analyzed using a descriptive coding method following an inductive analysis approach. After the data were coded, themes were identified to answer the research question. The information obtained from the LCSWs may clarify how clinical supervision in TF-CBT affected the LCSWs' feeling of confidence in implementing the model. The research findings will be shared with the LMSO to enhance clinical supervision provided in TF-CBT. In Section 3, I describe the data analysis techniques and findings. I also present themes that emerged from the interviews and unexpected findings.

Section 3: Presentation of the Findings

The purpose of this qualitative study was to understand the clinical supervision needs of LCSWs and the impact supervision had on their feelings of confidence in their ability to implement TF-CBT to youths in a North Carolina IIH program. Through the lens of social cognitive theory, I explored how supervision impacted the LCSWs' feelings of confidence in applying TF-CBT. Clinical supervision in LMSO had been researched from the perspective of the supervisor, focusing on the supervisor tasks needed to increase the supervisee's job performance. The supervisee's perspective and the relationship with their supervisor were lacking from recent research on clinical supervision. Researchers agreed that clinical supervision impacts confidence and job performance (Alfonsson et al. 2018; Kühne et al. 2019; Lucid et al. 2018; Watkins, 2019); however, there was little research on topics that must be included in supervision to be considered adequate clinical supervision (see Watkins, 2019). The current study added to existing clinical social work supervision knowledge by focusing on the supervisee and the impact supervision has on their feeling of confidence while implementing the TF-CBT model in a North Carolina IIH program. The qualitative study focused on one research question: How do LCSWs describe the impact of supervision on their feelings of confidence in their ability to implement TF-CBT with youths in a North Carolina IIH program? Section 3 includes a review of data collection and analysis techniques, validation procedures, and limitations. The findings of the research as they related to the research question are summarized, including a characterization of the participant

population, the themes that emerged from the data, and unexpected findings in the research.

Data Collection and Analysis

The data collection process began in February 2022 following final approval from the Walden University IRB. The participants included LCSWs receiving supervision in TF-CBT while working in a North Carolina IIH program. Using the purposive sampling method, I obtained a list of LCSWs receiving TF-CBT supervision from the LMSO.

Time Frame for Data Collection

Recruitment efforts began on February 15, 2022 and continued to February 25, 2022. Starting on February 15, 2022, 17 potential participants were contacted individually via email using the IRB-approved email and IRB-approved consent form. I received responses from 13 potential participants. Two potential participants declined to participate, citing that an increased workload limited their time. One potential participant initially agreed to be interviewed but separated from the agency before the interview, and I could not contact the participant. On February 25, 2022, a second recruitment email was sent to the remaining four potential participants. I did not receive responses from these remaining four participants. I exchanged emails with the remaining 10 participants who expressed interest in the study and arranged interview appointments. Interviews occurred between February 15, 2022, and March 2, 2022.

The individual interviews were scheduled during nonworking hours convenient for the participants. Eight interviews were completed in the early morning before traditional work hours, and two interviews were conducted in the evening. All interviews

were conducted via Microsoft Teams. The interviews were recorded for sound over Microsoft Teams and on a backup digital recorder. The interviews lasted between 55 and 80 minutes. I used a journal to take notes during the interview on touring questions and in vivo codes to increase validity.

Data Analysis Procedures

The interview recordings were downloaded to my personal computer and deleted from Microsoft Teams. The recordings were assigned an alphanumeric code of Interview A through Interview J. After the interview was downloaded to my personal computer, the participants were sent a 10-dollar Amazon gift card. Then, I manually transcribed the interviews and assigned the transcript the same alphanumeric code as the audio file.

I created a three-column table and copied the transcribed interviews to the middle column. The transcribed interviews were reviewed using inductive analysis to identify initial codes, create categories, and identify themes (see Patton, 2015). The codes were identified by highlighting portions of text and assigned an initial code in the first column. I also noted my in vivo codes in the first column. The initial codes indicated phrases or words that summarized a portion of the text (see Saldaña, 2016). I then created a list of codes on yellow sticky notes. I grouped common codes by sticking the notes on a wall. Informed by social cognitive theory, the codes were divided into groups related to self-efficacy, observational learning, and application of learning. I then moved the sticky notes around to create categories. Findings indicated participants felt confident understanding TF-CBT but did not feel confident implementing TF-CBT interventions. The social cognitive theory states 41nowledgee can be acquired by observing others in a

social context (Bandura, 2014). I began to form categories related to the participants' social experiences while learning TF-CBT. I labeled the categories with blue sticky notes and attached them to a wall. I also noted categories in the third column of my table. Themes that addressed the research question were developed using inductive analysis to examine the relationships of the categories (see Patton, 2015). I moved the blue sticky notes around on the wall to examine relationships between the categories. A whiteboard was used to draw lines demonstrating connections between the categories to identify themes. Themes were then noted with pink sticky notes. The themes represented the participants' feelings during supervision and explained why they did not feel confident implementing TF-CBT.

The participants were individually contacted to gain their perspective of the themes and complete member checking. I emailed the 10 participants a summary of the themes and asked for feedback about the themes. Four of the participants responded to the follow-up email. I sent an additional follow-up email asking for feedback but received no responses. The four participants who responded indicated the themes reflected their overall experience receiving clinical supervision in TF-CBT while working in the IIH program. Two of the participants expressed relief that they were not the only participant who did not feel confident implementing TF-CBT interventions.

Limitations

This study had a high participation rate. Out of 17 possible participants, I received responses from 13 and was able to interview 10. The limitations of the study were related to the homogeneous sample of participants. Race, gender, and age could not be examined

or noted without identifying the participants. The lack of diversity among the participants limited the generalizability of the information.

I used the agency to provide a list of participants currently receiving TF-CBT supervision while working in the IIH program. The sample population was limited to individuals currently working for the agency and did not include individuals who had previously worked for the agency. The agency's research department could not provide information on the number of times TF-CBT was attempted with youths and the number of times TF-CBT was completed with youths. As a result, I could not verify the number of TF-CBT cases the participants labeled as attempted and completed.

Findings

I sought to describe the impact of supervision on the LCSWs' feeling of confidence in their ability to implement TF-CBT to youths in a North Carolina IIH program. The responses from the participants were similar, and saturation was reached quickly. The data revealed four themes related to the RQ: (a) insufficient time, (b) low support, (c) fear, and (d) unprepared. I aimed to describe the impact supervision had on the LCSWs' feeling of confidence while implementing TF-CBT. The interview questions addressed the participants' perspectives on their learning style, experiences in training, experiences in supervision, and whether they felt confident implementing the TF-CBT model.

Social cognitive theory was used as the theoretical framework for this study. Social cognitive theory describes observational learning as beliefs that people can learn and their ability to apply concepts learned through observation (Bandura, 1998).

Additionally, individuals learn from within their social context, environment, and interactions with others (Bandura, 2014). Self-efficacy is a key concept in social cognitive theory because it influences an individual's confidence in their ability to perform behaviors needed to achieve the desired outcome (Bandura, 1998). If the individual has never done the behavior before or things are not going as expected, self-efficacy will determine whether the individual perseveres to overcome obstacles. The participants in the current study demonstrated a high level of self-efficacy. The participants were eager to learn, were open to new ideas, were willing to try different approaches, and sought out additional sources when their questions were not answered.

All participants reported confidence in conceptually understanding TF-CBT. All participants also reported low ability to implement TF-CBT interventions and address barriers to treatment, and had low confidence that interventions would alleviate symptoms. The participants described using resources outside the agency to problem solve and teach themselves TF-CBT. They all described using peers to obtain resources, materials, and intervention forms. The participants noted they enjoyed doing TF-CBT with youths and felt the model addressed the cause of behavioral problems in youths. Participants described how understanding the model made them valuable team members, and they were recognized for their work with youths. Participants also described the same struggles with receiving feedback on the narrative and the assessment process taking a very long time. During data collection, I discovered the agency was planning to stop using TF-CBT as their trauma model. Despite their support for TF-CBT, the participants noted they agreed with the agency's decision to no longer offer TF-CBT.

Theme 1: Insufficient Time

The participants noted they had insufficient time to complete TF-CBT with youths due to the time constraints of balancing two models. Participants also noted they had inadequate time to staff cases and experienced untimely feedback on their work. Suzanne explained the difficulties with balancing the two models,

> It is very challenging trying to do the IIH model on top of a whole different model (TF-CBT), so two models within one. I think just having enough time during the week to meet with the youth and fully commit to the models, within the four-hour prescription and not feel like I'm going over or doing lots of extra hours with the family. It is just very difficult. Then, another thing that made it challenging was if a crisis came up during that week. Having to shift gears to address the crisis and then coming back to treatment it made it challenging, for everyone.

The participants discussed various ways the time constraints of the two models impacted treatment. The participants explained the timeline of the IIH program was 4 to 6 months, and they saw the family three times a week. However, if the family did TF-CBT, the counselor had only 2 days a week to target the IIH program because 1 day a week was spent on TF-CBT. Christopher reported "the timelines do not match. I often had to repeat information I went over in IIH sessions to satisfy the TF-CBT model." The participants explained they were unsure if they were doing either model with fidelity. The participants all noted spending extra hours working with the family to accomplish goals and provide treatment.

Staffing Cases

The participants noted they also had insufficient time to staff cases and obtain feedback. All participants noted they participated in biweekly 1-hour phone calls to staff their cases with an agency TF-CBT model expert. The participants stated they had 5 to 10 minutes to staff their cases. Several participants explained it was difficult to explain complex treatment barriers in such a brief amount of time. Morgan said

> I don't think that I can really get at the depth or really explain what's going on in session. For example, one time, a case was having a really hard time with going through the emotion regulation piece of TF-CBT. And I feel like we have spent forever on that section. We were really taking our time, but when I explained it to the person leading the call, there was a disconnect and no real understanding of what's going on with the family. We could not get to the root of the problem. I'm just asking like, "Okay, we've got through this, this, this, this, and this intervention, what's the next intervention that might help?" But I can't really get at the specifics of my client and how she's taking it because everyone is listening in on the call, and I am taking too long to staff my case. I just felt a lot of pressure, like I needed to rush through this call and just get on with my day of doing treatment with youth.

Kieran noted how minimal the communication was on the TF-CBT supervision phone call:

> And then you would just say, "Okay, I'm going to go do my case." She says, "Okay, where are you at in the model?" "I'm here." "Do you have any questions?" "No." And then you move on. There wasn't really much else outside

> of the check-in. It really just felt like a check box that had to be completed. It really was more of a waste of time, honesty.

Other participants noted their office was often skipped or left to the end, and they would not be able to staff their cases during the calls. The participants went on to explain worries that they were harming children due to insufficient time to receive feedback about their cases.

Untimely Feedback

All participants noted the lag time between completing the University of California Los Angeles posttraumatic stress disorder reaction index (UCLA) assessment and receiving approval to start TF-CBT. The participants stated the approval time of the UCLA could take anywhere from 2 weeks to 3 months. During the wait time, the counselor teaches the family information that they know they will repeat once TF-CBT is approved. Shelby explained the UCLA approval process often meant she could not start TF-CBT:

> Not everyone is trained in TF-CBT, because they must have a clinical license to do TF-CBT. It made it hard to get UCLAs completed in a timely manner to start TF-CBT. Then, the barrier we were seeing was, the UCLA was not returned in a timely manner. It would get to the point where we would ask ourselves, “do we even start TF-CBT or does it become an aftercare option?” Because we are so far into treatment at this point, we don’t have enough authorization to even do the whole TF-CBT model with the kid.

David reported communication breakdowns led to untimely feedback from the TF-CBT supervisor:

> The communication was just horrendous. I knew if I had to email, text, or call, it wasn't going to be like a quick response. It was like, I'm going to have to harass this person for a couple of days of like, "Hey, just following up." Hey, just following up here." And then having to add in my supervisor, my regional, and my consult to the emails. Then still not getting responses. Meanwhile, the family is upset that I have not started TF-CBT, and they are complaining about the lack of organization.

The participants linked the untimely feedback to the low support they felt from their TF-CBT supervisor and agency. The participants conveyed they worked hard to support families in accomplishing treatment goals and address the trauma needs of the youth. The participants noted worries about youths not getting the treatment they needed. The participants also noted the unfairness of working long hours to meet the demands of two models only to be met with unhelpful case staffing and untimely feedback.

Theme 2: Low Support

All the participants stated their TF-CBT supervisor was very knowledgeable about TF-CBT. However, the agency structure of how they received supervision and the limitations in terms of who could provide TF-CBT supervision impacted their ability to complete TF-CBT with a high degree of efficacy. The participants described difficulties in receiving feedback during the TF-CBT phone calls, relying on outside resources, low support for the narrative sections, and poor communication.

Kay described needing to discharge a family early as a result of not receiving feedback during the TF-CBT phone call supervision:

> I ended TF-CBT with someone… because they had to discharge, and [I] didn't get any feedback on specific things that probably could have enhanced my ability to continue treatment, but I didn't feel like I couldn't butt in or have a conversation about it during the TF-CBT call.

This participant connected the inadequate support they received to insufficient time for discussing cases on the phone calls. The participant explained that the presence of a large number of people on the phone call prevented the provision of adequate feedback, leading to low support.

Five participants noted that although they were able to listen to the feedback of others during the TF-CBT phone call, they could not generalize the information to their cases. Marley succinctly described their inability to generalize:

> There's [*sic*] specific situations or specific information that's different in all cases, and so I feel like even the fact of who the person lives with and the relationship they have to that person can change the whole question and makes it so that it's a different answer. And so, I could listen in, and I could try to generalize the information, but I never would know if that was the same feedback that I would've received.

This inability to learn from past experiences speaks to the reciprocal interaction of the person, environment, and behavior. In social cognitive theory, a distinction is made between learning and performing actions that were observationally learned (Bandrua,

2014). The participants could not use the information they acquired by listening to others because previous experiences affected incentive motivators. The participants worried that generalizing the feedback from one family to another would have different outcomes because each situation was different.

All participants described using resources outside the TF-CBT call to enhance their understanding and complete the model with youths. According to Bandura (2014), intrinsic motivation causes people to satisfy their curiosity or master an area of knowledge. However, all other actions are extrinsically motivated by the desire to fulfill social values (Bandura, 2014). The participants were intrinsically motivated to seek out knowledge to enhance their practice. Thus, they all looked for additional resources to support their understanding. Their actions were then extrinsically encouraged to provide good treatment to youths.

In the absence of supervision that addressed their needs, the participants described that they sought out resources in manuals, from peers, on online websites, and from licensure supervisors. All the participants noted they taught themselves the model but had questions about whether they were following the model with efficacy. Hanna explained obtaining materials from a peer and discussing cases with the peer to obtain support:

> So, us getting together even, we've asked each other questions like, "Hey, how did you do this?" Or like, "Hey, I need the jeopardy game. Do you have that?" Or that kind of thing. We're able to bounce ideas off of each other. So, I think that's helpful too, but that's not like a [*sic*] formalized supervision. So, I don't know if that's helpful. Neither of us really knows what we are doing.

Eben described finding resources to enhance her learning and understanding of the model:

> I think that when I think about certain aspects of the TF-CBT model. I would say that I don't feel as comfortable. I would say I had to do a lot of side training of [*sic*] myself back in the manuals and everything before I did the cognitive coping or the cognitive triangle because we just have different interventions for those in [the IIH model].

Suzanne noted not feeling supported with the trauma narrative section of TF-CBT:

> I feel like I have a lot of the ideas, but I don't know that I have a lot of knowledge about how actually to write it or that the trainer will give helpful feedback when I send the trauma narrative. She's going to give me feedback, but I feel from the get-go of doing this with her [that] it has not been helpful. I really don't know, not what I'm doing, because I do know what I'm doing, but I could have had more support with knowing exactly like, "Okay, what is she really looking for when I send this to her?" Because we don't really talk about that in our trainings [*sic*]. I know people are sending the narratives to her, but I don't know what it is supposed to look like, if that makes sense. That is probably what I would say. I could use more support on the narrative and doing the narrative. It is so important, but we don't really talk about it in training. I just don't feel comfortable with it, and [going] back to what your project is about, no, I don't feel confident in TF-CBT, especially the narrative.

This participant explained the difficulties of combining the IIH model with TF-CBT. All the participants stated they received low support when combining the IIH model with the TF-CBT. The participants noted they had TF-CBT supervision to answer their questions about the TF-CBT model and supervision to answer questions about the IIH model. However, they did not receive support for merging the models. The participants also noted they could not ask questions about TF-CBT during supervision for the IIH model, as the person leading the meeting was not knowledgeable about the TF-CBT model. The participants explained they received supervision in the IIH model more often than TF-CBT supervision; having to wait to obtain answers to TF-CBT questions affected their ability to move forward in treatment.

All participants described poor communication with their TF-CBT supervisor affecting their ability to move forward in treatment. Only Kieran noted having phone conversations with the TF-CBT supervisor. The other nine participants stated they attempted to talk with their TF-CBT supervisor outside of the TF-CBT phone call but were unsuccessful in contacting their supervisor. Christopher described the difficulties of communicating with the TF-CBT supervisor:

> Or if we email the person who's in charge and just there's no communication back. I had that several times, and that really, I struggle with people who can't communicate. So if I'm emailing you consistently, and then my leadership is saying, "Oh, add in all these people." And you're still not answering. And it's just like, and I can't move forward until you give me this go-ahead. That's just... And then I didn't experience it directly, but I know I've had friends who can't even

> move forward, or they did move forward, and they were told, “Oh, you shouldn’t have done that.” It’s like, “Well, you’re not answering my phone calls. You don’t answer my email. The family’s waiting to discharge. And they’re just waiting, in general, to move on to the next section. And I can’t because I don’t have the green light from you.” So that whole thing was just not good.

The inability to move forward in treatment without the TF-CBT supervisor’s approval and the limited time to obtain the approval before discharge affected engagement with the family. Marley described how waiting for the UCLA approval affected engagement with the client:

> And I feel like it looks poor on us that we’re like, “Oh, we haven’t gotten it back yet.” “Oh, we haven’t gotten [it] back.” And like, “Oh, we don’t have an email, there’s nothing.” And I know we weren’t the only ones in that boat, but our family ended up discharging going elsewhere for TF-CBT. And we just gave the new therapist the results of the UCLA. We had to discharge because we could not do TF-CBT in the IIH timeframe. That kid really needed TF-CBT, and we could have made progress too.

The participants offered solutions to the low support they felt while performing TF-CBT within the IIH model. The participants explained they needed the ability to discuss cases individually with a supervisor who understands the youth’s whole picture. The participants explained that having separate staffing inhibited their ability to present a full picture of where they struggled with the TF-CBT and IIH model. The participants also wanted ongoing training to increase their understanding of the model. Finally, the

participants wanted greater autonomy to decide if a youth needed TF-CBT. The participants noted if they could complete the UCLA and then decide on the next steps based on the results, they could have started treatment faster.

Theme 3: Fear

The participants all discussed their fears around TF-CBT. Four participants worried that they had harmed children by not knowing how to perform TF-CBT correctly. Five participants worried they were following the model incorrectly, causing behaviors to increase. Six participants worried they were not presenting information actuarily and, thus, not getting appropriate feedback. The participants noted fears around staffing cases, training, and low support preventing them from feeling confident in performing TF-CBT.

Staffing

Shelby discussed concerns around the briefness of the TF-CBT supervision call and worries about not presenting enough information to obtain helpful feedback:

> Depending on how many people on the call were carrying cases, I know sometimes we weren't all carrying a case, but we still joined the call. Depending on the time, I would say 5 to 10 minutes total to staff my cases and I would have 2 or 3 cases at a time. I don't think I had enough time to staff, and I worried I was not giving a full description of what was happening. Like, if the feedback would have been different if I had more time.

The self-blame the participants engaged in likely affected their intrinsic motivation to learn. As stated earlier, self-efficacy is a key component of social cognitive theory. When

the participants engaged in self-blame, they experienced low self-efficacy or the belief that they did not have control over treatment (Bandura, 1998). When the participants experienced low self-efficacy, their sense of personal agency was impacted, and they believed they were the cause of treatment not going as expected.

Eben who completed TF-CBT with a youth connected self-doubt and low support. When asked if the participant felt confident in the model, the participant stated the following:

> Big picture answer? No. After I finished my first, I did the whole model with my first kiddo, [and] I felt a lot better. It felt good to have seen the success and have done that. This kind of goes back to a previous question, but I felt like I almost taught myself a lot of TF-CBT. But I don't know if I did it correctly or anything like that. I can check the box that I completed one, but did I do it right? I wonder if I was actually hurting kids by coercing them to talk about their trauma.

Training

A total of seven participants expressed fears and concerns around the training. All participants felt the training was too short and rushed. The participants noted they did not have time to practice interventions in training and felt unprepared when working with youths. The participants explained not having refresher training may have led to incomplete intervention or forgetting key components while working with youths. Hannah explained concerns about preparedness for the training:

> I remember feeling that the trainer kind of made comments as if I already was expected to know certain words and have an understanding of certain things. And

> I remember thinking like, "Should I have read something beforehand to know this, but I didn't." So I do feel like it was kind of rushed or not as thorough as it could have been. And I think there's areas where we need more support, but they don't give more support. And I think learning it and then actually implementing it is very different, and this was where I needed a lot more support, I think.

Kay noted being able to complete the skills section with youths but was unable to move forward with the narrative section:

> Most of the kids, when I got to the end, they did not want to continue on with the narrative. They did not want to do that. And if they started it, they didn't finish it. And so, I just wondered if there was something to do with something that I could have been trained on differently or something that maybe if I had additional supervision on it could have been different, or if that's just statistically, most people don't finish it. I don't know.

The participant later noted the TF-CBT supervisor would tell them to go back and do parts of the skill section over to prepare the youth, but the participant did not know what area of skill section they did not do correctly. The participant mentioned they felt unsupported in addressing the resistance of the youth. The participant explained the TF-CBT supervisor blamed them for not being able to move forward in treatment.

Low Support

All participants noted difficulties and a lack of support with staffing cases. Morgan noted concerns about not being able to support youths in treatment due to poor communication with the TF-CBT supervisor:

> I don't recall if we were able to move on to the next section, [or] if we had to get approval, but just trying to staff it, or if you're stuck in an area and they're [supervisor] not calling you back and it's like, "I can't just let this kid sit in limbo, because we're struggling to move on to something, but I need support because he needs this thing, and I don't know how to help him because we're stuck on something." Like it's just—it was not good. Just there needed to be a lot better communication, response, guidance, all these pieces. And I also think it depends on the kid for me; I've had the younger kids, when I'm like, "This is awesome, and it feels really great." And then I've had the older kids, where I'm just like, "This sucks." I don't know. I don't even know where to go with this kid. That was a really tough kid where I had no idea. And he was just really struggling. Just had a lot of avoidance. And I remember just not having any guidance because I'm like, "I don't even know what to say to this kid," let alone try to work on these things with him.

David described feeling confident in parts of the model but not knowing how to address resistance and avoidance in the model:

> There's aspects I understand about it, and things I'm like, "I know how to do the model. I feel confident in understanding what it is and why we do it." And then there's pieces where it's like, "If I get stuck, I wouldn't know what interventions to do with this kid." I have a handbook I found online that has been more helpful than the supervision, so that's really what I followed. So it depends on the case, how confident I would be.

All participants described using outside resources to meet their needs because they wanted to do the model well and help children. However, these resources were not provided by their TF-CBT supervisor or agency. Thus, it is unknown whether these resources complied with the TF-CBT model.

Theme 4: Unpreparedness

All participants stated they felt unprepared to implement TF-CBT intervention with youths. The participants noted not having trauma-specific training led to them feeling unprepared. Eben described the lack of training in trauma at the LMSO and in graduate programs:

> I didn't have any specific training in grad school or undergrad. I've done things with trauma, but didn't really have an intense trauma background, if that makes sense. I worked in an in-home service and a residential facility for teens. So obviously, there's a ton of trauma you're working with there, but there wasn't concrete training. And then, with the agency, it was really TF-CBT and then understanding what trauma is. I think understanding what trauma is and how it's in the body and that stuff came more from my schooling than it did from the agency. I wonder about the people that don't have training in trauma and are not doing TF-CBT. Like are we even helping kids with trauma?

All participants noted they needed refreshers for trauma-informed care. Suzanne stated the agency reviews core values and what to do in active shooter situations but does not provide refreshers for trauma. Christopher noted he was newer to the LMSO and did not understand large portions of the training and feedback in the TF-CBT supervision call:

> I don't feel confident in TF-CBT at all. I don't know if it is because I am new or if people just assume maybe we all know about trauma. But it's like, I didn't come into the agency knowing about trauma. I was already working in the field, but I didn't have anything related to TF-CBT. So, I just feel like there were certain things I didn't understand and jargon that didn't make sense. I don't know if it's because I am new. But yeah, the training and supervision, I feel like it just moved very fast. I feel like it was like a check mark. Like I had to do this. I had to just say everything was good or if there was a struggle, but it just felt very disconnected and everyone's waiting and everyone's listening, and I couldn't be like, "No, I don't understand. Can we break it down?" And so sometimes I'd be like, "Okay, well I'll try it. And just go on from that." Yeah. I feel like supervision is where it all comes down to and how they trained us.

The participants noted their TF-CBT training did not prepare them for working with the youth. The participants reported using resources not approved by the agency and self-directing their training. Hannah labeled specific areas where TF-CBT training could have been more supportive:

> Yeah. I think that maybe catching things sooner if kids are showing resistance and how we could have targeted that in the moment rather than ... I mean it was targeted in the moment for sure. I did target it in the moment; I just wonder if I had a chance to bring up that specific thing that I noticed, [the supervisor] would've been like, "Oh, that sounds like they are trying to sway away from that topic or it sounds like there's a lot of resistance. Let's brainstorm that," rather

> than getting through everything, feeling like, “Okay, I think that they’re getting it,” and then getting the end and them being like, “Yeah, I’m not doing the narrative.”

Other participants stated similar concerns about not having the skills to move forward in treatment. All participants noted they could not complete TF-CBT with youths due to lack of skill in addressing unexpected problems in treatment.

Unexpected Findings

During data collection, I discovered the LMSO was planning to move away from TF-CBT as the primary trauma model. The participants were still finishing their TF-CBT cases or had recently completed their TF-CBT cases. I contacted the clinical director for the agency to obtain information about the decision. The clinical director stated the agency implemented a best practice method to address trauma symptoms, due to limited master’s-level staff to be trained in TF-CBT, TF-CBT developers changing requirements for certification, and new research about bottom-up approaches to treat trauma (Agency Clinical Director, personal communication, March 31, 2022).

The clinical director noted the agency had been observing trends in the IIH program. At the time of the current study, most of the staff members working with youths in the IIH program were bachelor’s-level staff members who could not participate in the TF-CBT collaborative training. Thus, youths receiving services from a bachelor’s-level staff member were not receiving any trauma treatment intervention. The agency’s internal reviews and program model reviews demonstrated that youths were not receiving trauma treatment in services or as aftercare options once they completed the IIH program. The

program model reviews also noted that master's-level staff members were not screening youths for TF-CBT, there were delays with TF-CBT starting, and TF-CBT was not addressing the parent–child relationship concerns. The program model reviews identified that youths were receiving TF-CBT three or four times for new traumatic events. The clinical director stated that TF-CBT was not addressing the complex trauma symptoms of the youth in agency programs. The LMSO also noticed that staff members trained in TF-CBT were not addressing serious safety concerns in sessions because they were focusing on completing TF-CBT.

The clinical director explained the agency used a train the trainer learning collaborative to teach staff TF-CBT internally. The staff members who were not considered certified could provide TF-CBT under the supervision of a certified trainer. The TF-CBT developers noticed there were numerous learning collaboratives, and TF-CBT was not being done to fidelity under these collaboratives. The TF-CBT developers decided to eliminate the learning collaboratives and mandated every TF-CBT provider to be trained by the developers. The clinical director stated the LMSO was considering having all qualified staff trained by the TF-CBT developers. The clinical director posited that the training would be costly, but the agency wanted to provide the best treatment for the youth. The clinical director noted, at the same time, the agency was considering sending all qualified staff to be trained by the developers; the agency noticed that TF-CBT was not preventing the youth from future traumatic episodes. Youths were receiving TF-CBT multiple times for different traumatic incidents. TF-CBT was not addressing the

complex trauma symptoms and was not addressing the parent–child relationship concerns.

The clinical director explained the agency began looking at clearing houses to determine which evidence-based practice was doing a great job addressing complex trauma symptoms. The agency's partner agencies, such as child welfare agencies, need programs to provide evidence-based practice to the youth. The agency was weighing the cost of evidence-based practices and the need to incorporate an evidence-based practice into other evidence-based practices provided by the agency. The clinical director noted that the agency's IIH program was listed as an evidence-based practice and that a bottom-up approach to addressing trauma, as suggested by new research in trauma, was better than a top-down approach. The clinical director insinuated the agency had begun creating its own best practice method to address complex trauma symptoms of the youth.

The agency began the rollout of its new evidence-based practice after data for this study were gathered. The participants in the study were all aware the agency was moving away from the TF-CBT model. Although the participants had not completed training on the new model, they all agreed the agency needed a better way to address the trauma symptoms of the youth. The participants stated they wanted the new model to integrate seamlessly with the other evidence-based practices the agency offered. They also wanted the supervision of the trauma model to be like the other evidence-based practices that impart the ability to graduate from supervision and make decisions in the moment about what the youth needed to address symptoms. The participants noted that TF-CBT supervision required them to wait long periods before answering their questions.

Therefore, they wanted the ability to engage in small groups with the model supervisor who knows the family they are working with, so the feedback is better suited to address the treatment issue.

Summary

The findings presented the impact of supervision on the LCSWs' feeling of confidence while implementing TF-CBT with youths in a North Carolina IIH program. The LCSWs shared their experiences with receiving supervision and the impact of supervision on their confidence. All participants reported confidence in understanding the TF-CBT model. However, all participants reported low confidence in implementing TF-CBT interventions and addressing barriers to treatment and low confidence that interventions would be successful.

Although the participants noted they enjoyed doing TF-CBT with youths and felt valuable to the organization because they could provide TF-CBT, they struggled significantly with completing the therapy. The participants noted having insufficient time to complete TF-CBT. The participants struggled to balance the demands of the two models and had limited time to staff their cases. The participants noted they received limited support with their cases due to poor communication and difficulties receiving feedback. The participants expressed fears they were harming children by not doing the model to fidelity, increasing disruptive behaviors by not doing the model correctly, and worried they were not getting appropriate feedback from their supervisor. The participants felt unprepared to provide TF-CBT to youths due to a lack of training in trauma-informed care and limited education on trauma provided by graduate programs.

The LMSO decided to move away from TF-CBT as its trauma model. The LMSO completes internal reviews and program model reviews on the IIH program. The LMSO noticed that TF-CBT was not addressing the complex trauma symptoms of youths and the parent–child relationship concerns. The LMSO used a learning collaborative to train staff and supervise TF-CBT. The TF-CBT developers noticed concerns with learning collaboratives not providing TF-CBT with fidelity. Therefore, they decided to eliminate the learning collaboratives and required all providers of TF-CBT to be trained by the developers. The LMSO considered having all clinicians trained to provide TF-CBT by the developers and researched other trauma models. It then decided to create its own evidence-based practice to address complex trauma symptoms that would intertwine with the other evidence-based practice the agency provided. In Section 4, I discuss how the findings impact professional ethics in social work practice and provide recommendations for social work practice. Moreover, I present implications for social change.

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

The purpose of this basic qualitative study was to understand how LCSWs describe the impact clinical supervision had on their feelings of confidence in their ability to implement TF-CBT to youths in a North Carolina IIH program. Purposive sampling was used to recruit LCSWs working in the IIH program. Data were collected using semistructured interviews. Creating evidence-based practices to address childhood trauma and provide uniform methods of supervision for practitioners is an area of interest in the social work field (O'Donoghue et al., 2018; Watkins, 2019). Understanding the supervision needs of LCSWs and the impact supervision had on their ability to provide services had been minimally studied. Current study findings on supervision's impact on LCSWs' confidence may inform supervision methods and lead to better client results.

Findings included four themes related to understanding how LCSWs described the impact of clinical supervision on their feeling of confidence. The four themes captured the perspective of the participants learning to implement TF-CBT with youths through supervision: (a) insufficient time, (b) low support, (c) fear, and (d) unprepared. All participants reported confidence in conceptually understanding TF-CBT. All participants also reported low ability to implement TF-CBT interventions and address barriers to treatment, and had low confidence that interventions would alleviate symptoms. Another finding was support for the agency moving away from TF-CBT as the primary trauma model. The participants worked hard to be well versed in the agency's treatment models and felt like valued members of the team because they could

provide the trauma model. However, the LCSWs receiving supervision in TF-CBT did not feel confident implementing the model.

The findings added to the existing knowledge of clinical supervision in the social work field and the existing knowledge of supervision in TF-CBT. Researchers agreed that the relationship between the supervisor and supervisee significantly impacts confidence and job performance (Alfonsson et al. 2018; Kühne et al. 2019; Lucid et al. 2018; Watkins, 2019). Providing supervision that meets the clinical needs of LCSWs can improve client outcomes and retention in agencies (Barnett et al., 2019**)**. There has been a scholarly debate over what clinical social work supervision should provide and how the supervision should be structured (Bostock et al., 2019; Dan, 2017; O'Donoghue et al., 2018; Unguru & Sandu, 2018; Watkins, 2019; Wilkins, 2019). The current research findings suggest that LCSWs need timely feedback, training, and sufficient time to staff cases. LCSWs need to feel supported by the agency with high communication, problem solving in technical areas, and resources. The findings also suggest the LCSWs need individual attention to address fears that impact their confidence. Finally, the findings suggest LCSWs must feel prepared to address trauma symptoms through graduate education and agency training. Clinical supervision that addresses the concerns of LCSWs will improve confidence, client outcomes, and retention (Alfonsson et al., 2018; Bostock et al., 2019; Kühne et al., 2019; Lucid et al., 2018; Watkins, 2019). Section 4 presents the study's application for professional ethics in social work practice and recommendations for social work practice. I also discuss the implications for social change based on the study's results.

Application for Professional Ethics in Social Work Practice

The NASW (2021) code of ethics was created to guide the profession. These principles guide social workers' actions in the field, support social workers in their roles, and provide a foundation for social work practice. The code of ethics informs clinical practice in the social work field by valuing the dignity and worth of the person (NASW, 2021). When social workers are working with families, the social worker is expected to treat the family with respect; be mindful of individual differences, culture, and ethnicity; and promote the family's self-determination (NASW, 2021). When LCSWs are teaching, they must also adhere to the ethical principle of valuing the dignity and worth of the person. LCSWs providing supervision are expected to demonstrate professionalism and conduct themselves ethically, consistent with the code of ethics.

The NASW (2021) social work values related to the current study were the importance of human relationships, integrity, and competence. The findings regarding how supervision impacts the feeling of confidence social workers have while implementing TF-CBT within an LMSO demonstrated that social workers value the importance of human relationships. Senior social workers participate in the profession's advancement by training and teaching junior social workers. The findings of this study indicated that supervision plays a vital role in social workers feeling confident while implementing interventions in TF-CBT.

Social workers value integrity and competence by practicing within their scope of knowledge (NASW, 2021). Junior social workers or social workers new to a particular intervention/technique require additional guidance to provide treatment to clients. Senior

social workers must guide junior social workers to enhance the field and ensure client safety. The current study participants demonstrated the level of active participation needed from junior LCSWs to learn and implement new skills successfully. The study participants discussed seeking information and using resources to enhance their knowledge. This tenacity for learning, coupled with supervision that meets the needs of LCSWs learning new skills, is likely to produce clinicians with the skills needed to work with clients.

The findings of this study may impact clinical social work practice by adding to the existing body of knowledge related to supervision in the field of social work. The LCSWs' experience while receiving supervision in TF-CBT had been minimally studied. The current findings demonstrated that although LCSWs may feel confident in their understanding of TF-CBT, they may not feel confident implementing interventions with clients. The results illustrated the gap between educationally understanding a topic and using this education to provide treatment. These results added evidence to why clinical supervision is needed in the field. LCSWs need supervision that enhances their understanding of topics such as trauma, but LCSWs also require this education balanced with the ability to put this education into practice.

LCSWs providing supervision need to ensure the LCSWs they are supervising are confident in their education and techniques. Supervisors can accomplish this task by valuing the dignity and worth of their supervisees and human relationships, and by being attuned to the needs of their supervisees. Supervisors who listen to the needs of their

supervisees are preparing the next generation of social workers to value human relationships, integrity, and competence.

Recommendations for Social Work Practice

Clinical social workers providing services to children and families value the safety of children, integrity, and competency of their practice. Informed by social cognitive theory, two action steps are recommended for LMSOs that provide TF-CBT: develop proficiency markers and use smaller supervision groups. These two action steps have the potential to address the LCSWs' concerns of insufficient time, low support, fear, and unpreparedness while providing TF-CBT.

The development of proficiency markers may not only allow supervisees to graduate from training with the skills needed to provide TF-CBT, but may also provide feedback on training needs. If the agency notices that supervisees routinely are unable to address avoidance in TF-CBT, this trend can be addressed through additional education and field practice. Developing methods to indicate proficiency may provide the agency with valuable information about its staff's capabilities. The LCSWs will have a standard that identifies areas to work on and where they are doing well. The proficiency marker system that allows the LCSW to demonstrate skill and ability could enable the supervisor to provide specific feedback while also building the confidence of the LCSW. A proficiency marking system could address the fears and feelings of unpreparedness the current participants reported during this study by having an outline of skills acquired and specific feedback to improve.

The participants reported significant concerns about the amount of time they had to staff cases in supervision. The participants noted they were staffing cases within a large group of people who were waiting to staff and listening to them staff cases. The participants reported fear that they were not getting the support needed or providing the appropriate information. Acknowledging that the cases are complex and require time to give updates about concerns could address the insufficient time and low support the LCSWs reported. The LMSO could decrease the size of the supervision group, which would increase the amount of time supervisees have to staff. Two participants suggested having in-the-moment feedback about cases would be helpful, or even the ability to record themselves for feedback would be helpful. Another participant noted a smaller supervision group would allow for greater peer-to-peer support.

The findings from this study impact my own social work practice as I move into a more senior role of guiding the next generation of social workers. I currently provide licensure supervision to associate licensed LCSWs. The findings of this study encourage me to listen to my supervisees' concerns and meet their individual supervision needs. This study encourages me to provide supervision that reflects the best of social work practice. I am inspired to know that supervision helps put education into practice. Understanding a topic and feeling comfortable using the information to address a problem are different. The results of this study demonstrate that although a supervisee may understand how to provide TF-CBT to children, they may not be confident using this information when working with clients. Supervision that meets this need is necessary to promote confidence.

The 10 participants were geographically diverse and practiced in different areas of North Carolina. However, the participants were a homogeneous group of similar age, gender, and experience level. The sample size was not large enough to be considered transferrable. The information gained in the study indicated how these participants described the impact supervision had on their confidence in implementing TF-CBT. The participant responses were consistent with each other, thereby potentially increasing transferability. The LMSO would benefit from considering these findings as consistent across all LCSWs receiving supervision in TF-CBT while working in a North Carolina IIH program.

The findings were focused on describing how supervisions impacted the LCSWs' feeling of confidence with TF-CBT interventions at a specific LMSO. These findings added to existing clinical supervision knowledge and provided supervisees a voice to describe their needs. More research is needed to understand the supervisees' needs in supervision and how supervision impacts clinical practice. The social work field must understand the needs of supervisees and the impact supervision has on clinical practice before making policies regarding supervision.

There were several limitations in the study. The sample size was small and demographically homogeneous. Although participants represented the state of North Carolina, a more diverse population that represented the LMSO may have provided additional findings that would have been more transferable to the LMSO. Additionally, although all participants were sent a summary of the themes, only four responded with

feedback. The low response rate to the summary may have impacted the trustworthiness of the data.

Recommendations for Further Research

Several findings highlighted the potential for future research on how supervision impacts confidence. One potential area could be focused on the optimal size of a supervision group. Researchers could also examine whether the length of time a case is staffed in supervision is related to confidence in providing TF-CBT. Additionally, further research could determine whether small supervision groups allow LCSWs to feel supported with TF-CBT.

Similarly, further research would be beneficial to examine whether proficiency markers help agencies and LCSWs feel confident that supervisees are prepared to provide TF-CBT. Further research in this area could address whether role-plays and demonstrations improve the feeling of confidence. Finally, research is needed on how educational programs can increase the readiness of LCSWs entering the field to put knowledge into practice. Further research could inform educational programs of the skills LCSWs need to be ready to work with clients. Researchers could also look at the impact of the COVID-19 pandemic on master's programs and subsequent confidence in social work practice.

Dissemination

The findings of this research can be used to inform clinical supervision practices at LMSOs that use multiple clinical models. I plan to share the results with the LMSO to benefit the clinical supervision provided at the agency. Additionally, the results of this

study may be presented at conferences focusing on clinical supervision in the social work field.

Implications for Social Change

The research findings have the potential to impact positive social change at micro, mezzo, and macro levels of practice. Social work clinical practice can be affected at the micro level by improving clinical supervision leading to better training for LCSWs working with clients. The study participants were so eager to learn TF-CBT that they sought other resources when their needs were unmet by supervision. Clinical supervision that supports LCSWs who want to learn and instructs them on the best ways to find the answers to their questions would benefit client outcomes. Additionally, on a micro level, this research gave a voice to the recipients of clinical supervision. The participants provided information about their experiences and established a platform for self-advocacy. The LMSO can use the information the participants provided to shape policy around supervision practices in their programs.

At the mezzo level of practice, the LMSO has phased out using TF-CBT as the clinical model to treat trauma. The LMSO noticed that TF-CBT was not as effective at treating complex trauma symptoms that are prevalent in the treatment population. The LMSO has created its own protocol for addressing trauma instead of using an evidence-based practice treatment model. The findings of this research may inform the agency as they move forward with their trauma model to ensure employees have access to supervision to support their work with children and families.

On a macro level, continued research in clinical social work supervision has potential implications for supervision in other mental health agencies. LMSOs that expect their employees to use clinical models such as TF-CBT can use the findings to understand the learning process of their new clinicians. New employees have many training needs. An LMSO that recognizes the difference between understanding material taught and implementing it in practice will enhance their training methods by offering a higher degree of support, increasing the length of training, providing the opportunity to practice material, and having greater flexibility with asking questions.

Summary

LCSWs who provide TF-CBT services to children need clinical supervision to treat the trauma symptoms of youths. LCSWs who received clinical supervision in TF-CBT did not feel confident implementing TF-CBT to youths due to insufficient time to staff cases, low support with cases, fear, and feeling unprepared to provide treatment. Although LCSWs may understand TF-CBT and childhood trauma educationally, they may not have the skills needed to implement TF-CBT with youths. The findings of this study suggest the LMSO could develop proficiency markers to ensure clinicians are properly trained and conduct supervision in smaller groups to allow more time to staff complex cases. The results of this study will be provided to the LMSO and will be presented at conferences on clinical supervision.

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Appendix: Interview Questions

Interview Guide

Thank you for agreeing to speak with me about your experiences receiving TF-CBT supervision within the North Carolina IIH program. I appreciate your willingness to participate in this project. I am a doctoral student at Walden University. I am conducting a study on the impact supervision has on the LCSWs feeling of confidence in their ability to implement TF-CBT with youth in the North Carolina IIH program. The interview should last between forty-five minutes to an hour. While your answers will be incorporated into the study's findings, no one will be able to identify you from your answers, and I will not identify you in my documents. I am recording the interview to capture your input. The recording will be transcribed and coded, looking for themes. You will be provided a summary of findings and asked to comment on the findings. The interview is voluntary. You may stop the interview at any time for any reason. Do you have any questions? Are you ready to begin?

My research question is:

How do LCSWs describe the impact of supervision on their feelings of confidence in their ability to implement TF-CBT with youth in the North Carolina IIH program?

- How long have you been working with the LMSO?
- How long have you been doing TF-CBT?
- Have you completed TF-CBT with any youth? How many?

- Tell me about your training in TF-CBT, trauma-informed care, and working with youth.
- Tell me about your learning style
- What aspects of the training matched your learning style? What aspects of the training did not match your learning style?
- What is it like working with youth in the IIH program while also doing TF-CBT?
- Tell me about the supervision you receive in TF-CBT.
- How does your supervisor support your learning style?
- How often do you meet for supervision?
- Are there helpful aspects of TF-CBT supervision? What are the helpful aspects of TF-CBT supervision?
- Are there unhelpful aspects of TF-CBT supervision? What are the unhelpful aspects of TF-CBT supervision?
- Tell me about your interactions with your TF-CBT supervisor?
- Do you feel confident completing TF-CBT with youth? Why or why not?
- Are you able to contact your TF-CBT supervisor if you are struggling with an intervention or aspect of the model? Can you provide any examples?
- Is there anything else you would like to share with me about doing TF-CBT within the IIH program?