Reducing the Impact of Traumatic Events with Trauma-Focused CBT

Agenda

- Basic concepts of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Overview of benefits and challenges of providing TF-CBT
- Signs and symptoms of trauma across diverse populations
- Readiness Steps for Implementing TF-CBT
- Screening tools and Assessment protocols for identifying trauma
- Commonly used TF-CBT interventions
- TF-CBT Training and Continuing Education
- Fidelity Steps to Ensure Positive Outcomes
- Sustainability Factors

Learning Objectives

At the conclusion of this training, participants will be able to

1. Explain the basic concepts of trauma-focused cognitive behavioral therapy (TF-CBT).
2. Identify the indications, benefits, and challenges of providing TF-CBT.
3. List common signs and symptoms of trauma across diverse populations and gain awareness of screening tools and sustainable workflows useful for meeting the needs of individuals who may benefit from TF-CBT.
4. Identify commonly used interventions when providing TF-CBT.
5. Recognize opportunities for training and continued education in TF-CBT.

Disclaimer

Please note that this training is NOT for certification in TF-CBT but is designed to provide attendees with an overview of what it offers, general concepts, and ways to apply it in practice. Information on where attendees can go to register for training in TF-CBT is provided later in the presentation.

What is TF-CBT From a 30,000-Foot View?

- Developed by Drs. Judith Cohen, Esther Deblinger, and Anthony Mannarino
- Evidence-based treatment for reducing emotional and behavioral symptoms resulting from trauma exposure
- Short-term treatment approach
- Individual and Family Therapy Sessions
- Parents/caregivers and child receive all TF-CBT components in parallel

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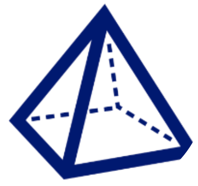
4 Core TF-CBT Principles

1. Phase- and components-based;
2. Component order and proportionality of phases;
3. Use of gradual exposure; and
4. Parents/primary caregivers integral to treatment.

3 Core TF-CBT Phases



STABILIZATION PHASE
(4–12 sessions)

TRAUMA NARRATIVE AND PROCESSING PHASE
(2–6 sessions)

INTEGRATION AND CONSOLIDATION PHASE
(2–8 sessions)

TF-CBT Components

Psychoeducation & **P**arenting Skills
Relaxation
Affective Expression and Modulation
Cognitive Coping and Processing
Trauma Narrative
In-Vivo Exposure
Conjoint Parent-Child Sessions*
Enhancing Future Safety and Development

*works even if there is no parent or caregiver to participate in treatment.

Who is TF-CBT Designed to Best Benefit?

Indicated	Not Indicated

• Ages 3-17 (and adults);
• Who experienced at least one *remembered* physical abuse, sexual abuse, interpersonal violence, or natural disaster; and
• Who meet or do not meet post-traumatic stress disorder (PTSD) DSM 5-TR criteria
	• No Trauma history;
	• No significant mental health symptoms related to trauma event;
	• Severe cognitive disabilities or severe autism spectrum disorder; or
	• Issues with the following problems that need to be managed first:
	  ○ Safety
	  ○ Caregiver system
	  ○ Severe disruptive behavior problems
	  ○ Substance abuse

What Factors Should We Consider for Successful Care?

1. Age
2. Relationship to Responsible Person/Entity
3. Building Resilience
4. History of Mental Illness
5. Secondary Trauma Losses
6. Perceived & Cultural Meaning of Trauma
7. Prior Trauma
8. Race, Ethnicity, & Culture
9. Gender
10. Sexual Orientation & Gender Identity
11. Socioeconomic Factors
12. Time Since Traumatic Events

Factors Influencing Trauma Outcomes

1 | Age

- Traumatic stress signs differ across ages of children:
  - **Preschool Children** (e.g., nightmares)
  - **Elementary School Children** (e.g., hard time concentrating, stomach complaints)
  - **Middle and High School Children** (e.g., develop eating disorders; self harming behaviors)

2 | Relationship to Responsible Person/Entity

- Lower levels of parental distress about the child's trauma, and greater parental support, predict more positive outcomes after child trauma exposure whereas greater parental PTSD symptoms predicts more negative child outcomes

- Acknowledgement of parental/caregiver distress is why TF-CBT trains therapists to provide individual and conjoint sessions and help the whole family system heal together.

For a list of references, please see the reference slide in the appendix at the end of this deck.

Factors Influencing Trauma Outcomes (part 2)

3 | Building Resilience

- Although most children are resilient, trauma exposure is associated with increased risk for medical and mental health problems including Posttraumatic Stress Disorder (PTSD), depression, anxiety, substance abuse, and attempted and completed suicide
- Parents and children who practice TF-CBT skills together at home encourages the development of family resilience rituals that continue long after therapy ends.

4 | History of Mental Illness

- TF-CBT is superior to other treatments for improving PTSD, as well as other mental health conditions such as depressive, anxiety, behavioral, cognitive, relationship, and other challenges.

For a list of references, please see the reference slide in the appendix at the end of this deck.

Factors Influencing Trauma Outcomes (part 3)

5 | Secondary Trauma Losses

- Secondary trauma can be incurred when exposed to others who have been traumatized themselves. Symptoms are similar to those of PTSD.
- If unaddressed, the symptoms can result in problems with mental and physical health, strained personal relationships, and poor work/school performance

6 | Perceived & Cultural Meaning of Trauma

- Therapists need to practice from a position of cultural humility when working with diverse populations and support different cultural groups in their healing and treatment experience.
- There are cultural considerations that are critical to successfully delivering TFCBT and a lot of this work starts with one's own awareness of what they do and do not know about a person's cultural identity and how it is defined and described.

For a list of references, please see the reference slide in the appendix at the end of this deck.

Factors Influencing Trauma Outcomes (part 4)

7 | Prior Trauma

- It is important to think about prior traumas experienced by the individual and/or their family members and how these may have long term health effects.
  - For example, people who survived the sudden loss of a loved one and who also survived prior traumas such as a significant illness event, natural disaster, or incarcerated parent.

8 | Race, Ethnicity, & Culture

- The effects of trauma are shown to differ across ethnoracial and religious groups.
- TF-CBT has been modified to address the needs of diverse groups (e.g., Latino, Native American, deaf and hearing impaired, military and many international populations).

For a list of references, please see the reference slide in the appendix at the end of this deck.

Factors Influencing Trauma Outcomes (part 5)

9 | Gender

- Despite similar levels of childhood trauma, early life trauma in women was associated with cognitive disorganization, increased depression, anxiety and stress later in life, but no correlations were observed in men.
- As they age, women are more likely to report co-occurring internalizing disorders like anxiety and depression and men are more likely to reporting externalizing disorders, like substance abuse.

10 | Sexual Orientation & Gender Identity

- LGBTQ youth were found to experience more trauma, both in childhood and while homeless in adolescence, than their heterosexual peers.
- Trauma-Focused Cognitive Behavioral Therapy LGBTQ Implementation Manual addresses modifications to the TF-CBT model for LGBTQ youth who develop significant trauma symptoms.

For a list of references, please see the reference slide in the appendix at the end of this deck.

Factors Influencing Trauma Outcomes (part 6)

11 | Socioeconomic Factors

- Families with low SES report high levels of exposure to childhood trauma report high levels of exposure to childhood trauma and a good response to TF-CBT.
- It is important that therapists providing TF-CBT are mindful of the health-related social needs and resource factors that impact level of trauma exposure and resiliency.

12 | Time Since Traumatic Event

- With time and ongoing practice, adaptive cognitions become stronger and generalize to other situations, gradually replacing the maladaptive ones they initially had about the child's traumatic experience.
- TF-CBT is designed to be delivered over a series of sessions to create an environment for this level of healing, practice, and resiliency reinforcement to occur.

For a list of references, please see the reference slide in the appendix at the end of this deck.

Let’s Apply!

Based on the information shared about TF-CBT with diverse populations, what would be 3 unique aspects about the population you serve that you want to keep in mind when implementing TF-CBT?

What Clinical Environments Are Best for Optimal Outcomes?

TF-CBT has been used successfully in:

- Community based organizations,
- Detention facilities,
- Foster care,
- Schools (K-12),
- Group homes,
- Inpatient settings, and
- Outpatient settings.

Ready, Set, Go!

At the starting line…..

What are some commonly reported challenges/ organization readiness limitations you have heard about with implementing trauma-informed care?

Agency/Practice Implementation Readiness Steps (High Level):

1 Agency & Community Stakeholders

Administrative decision makers, clinical supervisors, direct service providers, staff from finance and medical information, parents/ consumers, childcare provision while parents attend sessions.

2 Organizational Readiness

Organizational Readiness and Capacity Assessment- helps your agency identify issues that are known to impact readiness for adoption of a new practice [1,2]

3 Pre-Implementation Training

Provide training to all appropriate stakeholders before attempting implementation (e.g., therapists, administrators, supervisors, intake coord)

4 Implementation

Provide training to all appropriate stakeholders before attempting implementation (e.g., therapists, administrators, supervisors, intake coord)

5 Sustaining the Practice

How can an agency sustain the practice of TF-CBT after the support phase is over?

10 Strategies for Successfully Implementing TF-CBT in Your Setting

1. Train multiple therapists in TF-CBT

2. Integrate trauma work into a clinician's caseload to ensure a mix of client needs

3. Identify a clinical supervisor to become TF-CBT trained and certified

4. Consider planning for more consultation calls than are required

5. Consider including Advanced TF-CBT Training as part of your implementation plan

10 Strategies for Successfully Implementing TF-CBT in Your Setting (continued)

6. Before selecting TF-CBT trainees, know the certification requirements

7. Make caregiver involvement an expectation, not an exception, when planning your implementation

8. If applying for a grant, consider budgeting therapist hours instead of salary

9. Budget for the time therapists will spend in training.

10. Be deliberate in planning support for your trauma therapists

10_Tips_TFCBT_Planning.pdf (psu.edu)

Our system wants to make sure that we are providing the best training in TF-CBT for our interventionists.

What TF-CBT training recommendations and resources are available?

Ideal TF-CBT Training Sequence

- ***First***, they should take the 11-learning module (TF-CBT***Web)*** Web-based course through https://tfcbt2.musc.edu/
- ***Second***, they should read the TF-CBT treatment manual, *Treating Trauma and Traumatic Grief in Children and Adolescents* (Cohen, Mannarino, & Deblinger, 2006, NY: Guilford Press)
- ***Third***, they should attend a 3-day initial training and 1-day booster of intensive skills-based training in the TF-CBT model
- ***Fourth***, and perhaps most important, they should secure ongoing consultation (12 group consultation calls) with a clinical supervisor or other expert in TF-CBT who can help apply the components of the model with fidelity in real-life cases.
- ***Fifth***, they should address the barriers and challenges around implementing TF-CBT. This means working collectively with supervisors, senior leaders, and clinicians in an ongoing manner during the adoption and implementation phase.

Where Can One Go for TF-CBT Training?

Training Resources for TF-CBT

- TF-CBT Official Website

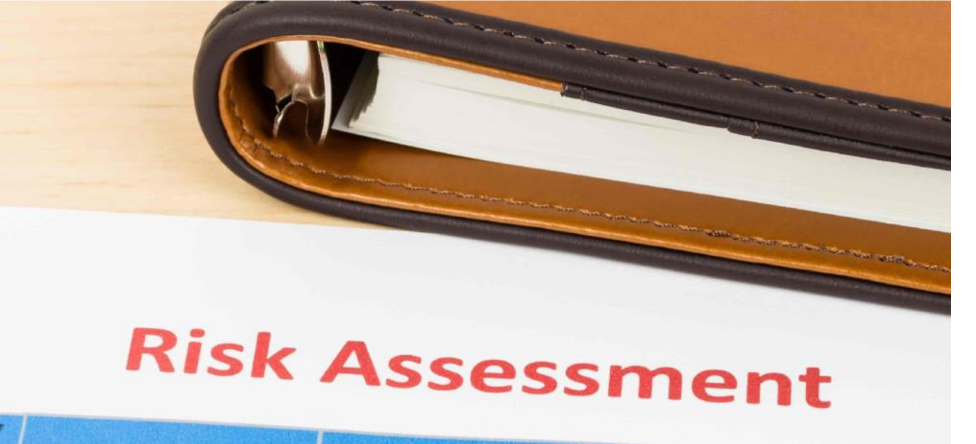
  TF-CBT Certification Program - Official Website (tfcbt.org)

- SAMHSA Website

  TFCBT-Web (musc.edu)

The agency has gone through the training steps and is ready to go!

How do we assess for those individuals who would benefit from TF-CBT?



Assessment Strategies

Take a few minutes to think about your practice/agency's standard intake process.

Are there standing assessments given universally to all clients at intake to screen for trauma?

If no, when is trauma is assessed and at what time points?

Are the screening tools available for different age groups, in multiple languages, and at appropriate reading levels for your population served?

What are the Best Practice Screening/Assessment Tools for Identifying Individuals Who Have Experienced Trauma?

- UCLA PTSD Reaction Index for DSM-5 for Children/Adolescents and Parents/Caregivers
- Children's Posttraumatic Symptom Scale is the child version of the Foa et al. (1997) Posttraumatic Diagnostic Scale (PTDS) for adults
- Clinician-Administered PTSD Scale for DSM-5–Child/Adolescent version (CAPS-CA-5; Pynoos et al., 2015)
- Child PTSD Symptom Scale—Interview version for DSM-5 (CPSS-5-I; Foa et al., 2018).
- Other commonly used evidence-based trauma tools for screening children/parents and adults (e.g., SCARED, CANS, Trauma Assessment for Adults)

*All may be useful for following PTSD symptoms but are not a replacement for a thorough clinical interview.

Assessing for Biological, Psychological, and Social Symptoms of Stress and Trauma

Biological

- E.g., Headaches, Digestive Symptoms

Psychological

- E.g., Panic Attacks, Difficulty Sleeping

Social

- E.g., Withdrawing, Dependent/Avoidant behaviors

Spiritual

- E.g., Increased or decreased sense of spiritual or religiosity

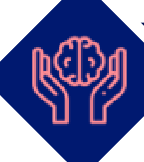
Exercise - How Does STRESS Show Up In You?

Biological

Headaches

Muscle Tension

GI Issues



Psychological

Negative thoughts

Change in sleep hygiene

Increase in eating

Social

Need to process with others

Isolate from others

Change friend groups

Other

Increased spirituality

Decreased spirituality

We have assessed for trauma and identified individuals in need of TF-CBT.

What interventions does TF-CBT use to promote positive clinical outcomes for those we serve?

Examples of Common TF-CBT Treatment Model

	Practice Components	Purpose
	Psychoeducation	normalize the child's and parent's responses to the traumatic event and helps to reinforce accurate cognitions about what occurred.
	Parenting skills	decrease unhealthy, ineffective, or unsafe discipline techniques and increase use of positive, effective, and safe discipline strategies for child behavior problems.
	Relaxation skills	reduce physiologic manifestations of fear, anxiety, stress and PTSD
	Affective modulation skills	help children and caregivers understand healthy vs. unhealthy or maladaptive forms of emotional expression
	Cognitive coping skills	identifying and altering cognitions that are leading to distressing feelings and behaviors and replace them with appropriate thoughts that will improve their functioning

Examples of Common TF-CBT Interventions

Intervention	Purpose
Trauma narrative	helps the child approach rather than avoid negative feelings associated with the traumatic events and reduce intensity of overwhelming negative emotions such as fear, anxiety, helplessness, guilt, and shame.
In vivo mastery of trauma reminders	help reduce and master fears and enable child to function appropriately around people, places, things, or activities that may be associated with abusive/traumatic events
Conjoint child-parent sessions	promote positive, healthy communication between caregivers and children about the traumatic events and the child's reactions
Enhancing safety and future developmental trajectory	identify points of potential danger and help build skills to keep safe in the future.

Stop and Reflect

- Which TF-CBT components are you most and least comfortable applying with your current level of training?
- What is an example of a Relaxation Skill that can help someone alter an unwanted stress response?
- What is an example of a Psychoeducation strategy that can help someone feel safe in unfamiliar surroundings?
- What are skills that parents can learn in the context of a Conjoint Child-Parent session that would facilitate open communication between them and their child(ren)?

We are actively providing TF-CBT in our setting.

How do we know that our interventionists are applying it with fidelity?

Fidelity Steps to Ensure Positive Outcomes

Avoiding the Drift

Regular training, supervision, consistent organizational expectations, and follow-up

Balancing Fidelity & Flexibility

Treatment is fluid, and components may overlap and be repeated.

Addressing Fidelity Issues with Novice & Experienced Therapists

Both face unique challenges

Meeting Fidelity Standards

Using it the way it was tested

Fidelity Measurement

Measuring for the extent to which the delivery adheres to the way the protocol or program was designed.

Fidelity Standard Criteria

The TF-CBT components must be implemented in the “PRACTICE” order unless there is a compelling reason to change the sequencing.

However, returning to a previously provided component to reinforce its use is permitted.

Each TF-CBT component must be implemented for each child

Unless there are clinical reasons for deleting a component; such as, there are no trauma triggers the child is avoiding, so in vivo mastery is not needed.

Progression from one component to the next must occur within a reasonable time period

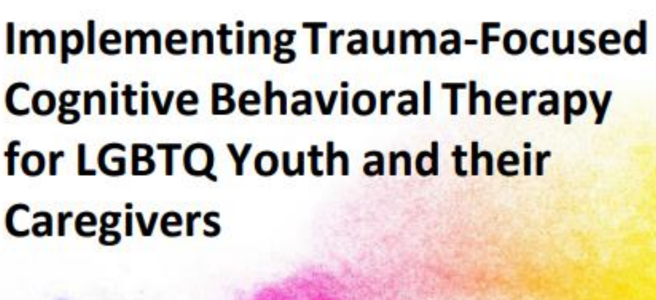
Treatment is completed within 12 to 16 sessions for usual cases, and 16 to 20 sessions for complex cases.

While we are getting good outcomes for some of our clients, our data is letting us know we need to do more for others.

What adaptations of TF-CBT are available for specific populations?

TF-CBT Treatment Adaptations

- LGBTQ Youth and Caregivers
- TF-CBT and Racial Socialization
- Youth with Developmental Disabilities (TF-CBT IDD) and their Caregivers
- TF-CBT for the Commercial Sexual Exploitation of Children (CSEC): An Implementation Manual
- Trauma-Focused Cognitive Behavioral Therapy for Military Families: An Implementation Manual
- Trauma-Focused Cognitive Therapy in Residential Treatment Facilities: An Implementation Manual



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Citation: Cohen, JA, Mannarino, AP, Wilson, K & Zinny, A (2018): Trauma-Focused Cognitive Behavioral Therapy LGBTQ Implementation Manual. Pittsburgh, PA: Allegheny Health Network.

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TF-CBT with LGBTQ Youth and Caregivers- TF-CBT Checklist Addendum

- A checklist developed to use in conjunction with the TF-CBT Brief Fidelity Checklist (Deblinger et al., 2014) when implementing TF-CBT for trauma-impacted LGBTQ youth.
- Prepared by Antonia Barba, LCSW, The Jewish Board
- Includes optional interventions for working with trauma-impacted LGBTQIA+ youth and their caregivers.

[Integrating TF-CBT and Racial Socialization for Black Youth and Families: An Implementation Manual]

Integrating Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Racial Socialization for Black Youth and Families: An Implementation Manual

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This manual was developed through funding from grant number SM 85068 from the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services (HHS), to Allegheny Singer Research Institute's Allegheny General Hospital Center for Traumatic Stress in Children & Adolescents.

Dr. Metzger is also supported by the Department of Health & Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention Grant #1H79SP082105-01.

Citation: Metzger, I, Dandridge, A, Cohen, JA, & Mannarino, AP (2023). Integrating Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Racial Socialization for Black Youth and Families: An Implementation Manual. Pittsburgh, PA: Allegheny Health Network.

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Manual addresses strategies for implementing an evidence-based trauma treatment for youth and families, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT, Cohen, Mannarino & Deblinger, 2012, 2017), for self-defined Black youth ages 3-17 years and their parents and/or other caregivers who experience racial-related stress or trauma as well as other types of significant trauma.

Tailoring Trauma-Focused Cognitive Behavioral Therapy for Youth with Developmental Disabilities (TF-CBT IDD) and their Caregivers.

This manual was prepared as part of the STRYDD Center (Supporting Trauma Recovery for Youth with Developmental Disabilities) funded by SAMHSA grant1H79SM05062-01

Tailoring Trauma-Focused Cognitive Behavioral Therapy for Youth with Developmental Disabilities (TF-CBT IDD) and their Caregivers

- Aids in tailoring each of the TF-CBT PRACTICE components according to the individual domains of the client's functioning.
- Offers recommendations around case complexity, common comorbidities, adjunctive treatments, etc.
- Supplemental resource guide to the manual is a living document that will be regularly updated.

TF-CBT FOR THE COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN (CSEC): AN IMPLEMENTATION MANUAL

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Citation: Kinnish, K., Cohen, JA., Mannarino, A., Kliethermes, M., Rubiales, R., & Wozniak, J. (2021). TF-CBT for the Commercial Sexual Exploitation of Children: An Implementation Manual. Pittsburgh PA: Allegheny General Hospital.

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TF-CBT for the Commercial Sexual Exploitation of Children (CSEC): An Implementation Manual

This manual addresses strategies for implementing an evidence-based trauma treatment, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) with children who have experienced Commercial Sexual Exploitation (CSE) and their caregivers to address the trauma-related impacts of CSE

Trauma-Focused Cognitive Behavioral Therapy for Military Families: An Implementation Manual

Judith A. Cohen, M.D.
Anthony P. Mannarino, Ph.D.
Stephen J. Cozza, M.D.

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Trauma-Focused Cognitive Behavioral Therapy for Military Families: An Implementation Manual

Provides information and resources on how TF-CBT can be applied most effectively and culturally competently for trauma-affected military children and families.

Trauma-Focused Cognitive Therapy in Residential Treatment Facilities: An Implementation Manual

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Anthony P. Mannarino, Ph.D.

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Center for Traumatic Stress in Children and Adolescents

September, 2013

© 2013 JA Cohen & AP Mannarino, all rights reserved. This implementation manual was prepared through funding from grant number 5U79 SM 054319-11, Child Abuse and Traumatic Loss Treatment Services Development Center from the Substance Abuse and Mental Health Services Administration (SAMHSA) as part of the National Child Traumatic Stress Network to Allegheny Singer Research Institute. We gratefully acknowledge the assistance, support and valuable contributions of the following individuals in developing this manual: Esther Deblinger, Ph.D., Malcolm Gordon, Ph.D., Janet Chassman, NY Office of Mental Health, Scott Talley, PA Department of Mental Health, David Chambers, Ph.D., National Institute of Mental Health (NIMH), Daniela Navarro, MA, LPC, LCDC; and all of the therapists and supervisors who participated in TF-CBT RTF implementation consultation calls.

Trauma-Focused CBT in Residential Treatment Facilities: An Implementation Manual

This implementation manual focuses specifically on direct milieu staff, but similar considerations apply to other RTF staff members (e.g., teachers) who have regular interactions with residents in the RTF milieu

Trauma-Focused Cognitive Behavioral Therapy for Children in Foster Care: An Implementation Manual

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Melissa K. Runyon, Ph.D.
Elisabeth Pollio, Ph.D.
Judith Cohen, M.D.

Preparation of this manual was supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) National Child Traumatic Stress Initiative (NCTSI) Grant #54319 to Allegheny Singer Research Institute. Staff members from NCTSN sites who offer services to children and their caregivers in the foster care system participated in a series of calls to generate important topics to consider when offering TF-CBT to the foster care population.
The authors gratefully acknowledge the valuable contributions of the following participating NCTSN Community Treatment (Category III) Centers:

Family Services of Rhode Island, Providence, RI
Kempe Center, Denver, CO
Mt. Hope Family Center, Rochester, NY
The Children's Center, Salt Lake City, UT
University of Kentucky, Lexington, KY
University of Massachusetts, Worcester, MA

TF-CBT for Children in Foster Care: An Implementation Manual

Manual offers guidance to clinicians and supervisors on adapting TF-CBT to optimally address the unique circumstances of children in foster placement settings.

Now that we are serving the needs of our diverse population.

What factors do we need to keep in mind for sustainability?

Sustainability Factors for TF-CBT

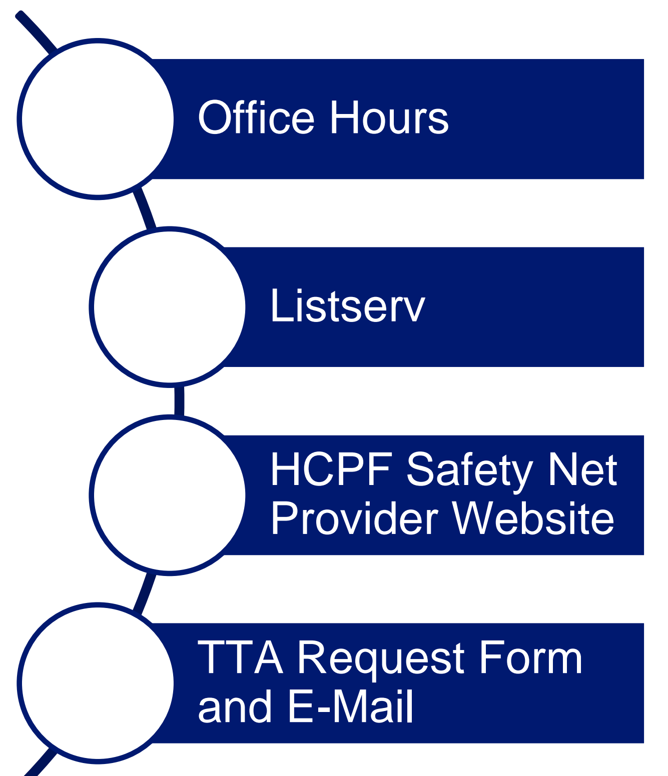
- Consistent referral base and protocol
- Trained therapists and retention plan
- Support from agency administrators
- Ability to demonstrate outcomes
- Source of on-going funding

Can you think of any others your setting would need for sustainability?

To better inform our future trainings and request topics for office hours, please complete this short survey. Use the QR code or short URL to access it. Your feedback is important. Thank you!

https://bit.ly/bhprovidertrainingsurvey

Appendix A: Additional Resources



Office Hours are offered on the last Friday of every month (through September 2024) at noon MT! Please visit the HCPF Safety Net Landing Page for details & registration information.

Join the Listserv to receive notifications of trainings, technical assistance, and other stakeholder engagement opportunities: Register Here

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Request TTA support or share your ideas, questions and concerns about this effort using the TTA Request Form or e-mail questions and comments to: info@safetynetproviders.com

Appendix B: References

Assari, S. (2020). Family socioeconomic status and exposure to childhood trauma: Racial differences. *Children*, *7*(6), 57. https://doi.org/10.3390/children7060057

Brivio, E., Lopez, J. P., & Chen, A. (2020). Sex differences: Transcriptional signatures of stress exposure in male and female brains. *Genes, brain and behavior*, *19*(3), e12643.

Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network. (2004). How to implement trauma-focused cognitive behavioral therapy.

Chipalo, E. (2021). Is trauma focused-cognitive behavioral therapy (TF-CBT) effective in reducing trauma symptoms among traumatized refugee children? A systematic review. *Journal of child & adolescent trauma*, *14*(4), 545-558.

Cohen, J. A., & Mannarino, A. P. (2015). Trauma-focused cognitive behavior therapy for traumatized children and families. *Child and Adolescent Psychiatric Clinics*, *24*(3), 557-570.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2012, April 1). *Trauma Focused Cognitive Behavioral Therapy Fact Sheet*. Retrieved April 6, 2024, from https://www.nctsn.org/sites/default/files/interventions/tfcbt_fact_sheet.pdfCohen, J. A., Mannarino, A. P., & Deblinger, E. (2016). *Treating trauma and traumatic grief in children and adolescents*. Guilford Publications.

Craske, M. G., Kircanski, K., Zelikowsky, M., Mystkowski, J., Chowdhury, N., & Baker, A. (2008). Optimizing inhibitory learning during exposure therapy. *Behaviour research and therapy*, *46*(1), 5-27.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*, *14*(4), 245-258.

Hodes, G. E., & Epperson, C. N. (2019). Sex differences in vulnerability and resilience to stress across the life span. *Biological psychiatry*, *86*(6), 421-432.

Mock, S. E., & Arai, S. M. (2011). Childhood trauma and chronic illness in adulthood: mental health and socioeconomic status as explanatory factors and buffers. *Frontiers in psychology*, *1*, 2184.

Pine, D. S., & Cohen, J. A. (2002). Trauma in children and adolescents: Risk and treatment of psychiatric sequelae. *Biological psychiatry*, *51*(7), 519-531.

Smidt, A. M., & Platt, M. G. (2018). Sexuality and trauma: Intersections between sexual orientation, sexual functioning, and sexual health and traumatic events. *Journal of trauma & dissociation*, *19*(4), 399-402.

Thielemann, J. F. B., Kasparik, B., König, J., Unterhitzenberger, J., & Rosner, R. (2022). A systematic review and meta-analysis of trauma-focused cognitive behavioral therapy for children and adolescents. *Child Abuse & Neglect*, *134*, 105899.

Thomas, E. H., Rossell, S. L., & Gurvich, C. (2022). Gender differences in the correlations between childhood trauma, schizotypy and negative emotions in non-clinical individuals. *Brain Sciences*, *12*(2), 186.

Tomfohr, L. M., Pung, M. A., & Dimsdale, J. E. (2016). Mediators of the relationship between race and allostatic load in African and White Americans. *Health Psychology*, *35*(4), 322.

Vogt, D. (2023, February 2). *Research on Women, Trauma and PTSD*. U.S. Department of Veterans Affairs. Retrieved April 6, 2024, from https://www.ptsd.va.gov/professional/treat/specific/ptsd_research_women.asp

Additional Resources

Source	Description	Link
Understanding PTSD and Aging	Written for older adults who have or think they may have PTSD, as well as people diagnosed with PTSD with reoccurring/changing symptoms.	https://www.ptsd.va.gov/publications/print/understandingptsd_aging_booklet.pdf
Resource Guide to Trauma-Informed Human Services	The Administration for Children and Families, the Substance Abuse and Mental Health Services Administrations, the Administration for Community Living, the Offices of the Assistant Secretary for Health, and the Assistant Secretary for Planning and Evaluation at HHS have worked together to develop this Guide to Trauma-Informed Human Services. The guide is intended to introduce the topic of trauma, a discussion of why understanding and addressing trauma is important for human services programs, and a "road map" to find relevant resources	https://www.acf.hhs.gov/toolkit/resource-guide-trauma-informed-human-services
Association for Autism and Neurodiversity	Offers mental health clinicians' resources to gain more competence in working with individuals with ASD and neurodiversity, as well as their intersectional identities	AANE Homepage - AANE
The National Child Traumatic Stress Network	Created by Congress in 2000 as part of the Children's Health Act to raise the standard of care and increase access to services for children and families who experience or witness traumatic events.	The National Child Traumatic Stress Network | (nctsn.org)