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Pepperdine University
Graduate School of Education and Psychology

DEVELOPING A SUPPLEMENTAL RESOURCE FOR TRAUMA-FOCUSED COGNITIVE-
BEHAVIORAL THERAPISTS WORKING WITH BLACK AMERICAN ADOLESCENTS

A clinical dissertation presented in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

Anthea A. Gray

December, 2017

Thema Bryant-Davis, Ph.D.—Dissertation Chairperson

This clinical dissertation, written by

Anthea A. Gray

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirement of the degree of

DOCTOR OF PSYCHOLOGY

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TABLE OF CONTENTS

LIST OF TABLES	vi
DEDICATION	vii
ACKNOWLEDGEMENTS	viii
VITA	ix
ABSTRACT	xi
INTRODUCTION	1
Prevalence Rates and Effects of Trauma Among Children and Adolescents	3
Trauma Focused-Cognitive Behavioral Therapy	4
Efficacy of TF-CBT In Treating Traumatic Stress Among Children and Adolescents	6
Adaptation and Modification of Evidence-Based Treatments	9
A Rationale for Developing Culturally Sensitive Treatments Specific to BA Youth	13
METHODOLOGY	19
Rationale for This Project	20
Resource Development	22
Evaluation of the Resource Manual	24
RESULTS	26
Summary of the Results	26
DISCUSSION	37
Strengths of the Resource	37
Weaknesses of the Resource	38
Limitations and Future Directions	38
REFERENCES	41
APPENDIX A: Summary Table of Selected Literature	52
APPENDIX B: Email to Recruit Expert Reviewer	99
APPENDIX C: Qualification Form for Expert Reviewer	102
APPENDIX D: Informed Consent Form	104

APPENDIX E: Evaluation Form	109
APPENDIX F: Supplemental Resource Manual	114
APPENDIX G: IRB Approval Letter	210

LIST OF TABLES

	Page
Table 1. Evaluators' Characteristics	27
Table 2. Feedback on Recommendations (Question 1)	27
Table 3. Feedback on Recommendations (Question 2)	27
Table 4. Feedback on Recommendations (Question 3)	28
Table 5. Feedback on Recommendations (Question 4)	29
Table 6. Feedback on Recommendations (Question 5a)	29
Table 7. Specific Feedback on Recommendations (Question 5b)	30
Table 8. Specific Feedback on Recommendations (Question 5c)	31
Table 9. Specific Feedback on Recommendations (Question 5d)	31
Table 10. Specific Feedback on Recommendations (Question 5e)	32
Table 11. Specific Feedback on Recommendations (Question 5f)	32
Table 12. Specific Feedback on Recommendations (Question 5g)	33
Table 13. Specific Feedback on Recommendations (Question 5h)	34
Table 14. Specific Feedback on Recommendations (Question 5i)	34
Table 15. Specific Feedback on Recommendations (Question 6)	35
Table 16. Specific Feedback on Recommendations (Question 7)	36

DEDICATION

To my dearest mother – And still, you rise. You are the epitome of resiliency, beauty, and intelligence. I owe all that I have and ever will be to your love and unconditional support.

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To my Papa – It is from you that I learned persistence in the face of adversity, an appreciation and curiosity for cultural difference and acceptance, and giving to those less fortunate than myself. You once told me that I could do anything that I put my mind to when I was a little girl and you know what, “You were right.” Proud to be a Gray girl and your Baby girl.

To my Dad – You have taught me the true meaning of compassion. I am so grateful to have you in my life and feel so thankful to have your love and support.

To my brother – You will always be my Buddy.

To my ancestors – Your sacrifices were not in vain. With the essence of your souls behind me: we’re stand here together.

To my dissertation chair, Dr. Thema Bryant-Davis – I am so grateful for your encouragement throughout the years. Your passion for scholarship, energy, and vigor for life has inspired me to keep reaching for the stars. I am so thankful to have been under your wing.

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To my committee member, Dr. Leslie Ross – Thank you so much for your time, feedback, patience, and support during this process.

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ABSTRACT

The prevalence of trauma for Black American youth is disproportionate to other cultural groups. Child and adolescent exposure to interpersonal trauma has been found to increase the risk for both immediate and long-term mental health impairment. Research of childhood trauma has made clear the adverse effects of childhood trauma, and its' lifelong impact in domains of psychological, interpersonal, and cognitive functioning. Trauma-Focused CBT (TF-CBT) is an evidence-based treatment that has repeatedly proven to be efficacious in the treatment of childhood trauma. By offering culturally mindful recommendations for treatment, this dissertation lends a potentially useful supplement to providers utilizing TF-CBT with Black American adolescents.

Introduction

The figures of trauma occurring within child and adolescent youth are alarming. Child and adolescent exposure to interpersonal trauma has been found to increase the risk for both immediate and long-term mental health impairment. Research of childhood trauma has made clear the adverse effects of childhood trauma, and its' lifelong impact in domains of psychological, interpersonal, and cognitive functioning. Trauma-Focused CBT (TF-CBT) is an evidence-based treatment that has repeatedly proven to be efficacious in the treatment of childhood trauma. Trauma-Focused CBT has been used successfully amongst traumatized children and families. Although several evidence-based treatments have been utilized in treatment of childhood trauma, TF-CBT has been found to successfully treat children and families experiencing ongoing trauma. A breadth of empirical data demonstrates TF-CBT's effectiveness with trauma-related outcomes amongst youth. It should be noted, however, that the majority of the identified and well-researched evidence-based treatments for youth have been primarily developed and applied to homogeneous samples of majority group families. This being said, further exploration is warranted to determine if cultural modifications of TF-CBT can be utilized to enhance utility amongst specific cultural groups or minority populations. Research has exemplified the potential efficacy of TF-CBT in multicultural settings, when culturally congruent modifications occur. More specifically, culturally adapted TF-CBT has proven applicable with complex trauma, and has shown positive treatment outcomes when implemented by trained individuals of the health and mental health professions. Culturally modified TF-CBT could potentially serve to foster the preexisting literature and strong empirical support that credits TF- CBT for its efficacy in increasing the overall mental health of children affected by interpersonal trauma.

Objectives. The basis for this dissertation is underscored by four guiding objectives: (a) develop an understanding and conduct an exploration of the current trauma literature related to

Black American youth. More specifically, to understand the prevalence rates, sequelae, and common forms of treatment of interpersonal trauma within this particular minority population; (b) establish a comprehensive understanding of trauma-focused cognitive behavioral therapy (TF-CBT); (c) utilize the knowledge of TF-CBT and Black Americans to enhance the TF-CBT model through the development of culturally modified recommendations for clinicians working with Black youth; and (d) strengthen the culturally modified recommendations with the evaluation of experts in each of the following fields: interpersonal trauma, TF-CBT, child and adolescence, and Black American issues.

African American. Black. Race? In contemporary literary discourse, the term Black American is often used to describe individuals of full or partial African descent that were brought to the United States through the slave trade. Though the reasons for its popularization (e.g., cultural affirmation, recognition of origin, political correctness), this author uses the term Black throughout this dissertation. In some circles, the term “Black” is reserved for individuals of African descent that have non-American nationalities (e.g., Caribbean, Cuba, etc.). It is in this authors opinion that the efforts to deconstruct and reassemble the meaning of the term Black are counterproductive. The term “Black” was popularized in a time of change and forward movement. For the first time in United States history, Americans of African descent self-selected an identifying term that could be uttered without shame. The term Black embodies the experience of many, non-indigenous American experiences, who came to a new country and overcame/continue to overcome hardships with resilience. Additionally, the term Black carries African *and* American heritage and pride. Though some might consider the term too political, the concept of race is political, as it is a manmade construct that has been used historically to dehumanize cultural groups. The term race is fluid with no biological underpinnings, though it

has been presented as such over the course of history – the consequences of such have been catastrophic and served as the basis for many genocides and biases. Continued utilization of the term race gives credence to the proposition that race is a biological term. As a result, this author replaces the term race with culture, which represents the language, customs, and traditions of a group of people. It is important to remember that this author's opinion is just that – an opinion. When working with clients of African descent, it will be important to ask how they identify, as Black American culture is not a homogenous group. This dissertation and cultural modification of TF-CBT was developed with youth that primarily or partially identify with Black American culture.

Prevalence Rates and Effects of Trauma Among Children and Adolescents

Exposure to interpersonal trauma, community violence, and culturally motivated injustices and microaggressions have been correlated with both immediate and long-term mental health impairment (Cloitre et al., 2009; D'Andrea, Ford, Stolback, Spinazzola, & Van, 2012; Margolin & Vickerman, 2007). More specifically, childhood traumas are associated with social, psychological, cognitive, and biological challenges (Cloitre et al., 2009; D'Andrea, et al., 2012; Margolin & Vickerman, 2007). It has been noted that 65% (Copeland, Keeler, Angold, & Costello (2007) of children will experience at least one traumatic event before adulthood and of the aforementioned percentage, at least 50% will have encountered multiple traumatic experiences (Fitzgerald & Cohen, 2011). This sizable and significant portion of the child population affected by trauma demonstrates the need for an effective treatment. If left untreated, about one-third of children will experience symptoms of PTSD (Copeland et al., 2007) and others may exhibit affective (e.g. labile mood, sadness, fear, anxiety), behavioral (e.g., avoidant behaviors, sexually inappropriate behavior, school problems, abuse towards others), and or

cognitive difficulties (e.g., self-blame, guilt, low self-concept, shame; Cohen & Mannarino, 2008). The psychological and physical effects experienced by the trauma survivor might also carry into adulthood. Researchers (American Academy of Child and Adolescent Psychiatry, 2010; Felitti, et al., 1998) have found that children with PTSD are not only susceptible to particular psychiatric (i.e., depression, anxiety disorders, substance use) and medical problems, but could also encounter the possibility of interruptions to healthy childhood development.

Further illustrating the profound effects of traumatic stressors experienced in childhood are the results within the Center for Disease Control (CDC)-Kaiser Adverse Childhood Experiences (ACEs) Study (Felitti et al., 1998), a large-scale, longitudinal study that compared the effects of potentially traumatic events (i.e., psychological, physical, or sexual abuse; violence against mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned) with adult risk behaviors, health outcomes, and disease. Of the 9,508 respondents, over 50% reported at least one adverse childhood experience and 25% reported two or more adverse childhood experiences (Felitti et al., 1998). Felitti and colleagues (1998) also found a graded relationship between the number of ACEs and behavioral health risk factors and behaviors (e.g., substance abuse, number of sexual activity partners, low physical activity), health risk factors (e.g., obesity), and disease (e.g., STDs, ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease).

Trauma Focused-Cognitive Behavioral Therapy

TF-CBT is an evidenced based treatment (EBT) for children and adolescents, 3 to 18 years old, (Cohen, Mannarino, & Deblinger, 2006, 2016) that are experiencing trauma related psychological and behavioral symptoms in response to being witness or victim to a potentially traumatic event, such as interpersonal traumas (e.g., sexual abuse, physical abuse, emotional

abuse, neglect, domestic violence), community violence, natural and man-made disasters, grief in response to a traumatic personal loss, war, accidents, and medical treatment/issues (Cohen et al., 2006, 2016). These events can distal or ongoing (Cohen et al., 2006, 2016; Murray, Cohen, & Mannarino, 2013). Supported by a wide array of empirical data, the utility and efficacy of TF-CBT is evidenced across a host of studies that utilize this treatment modality to manage the sequelae of childhood trauma (Cohen et al., 2006, 2016; Murray, Cohen, & Mannarino, 2013). Characterized by its cognitive, behavioral, and exposure techniques, the module-based treatment model delivers psychoeducation and interventions to the youth and their caregiver to ameliorate psychological symptoms, maladaptive cognitions (e.g., shame, guilt) and behavioral issues that are causing personal and familial stress and disruption to the youth/family's overall wellbeing. TF-CBT is further noted for its accessibility (i.e., requires minimal resources to practice), flexibility, and time-limited protocol (i.e., between 12-25 weeks depending on the youth's needs) (Cohen et al., 2006, 2016; Murray, Cohen, & Mannarino, 2013).

TF-CBT is comprised of ten individual treatment components, summarized by the acronym *PRACTICE*, and include: Psychoeducation, Parenting Skills, Relaxation Skills, Affective Expression and Modulation Skills, Cognitive Coping, Trauma Narrative, In-vivo Exposure and Mastery of Trauma Reminders, Conjoint Parent Sessions, and Enhancing Safety and Future Developmental Trajectory. Gradual exposure is one of the key principles guiding TF-CBT, and is included in all components comprising the model, as a way to teach children skills they can use when trauma reminders or cues arise, both inside and outside of treatment. The graded exposure to the child's traumatic experience within a hierarchical, skills acquisition framework (i.e., mastery of one component points to the child's readiness for the following component; Cohen et al., 2006) is an essential component of this treatment model. This skill-

acquisition based model is designed so that the child's mastery of one-component points to the child's readiness for the component that follows. The developmentally sensitive approach of TF-CBT ensures that children learn coping strategies early on, to help them adaptively manage their trauma related-distress. The exposure component of TF-CBT (e.g., trauma narrative) allows the child to create their own story or narrative of their experienced trauma. A variety of exposure exercises encourage the gradual exposure to trauma reminders and cues, so as to teach the child appropriate ways to manage and control their emotional reactions. Following the completion of the trauma narrative, clients work with the therapist to identify, challenge, and replace cognitive distortions and beliefs. Parent involvement is central to TF-CBT, and has been identified to be an integral part of the model. Parental engagement in treatment is a central focus of TF-CBT, given that it serves to improve parenting skills and parental support of the child, and enhances parent-child communication, which have all been found to be directly related to treatment outcomes in traumatized youth.

Efficacy of TF-CBT in Treating Traumatic Stress Among Children and Adolescents

Additionally, it has been recognized as the most empirically supported and effective treatment for trauma survivors (Fitzgerald & Cohen, 2012). In a systematic review of TF-CBT, Cary and McMillen (2012) take notice of a number of organizations, which have recognized TF-CBT as a highly effective treatment. Those recognizing the value of TF-CBT include the U.S. Department of Justice (Saunders, Berliner, & Hanson, 2002), which found TF-CBT to be the greatest treatment in a comparison of 24 interventions, the Kauffman Best Practices Project (2004), which regarded TF-CBT as the "best practice" for child abuse treatment, the California Evidence Based Clearinghouse for Child Welfare (2011), which gave TF-CBT the highest rating of efficacy, and the National Registry of Evidence-Based Programs and Practices, a sector of the

US Department of Health and Human Services (SAMHSA, 2008), which issued TF-CBT a 3.6-3.8 out of 4.0 points on ability to treat PTSD, depression, and behavioral problems and 3.6 out of 4.0 on its quality of research rating (Cary & McMillen, 2012).

Further exemplifying the efficacy of the trauma-centered therapy are randomized controlled trials (RCT; Cohen & Mannarino, 1996; Cohen & Mannarino, 1998; Cohen, Mannarino, Perel, & Staron, 2007; Deblinger, Lippmann, & Steer, 1996; Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011; Deblinger, Stauffer, & Steer, 2001; King et al., 2000) which are predominantly marked by child and adolescent sexual abuse survivors with PTSD symptoms (Fitzgerald & Cohen, 2012). However, the TF-CBT RCTs have not been restricted to the previously mentioned trend in subject focus. Cohen, Deblinger, Mannarino, & Steer (2004) conducted a study that found TF-CBT to be highly efficacious in its application with youth traumatized by more than one event. Also, in a study measuring the efficacy of TF-CBT when applied to children who have witnessed/are currently witnessing intimate partner violence, a modified TF-CBT, which focused on the installation of safety, was responsible for reducing the severity of PTSD (i.e., hyperarousal and avoidance) and anxiety related symptoms when carried out by community therapists in a domestic violence center (Cohen, Mannarino, & Iyengar, 2011).

The significance of the previously mentioned RCTs is powerful. In a relatively short amount of time (8-16 sessions & 1-1.75hrs per session), a significant portion of a child's trauma related symptomatology (i.e., affective, cognitive, & behavioral) can be alleviated (Cohen et al., 2004; Cohen & Mannarino, 1996, 1998a; Cohen et al., 2011; Deblinger, et al., 1996;). When compared to other treatment models geared towards the reduction in mental health disturbances related to trauma, such as nondirective, supportive therapies, and child-centered therapies

(CCTs), a waitlist control (King et al., 2000), and a community control condition (Cohen et al., 2011; Deblinger et al., 1996) the efficacy of TF-CBT was superior (Fitzgerald & Cohen, 2012). Based on the findings of Deblinger, Mannarino, Cohen, & Steer (2006), TF-CBT has also been found to be more efficacious than Child-centered therapy (CCT) in treating severe cases of child trauma, which are marked by prominent features of depression and PTSD symptoms and multiple traumatizing encounters (Deblinger et al., 2006). It is important to mention that though TF-CBT surpassed comparison interventions such as attention control, standard community care, and waitlist control conditions during respective studies, those children who had the three aforementioned comparison treatments showed effects similar to the TF-CBT treatment groups when reassessed twelve months later (Cary & McMillen, 2011). More specifically, those studies with a twelve month follow up found that the TF-CBT treatment groups attained faster relief from depression and behavioral difficulties than the control groups; however the comparison groups eventually caught up to the TF-CBT by the twelve-month follow up (Cohen et al., 2004; Cohen, Mannarino, & Knudsen, 2005; Deblinger et al., 1996; Deblinger et al., 2006; Deblinger, Steer, & Lippmann, 1999). TF-CBT was also found to contribute to the reduction in feelings of shame; a change, which proved to be long lasting at a one year, follow-up (Deblinger et al., 2006).

Complex trauma. It is not uncommon for trauma survivors to endure multiple traumas (e.g., maltreatment, neglect, witnessing domestic violence, sexual abuse, physical abuse) (Copeland et al., 2007) and can greatly affect a child's ability to develop secure attachments, a positive self-concept, and self-regulate affectively, biologically, and behaviorally (Cook et al., 2005). Despite the prevalence of multiple traumas in children, randomized controlled trials (RCTs) ordinarily focus on a singular type of trauma, such as physical or sexual abuse, which

has contributed to the widespread belief that evidence-based treatments (EBTs) are not applicable to children and adolescents who experience complex trauma (Cohen, Mannarino, Kliethermes, Murray, 2012). TF-CBT lends strong evidence to the contrary. In fact, the flexible, as well as structured and tiered components of TF-CBT make it highly sensitive and adaptive to the needs of children who experience complex trauma.

Evidence Based Practices versus Evidence Based Treatments

Though the terms evidence based practice (EBP) and evidenced based treatments (EST/EBTs) are often used interchangeably, there exists a distinct difference. An Evidence-Based Practice (EBP) is defined as the integration and implementation of the best available research and clinical knowledge as those two variables relate to a client's individual characteristics, culture, and preferences (APA, 2005). By contrast, Evidence-Supported Treatments/Evidence-Based Treatments (EST/EBTs) require (1) empirically validated support from two or more experimental studies that are not published by the creators of the treatment and be manualized (Task Force on the Promotion and Dissemination of Psychological Procedures, 1995).

Opposition to manualized interventions rests upon the primary argument that raises concern of applying a one-size-fits-all approach to treatment (Addis, Cardemil, Duncan, & Miller, 2006; Westen, Novotny, & Thomspon-Brenner, 2004). In an effort to address this concern, a reasonable degree of flexibility that would not compromise the fidelity of the respective EBT is suggested (Kendall and Beidas, 2007). Given TF-CBT's manualized protocol and supportive RCTs illustrating its efficacy, the Cohen and colleague's (2006, 2012) treatment is an empirically supported treatment.

Adaptation and Modification of Evidence-Based Treatments

EBTs. Cultural competence – isn't that what *all* clinicians strive for in their overall practice of assessment, research, and intervention? Though a guiding principle advocated by the American Psychological Association (APA, 2003) and other researchers (e.g., APA, 2003; Bernal, Bonilla, & Bellido, 1995; Cardemil, 2010; de Arellano, Ko, Danielson, & Sprague, 2008) through a variety of medium including multicultural education, training, research, clinical practice, and organizational practice, the utilization of culturally mindful practice is not always exercised for a number of reasons, which might include a misunderstanding or the definition of cultural competence, clinician's biases (Harrell & Rowe, 2014), the clinician's lack of understanding and awareness of different cultures, and or basing practices on published EBTs that lack ecological validity.

Cultural adaptation of EBTs. Fostered by the burgeoning awareness and guidelines for culturally competent research and practice, studies that examine the efficacy of treatments with ethnic minorities and culturally adapted interventions appears to be on the rise. Griner and Smith (2006) found moderately significant outcomes ($d = 0.45$) across a review of 76 culturally adapted interventions; of note, the authors' review found inconsistent articulation and specification of the cultural adaptations utilized in these modified treatments. Added support for EBTs was also found in a meta-analysis that found 67% of individuals of color reported symptom reduction. (Huey & Polo, 2008). Though these treatment effects of medium magnitude ($d = 0.44$) suggest beneficial utility with minority youth, Huey and Polo (2008) acknowledge the potential lack of generalizability due to the low statistical power and small sample size.

Researchers have noted numerous strategies to develop cultural adaptations. In an effort to assess the various ways in which a client may self-identify, Hays (2001) suggests using the *ADDRESSING* acronym: age, generational influences, developmental or acquired disabilities,

religion and spiritual orientation, ethnicity, socioeconomic status, sexual orientation, indigenous heritage, national origin, and gender. Bernal et al. (1995) suggest using eight guiding principles to inform cultural adaptations: language, persons, metaphors, content, concepts, goals, methods, and context to identify areas for adaptation. Hwang's (2006) framework for psychotherapy and adaptation is a multitiered approach that specifies an acute awareness and assessment of the various ways in which culture feeds into the mental health framework by examining the following variables: (a) the prevalence of mental health concerns; (b) etiology of disease; (c) the experience and consciousness of distress within a cultural group; (d) diagnostic and assessment issues and potential barriers; (e) common coping tools, styles, and sources of support; and (f) clinical intervention and treatment issues. The first framework, the cultural influences on mental health model, was developed to identify salient domains that culture influences (Hwang, 2006). Culture is posited to affect different domains including (a) the prevalence of mental illness, (b) etiology of disease, (c) phenomenology of distress, (d) diagnostic and assessment issues, (e) coping styles and help-seeking pathways, and (f) treatment and intervention issues. Hwang's (2006) model further identifies general domains for adaptations that include: (a) understanding dynamic issues and cultural complexities; (b) orienting clients to psychotherapy and increasing mental health awareness; (c) understanding cultural beliefs about mental illness, its causes, and what constitutes appropriate treatment; (d) improving the client-therapist relationship; (e) understanding cultural differences in the expression and communication of distress, and (f) addressing cultural issues specific to the population.

Cultural modifications of TF-CBT. Integrating traditional Latino values (e.g., spirituality/religiosity, gender roles, beliefs surrounding sexuality, approaches to raising children, personal and warm interactions with the therapist, and treatment engagement by individuals

outside of the family of origin) into the TF-CBT framework and treatment, authors adapted the model for members of the Latino community (de Arellano, Danielson, & Felton, 2012).

Utilizing the seminal model's ingrained flexibility, CM TF-CBT allows clinicians to adjust their treatment approach based on the youth and their family's individual needs, as well as level of acculturation and language preference.

In another example of culturally modified TF-CBT, O'Callaghan, McMullen, Shannon, Rafferty, & Black (2013) conducted a RCT in the Democratic Republic of Congo (DRC) which utilized TF-CBT amongst a group of girls who were afflicted by multiple traumas instigated by the DRC's civil war. O'Callaghan et al. (2013) integrated modifications congruent to the Congolese way of life to make TF-CBT more culturally adaptive. Cultural modifications featured in the study (O'Callaghan et al., 2013) included sexual violence prevention education disseminated by female administrators, well known Congolese stories, songs, and references, Swahili (the country's primary, national language) translation, and an effort to rebuild and reintegrate sexual trauma survivors – who are often ostracized because of the common stigma associated with sexual assault in Congolese culture - back into their families and communities. TF-CBT was used collectively in a group format and was found to reduce or maintain symptoms of depression, anxiety, and pro-social behavior (O'Callaghan et al., 2012). The study's authors (O'Callaghan et al., 2012) ruled out confounding variables, such as vocational training or the natural progression of time, by including a control group which was administered vocational training as a stand-alone treatment and they did not show any improvement in symptom reduction. O'Callaghan and colleagues' (2012) study exemplifies the potential efficacy TF-CBT in multicultural settings, when culturally congruent modifications occur, its applicability with complex trauma, and the efficacy when implemented by trained

individuals outside of the health and mental professions. Further research would only foster the preexisting literature and strong empirical support that credits TF-CBT for its efficacy in increasing the overall mental health of children affected by trauma.

Afrocentric approaches to treatment. Though not considered an evidenced based treatment, proponents of an Afrocentric paradigm suggest two general issues associated with modification of ESTs or making informal, culturally competent addendum to theoretical orientations and practices: (1) Many ESTs are grounded in Eurocentric theory that the individual is a singular entity, as opposed to a part of a greater whole (Stewart, 2004) and (2) Eurocentric models are adapted to address presenting issues from a Eurocentric perspective, as opposed to utilizing Black American worldviews (Stewart, 2004). Though there are various types of Afrocentric therapies, the general goals within many of them is to create a sense of oneness and connectedness between the individual, family, and community; acknowledge and fight multi-tiered variables of oppression; use a strengths-based approach to treatment; integrate culturally congruent practices; and conceptualize clients as equal collaborators versus the recipient of services (Stewart, 2004). infused with traditional Black American tenants and values, such as resilience, faith, family and social support, and hope (Azibo, 1992; Jackson & Sears, 1992).

A Rationale for Developing Culturally Sensitive Treatments Specific to BA Youth

Prevalence. In 2011, the rate of child maltreatment reports to Child Protective Services (CPS) within the United States (U.S.) was highest amongst Black American children (14.3% per 1,000 children of the same race or ethnic group; U.S. Department of Health and Human Services, 2012) [1]. Additionally, 28.2% of child fatalities were Black American victims of abuse or neglect (U.S. Department of Health and Human Services, 2012). Though the Child Maltreatment Report (U.S. Department of Health and Human Services, 2012) did not specify the

types of abuse and neglect that occurred within each racial and ethnic group, the Fourth National Incidence of Child Abuse and Neglect (NIS-4): Report to Congress, Executive Summary found that within the Harm Standard and Endangerment Standard constructs, Black children had higher rates of overall maltreatment, overall abuse and physical abuse, as well as overall neglect in comparison to White and Hispanic children. Further, Black victims also experienced greater rates within components of the Harm Standard: sexual abuse (Finkelhor & Dzuiba-Leatherman, 1994; Sedlak et al., 2010) and inferred maltreatment (Sedlak et al., 2010). Rates compared to White and Hispanic children were also greater for Black children in modules of the Endangerment Standard: physical neglect, emotional maltreatment, and endangerment with no demonstrable harm.

Historical and contemporary risk factors. A number of historical, societal and environmental factors experienced by Black children could explain, in part, the elevated rates of maltreatment in comparison to other racial and ethnic groups. Historically, the Black American experience has been marked by oppression and events that are unique to most people living in the U.S. (Hollar, 2001; Kelly, 2006). The essence of Black Americans' plight is captured temporally by cataloging markers of injustice throughout history: the end of slavery (1619 - 1865) (Hollis, 2001), Jim Crow laws (1870 – 1959) (Hollis, 2001), lynchings (19 – 20th centuries) (Hollis, 2001), school segregation (ended in 1954) (Hollis, 2001), the urban migration from the south to attain better job opportunities and escape southern discriminatory practices and brutality (Young, 2003; Kelly, 2006), and modern-day racism (Coleman, 2003; Ross & Turner, 2005) and microaggressions (Pierce, 1974). Many of these events have gone, but the remnants of history's past linger within Black Americans on a personal, interpersonal, collective, and societal level (Leary, 2005).

Many Black Americans have not overcome the nation's superimposed barriers to success or the psychological, physical, and emotional repercussions of racism and discrimination which has contributed to the mass amounts of Black people living in poverty (25.8%) – the second highest rate of poverty (American Indians and Alaskan Natives, 27%) experienced by any racial or ethnic group in the U.S. (Macartney, Bishaw, & Fontenot, 2013). As a point of comparison, American Indians and Alaskan Natives have a 27% rate of poverty and Whites have an 11% rate of poverty (Macartney, Bishaw, & Fontenot, 2013). Also, Black children account for 35% of the nation's poor, as opposed to 12% of White children and are almost seven times more likely to experience ongoing poverty in comparison to their White counterparts (U.S. Census Bureau, 2012). Low social economic status is often a risk factor associated with abusive and neglectful parenting (Child Welfare Information Gateway, 2012; Krug, Mercy, Dahlberg, Loman, 2006; Zwi, 2002; Runyan, Wattam, Ikeda, Hassan, & Ramiro, 2002).

One of the many consequences of poverty is living in communities with minimal resources (e.g. safe parks, schools, healthy foods). High incidences of crime, exposure to violence, low levels of education, and substance abuse - risk factors for abuse and neglect - often characterize these neighborhoods (Child Welfare Information Gateway, 2012; Gallup Organization, 2005; Krug et al., 2002; Loman, 2006; Runyan et al., 2002)

Black Americans living in low SES communities are often exposed to high levels of interpersonal violence (Richards et al., 2004), which is a likely correlate of child abuse and neglect (Child Welfare Information Gateway, 2012; Gallup Organization, 2005; Krug et al., 2002; Loman, 2006; Runyan et al., 2002). In comparison to White children, Finkelhor, Ormrod, Turner, and Hamby (2005) found that Black children were more likely to witness domestic violence (61 per 1,000 versus 29 per 1,000), have someone close murdered (70 per 1,000 versus

9 per 1,000), witness murder (20 per 1,000 versus 1 per 1,000), and be exposed to gunfire, bombs, or riots (110 per 1,000 versus 37 per 1,000). Community violence has been associated as a risk factor for Post Traumatic Stress Disorder (PTSD) (Hunt, Martens, & Belcher, 2011; Okundaye, 2004), however this finding has been met with opposition. Edlynn, Gaylord-Harden, Richards, & Miller (2008) suggest that volume of exposure experienced by Black children might create emotional coping strategies for managing stress, thus reducing risk for PTSD.

Many Black Americans have also been impacted by the intentional (i.e., enslavers active efforts to break up Black families) or the inadvertent dissolution of the familial structure. The division of Black American families has had profound effects on the Black American population and left Blacks particularly susceptible to a number of risk factors commonly associated with neglect and abuse. Characteristics of an unstable household often include periods of homelessness, living in overcrowded housing, frequent moving, minimal social support, and single parenting – all of which research has found to correlate with abuse and neglect (Child Welfare Information Gateway, 2012; Federal Interagency Forum on Child and Family Statistics, 2013). Black Americans are well accounted for by these risk factors statistically. A mere 33% of Black families are comprised of two married parents, as opposed to 74% of Whites and 59% of Hispanics (Vespa, Lewis, & Kreider, 2013). Furthermore, unemployment rates for Blacks have been historically low (Athar, Chang, Hahn, Walker, & Yoon, 2013) and were estimated at 16.5% in 2010. Comparatively, unemployment for Blacks was greatest when compared to all other racial and ethnic groups – Whites (8.3%), Hispanics (12.4%), Asian Americans (9.7%), and American Indians/Alaska Natives (15.8%) (Athar et al., 2013).

Effects. Many researchers argue that chronic exposure to racism, microaggressions, and discrimination are physiologically, psychologically, and emotionally damaging (Carter, 1994,

1995, 2004, 2005, 2007) and that they are in fact a form of trauma (Daniel, 2000; Butts, 2002; Kelly 2004; Bryant-Davis & Ocampo, 2005; Carter, 2007; Carter & Forsyth, 2009). In keeping with this argument, Black children are at greater risk for experiencing child abuse and neglect based on their predisposition to intergenerational trauma coupled with the risk factors mentioned within this paper.

[1] The data of 49 states contributed to this statistical analysis by race. The evaluation excluded reports by states that did not differentiate between race and ethnicity as two distinct constructs (Department of Health and Human Services, 2012). The prevalence of victimization within Black American children accounted for 21.5% of unique cases (U.S. Department of Health and Human Services, 2012). The U.S. Department of Health and Human Services (2012) refers to figures as unique or duplicate. Unique figures do not include multiple reports for a single minor. Duplicate figures keep record of the total times a child was a victim of maltreatment. As a point of reference, White and Hispanic children experienced victimization at rates of 43.9% and 22.1%, respectively (U.S. Department of Health and Human Services, 2012).

[2] Fourth National Incidence Study of Child Abuse and Neglect (NIS-4): Report to Congress, Executive Summary Sedlak et al. (2010) differentiates abuse and neglect into two groups: the Harm Standard and the Endangerment Standard. The Harm Standard classifies an act or omission as abuse or neglect if there is demonstrable harm. The less restrictive construct, Endangerment Standard, includes maltreatment that would fall into the Harm Standard, but also includes acts or omissions that have not yet occurred that would compromise a child's safety or

wellbeing and/or have been either substantiated or indicated by CPS reports as maltreatment.

Despite the rate of mental illness within the Black American community, treatment seeking is markedly low due to numerous variables that may include historical and contemporary unethical, biased, discriminatory, and sociopolitical factors contributing to cultural mistrust of health care (Rusert, 2009; Whaley, 2001). When looking at potential treatment barriers specific to Black American women, researchers have found a preference for help from informal supports and religious leaders (Abrams, Dornig, & Curran, 2009; Neighbors, Musick, & Williams, 1998), a belief that family issues should be kept in the family – “don’t air your dirty laundry” (Alvidrez, 1999), and a need to preserve archetypal conceptions of strength (e.g., the Strong Black Woman) (Neal-Barnett & Crowther, 2000) and portrayals and beliefs about self-reliance (Matthews, Nelesen, & Dimsdale, 2005; Mays, Caldwell, & Jackson, 1996). It is hypothesized that these barriers might be passed down to Black American youth raised by Black mothers.

As far as this author knows, Warfield (2013) was the first individual to apply the TF-CBT modality to Black American youth. Current literature pertaining to culturally sensitive trauma treatment interventions for Black American youth is underdeveloped. Thus, the cultural competence of this TF-CBT modification, which gears itself towards black children, is supplemented with what relevant publications tell us about Black American children in general, as well as African American culture.

Methodology

This clinical dissertation has developed a culturally informed recommendations for Cohen, Mannarino, & Deblinger's (2006) seminal TF-CBT model by offering clinicians resources to facilitate optimal emotional and behavioral regulation for Black American (BA) child trauma survivors by supplying BA youth and their caregivers with psychoeducation about trauma and the cognitive triad – the interconnectedness of thoughts, behaviors, and emotions; strategies to identify emotions related to the trauma and ways to deal with those emotions using personalized stress management skills, encouragement and dialogue between caregivers, clinician, and the youth survivor about the trauma; modification of distorted and unhelpful thinking that relates to the trauma; and instillation of competence and confidence for caregivers to help them better deal with their child's emotional and behavioral experience post trauma (Cohen et al., 2006). Of note, there is a recently published second edition of this manual and though it was referenced, the basis for this dissertation is not based on the second edition because it was published far after this manual was in progress (Cohen, Mannarino, & Deblinger, 2016). The recommendations developed in this dissertation will also feature strategies and exercises that pertain specifically to the conceptualization and symptom management of trauma through the Black American experience. In addition, the needs of pre-adolescent and adolescent Black American trauma survivors, as well as their primary caregivers, in a host of settings (e.g., school, clinical, community settings, and church) will be addressed. This model will be most appropriate for Black American children who have experienced – directly or indirectly as witnesses - interpersonal violence, which includes physical, sexual, and emotional abuse, as well as neglect and community violence. Negative behaviors (e.g., substance use, aggression) that might result from traumatic experiences are not uncommon, however those behaviors that become the

primary focus of a child's treatment or risk the safety to the caregiver, clinician, or child could potentially circumvent TF-CBT's focus and should be treated by an outside provider first (Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network, 2004). The following criterion will exclude survivors from treatment: significantly disruptive and aggressive behavior, acute suicidality, frequent substance use, psychosis, clinical eating disorders, and serious self-harm behaviors. If any of the aforementioned negative behaviors or situations occurs during the course of treatment, TF-CBT should be suspended (Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network, 2004). Clinicians should follow appropriate protocol to ensure the child's safety and refer the child to another provider for more intensive treatment (Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network, 2004).

Special consideration must be made with regards to the legal implications of working with this population. Reports of abuse must be reported to a Child Protective Agency and law enforcement prior to TF-CBT's commencement (Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network, 2004). If a report is already in place, it is suggested that certain portions of the protocol might be left out in an effort comply with ongoing legal processes (Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network, 2004).

Rationale for This Project

Though Cohen and colleagues' (2006) TF-CBT model is currently utilized across wide range demographics, the need for a treatment manual attuned to the needs of Black American children is justified by a number of factors. First, the rate at which the United States is diversifying is great and in some parts of the country, the predominant cultural groups are those

of color (Barnett & Bivings, 2002). The expansive diversification of cultures across the country suggests that there lies a strong likelihood that clinicians will treat individuals whose cultural backgrounds differ from their own ethnic or cultural group (D. W. Sue & Sue, 2003). The implications of this information places mental health providers – a group of individuals who generally speaking want to help others - in a potentially precarious situation because “helping” through the lens of one’s own ethnic or cultural background may not be received as help when the receiver is of a different background (Sue et al., 2007). The risk for issuing predominantly Eurocentric “help” universally is commonplace; in fact, it is the scaffolding by which a number of assumptions and conceptualizations are made in American society because the forefathers of psychology’s approach to theory lacked culturally sensitivity (Burkard & Knox, 2004; D. W. Sue, 2005; Sue, et al., 2007). However, the APA Ethics Code (1992; 2002) has warned against monolithic informed treatment and advised against it (Barnett & Bivings, 2002). Second, the fact that Black American children experience the highest rates of trauma in the United States (U.S. Department of Health and Human Services, 2013) suggests that something is amiss not only with regards to environmental risk factors (e.g. poverty; microaggressions; postcolonial effects of slavery), but also the way a trauma survivor is tended to – by family, community, and self - post a traumatic event.

Goals of this project. The primary goal of the TF-CBT recommendations for Black American children is to increase dialogue surrounding the survivor’s trauma by building upon the evidence based foundation of Cohen et al.’s (2006) model. In doing so, the recommendations will diminish the subsequent shame that often accompanies trauma and establish greater resonance with the Black American community by providing an increased understanding of the variables (past and contemporary) that contribute to Black Americans’ unique experiences of

trauma and consequently creating emotional and behavioral well-being within the survivor and caregivers, which will reduce the likelihood of the intergenerational transmission of trauma.

Resource Development

Literature review. The literature review for this culturally modified version of TF-CBT will be quadrangular in nature. The first arm of the literature search will target general information about trauma within the Black American youth population. Included in the initial search will be rates of prevalence, as well as commonalities across symptomatology, ways of perceiving, and ways of treating their traumatic experience. The second arm of the literature search will pertain to historical and current cultural factors that might influence the prevalence, perception, and or treatment means amongst Black American traumatized youth and their families. The third arm of the literature search will seek out existing treatments that used and or did not use cultural adaptations for child trauma survivors. The fourth arm of the search will center upon the involvement of parental figures in trauma treatment in general and Black American parents in particular – identifying the benefits and challenges, as well as alternative solutions for children without parents.

The entirety of this dissertation's literature search will be conducted through Pepperdine's Wavenet, which offers access to a library of articles and e-books. Search terms for this project are as follows: Black American; trauma, Black; trauma, Black American; child trauma, Black; child trauma, racism; trauma, slavery trauma, effects of slavery on Black people, effects of slavery on Black Americans, microaggressions trauma, Black American prevalence trauma, Black prevalence trauma, race rates of trauma, Black rates of trauma, Black American rates of trauma, types of trauma Black, types of trauma Black American, treating trauma in children, clinical treatment trauma, cultural trauma treatment, cultural modification, evidence

based trauma treatment children, parental involvement trauma therapy, no parents trauma treatment.

Cohen et al.'s (2006) treatment text is primarily referred to over the course of this adaptation's development, as it is of utmost importance to adhere to the treatment's guiding principals to avoid compromising the fidelity of the well-supported and treatment of choice for many providers. However, three additional culturally modified treatments for trauma populations (O'Callaghan, McMullen, Shannon, Rafferty, & Black, 2013; Warfield, 2013; The Workgroup on Adapting Latino Services, 2008) were be referenced in an effort to locate opportunities for change and understand the maximal points of adaptation.

Format and structure of the model's recommendations. The format and structure of this TF-CBT supplement of cultural recommendations is consistent with the framework developed by founding authors' (Cohen, et al., 2006) in order to maintain the model's fidelity. This manual is merely meant to compliment the TF-CBT model (Cohen et al., 2006; 2016), as opposed to replace or act as a standalone manual. Implementation should be administered in an individual therapy format and feature culturally congruent recommendations for each of the model's core components. TF-CBT's ten components, commonly referenced using the acronym PRACTICE, include **P**sychoeducation, **P**arenting skills, **R**elaxation skills, **A**ffective expression and modulation skills, **C**ognitive coping and processing, **T**rauma narrative, **I**n-vivo exposure and mastery of trauma reminders, **C**onjoint parent sessions, and **E**nhancing safety and future developmental trajectory. In addition, the constructed recommendations will fall under three subcomponents: psychoeducation, an in-session activity or homework assignments. Treatment usually spans 12-20 sessions and operates on a skill acquisition based principle (i.e., mastery of one component points to the child's readiness for the following

component) (Cohen, et al., 2006). Though components are most often exercised in order, clinical and or legal indications leave room for excluding particular components without compromising the fidelity of the model developed by Cohen and colleagues (2006).

Content of the manual. The content of this culturally mindful compilation of recommendations for TF-CBT will feature culturally mindful interventions that may be included in addition to the activities within the standard intervention (Cohen et al., 2006) and include the identification of public figures that have survived trauma, colloquialisms, dissemination of subject matter through spoken word or music, faith-based references (if salient to the group's participants), and persons, places, or things well known in the Black American community (e.g., language, people, songs, television shows, movies, food).

Evaluation of the Resource Manual

Expert selection. The expert selection committee was be chosen based on the potential expert's field of expertise and experience within Black American community and or practicing culturally informed treatment. To ensure the expert's qualifications and availability fit the needs of this dissertation, a questionnaire will be created and sent alongside a formal invitation (sent via email) to participate in this dissertation's committee team. The questionnaire inquired about the prospective expert's primary theoretical orientation; years of clinical experience working with youth and in what type(s) of setting(s); years of clinical experience providing TF-CBT (group or individual); specialized training in TF-CBT or CBT; years of clinical experience working with Black American youth, years of clinical experiencing providing TF-CBT to Black American youth; and relevant scholarly research, consultation, or supervision activities related to Black American youth (i.e., between the ages of 13 and 25), CBT, and or TF-CBT.

Recruitment strategies and procedures. A total of three experts will be selected based on their area of expertise in interpersonal trauma, TF-CBT, CBT, and/or Black American youth, in order to review and provide qualitative feedback on the supplemental resource being developed through this research project. First, experts were selected through convenience and snowball sampling methods. Potential participants were sent an email with an explanation of the research project and their required level of involvement (See Appendix B), as well as an expert questionnaire (See Appendix C). After consenting to participation as an expert reviewer, they would be emailed a copy of the supplemental resource (see Appendix F), a consent form (see Appendix D), and asked to complete an attached evaluation form (see Appendix E) and return via email. The evaluation form included sections for providing written feedback regarding the supplement as a whole, as well as each area of specific content. Experts were then asked to return the evaluation form via email so that the feedback could be considered for incorporation into the final draft of the supplemental resource. Experts were be offered the opportunity to have their contribution to the research project recognized in the supplemental resource, or they may choose to have their contribution remain confidential. Upon completion of all requested materials, each reviewer was sent a \$50 Amazon gift card via email.

Analysis of the valuation. After each expert completed and submitted their respective evaluation forms, this author reviewed the documents to assure all items were completed and input the reviewer's feedback into the results portion of this dissertation (i.e., Chapter III).

Results

Summary of the Results

This supplemental manual for TF-CBT was sent to three expert reviewers, who each consented to provide written feedback on the manualized portion of this dissertation. These evaluators completed a set of questions (Appendix C) that indicated the types and amount of experience they had as a licensed mental health care professionals working with TF-CBT, Black adolescents, and or youth survivors of interpersonal trauma. Each evaluator completed the evaluation form and provided responses to each question. Responses relate to licensed experience only. Based on their responses, the following demographics were obtained (Table 1). Of the three evaluators, licensure was held across a span of regions: California, Texas, and Ohio. Specific to the type of licensure, two of the experts were licensed clinical social workers (LCSW) and one was a professional clinical counselor (PCC). Evaluator one has had three years of licensed experience, three years of practicing TF-CBT in outpatient, school, hospital, and private-practice settings with Black American adolescents; three years working with Black American adolescents in general; and three years of interpersonal trauma work with youth survivors; evaluator one's TF-CBT training was received through online training and consultation. Evaluator two has had six years of licensed experience, three years of practicing TF-CBT in an outpatient setting with Black American adolescents, six years working with Black American adolescents in general, and six years of interpersonal trauma work with youth survivors; evaluator two's TF-CBT training was received through "TF-CBT coursework." Evaluator three has had 25 years of licensed experience, 5 years of practicing TF-CBT in an outpatient setting with Black American adolescents, 25 years working with Black American adolescents in general, 25 years of interpersonal trauma work with youth survivors; evaluator

three's TF-CBT training was received through "a number of CEs" (*sic* continuing education credits).

Table 1.

Professional Profiles of the Expert Evaluators

Evaluator	Gender	Title	Years of Experience
1	Female	LCSW	3
2	Female	PCC	6
3	Male	LCSW	25

In addition to providing details of demographics, the experts also completed an evaluation form (Appendix E) that inquired about the reviewer's subjective experience of the manual (Tables 2 – 16).

Table 2.

Feedback on Recommendations (Question 1)

What do you consider to be the <i>strengths</i> of this manual?	
Evaluator	Comments
1	Keen ability to portray the BA experience and make treating BA's more assessable, especially for those less familiar with the cultural concerns and/or not belonging to the ethnic group themselves.
2	The manual is important work. I found the information regarding African Americans helpful. The specifics from the research and the practical approaches were appropriate. The order of the protocol is helpful as well.
3	Useful tool in working with Black adolescents.

Table 3.

Feedback on Recommendations (Question 2)

What do you find <i>least</i> helpful about the manual?	
Evaluator	Comments
1	There is nothing that was "least helpful," but please read the last question to see my recommendations.

(continued)

(continued)	
Evaluator	Comments
2	I would have appreciated a historical component that dates back to ancient Africa. African centered philosophy, psychology, and values can serve in the healing process.
3	I don't think the manual had enough case examples.

With regard to the strengths and weaknesses of the manual, which were addressed in Questions 1 and 2, the reviewers were largely in agreement that the manual carried relevance in terms of its clinical utility with Black American youth. In terms of areas for improvement, reviewers remarked upon the needed inclusion of greater historical context, "African centered philosophy, psychology, and values," and case examples.

Table 4.

Feedback on Recommendations (Question 3)

To what extent does the manual strengthen the relevance of TF-CBT for Black American adolescents?	
Evaluator	Comments
1	I believe the manual was highly specified and effective in this way. It gave a review of African American (AA) research while providing education to the reader toward the key themes and cautions to be aware of when working with AA youth. This manual eloquently, and in a non-intimidating manner, effectively addressed that trauma within the AA community is always complex and never single-incident, as there is a level of trauma that all Blacks experience simply by being Black and treated as such by institutions, other people, and society as a whole (some would call this Little "t" trauma). This manual had a rich understanding of the impact that being part of this marginalized group has on an individual's sense of self and worldview, and in attending to this disparity, the manual provided many opportunities for the clinician and caregiver to self-empower through: discussing AA history and acknowledging historical examples of AA's who overcame adversity or made a positive mark on the world; offering opportunities for the client to discuss individual attributes (such as hair) that may lead to negative thoughts about self-given society's value of beauty and worth, so the clinician may have the chance to address these negative self-thoughts; engaging in reflection and dialogue to increase feelings of Black pride, faith and mastery.
(continued)	

Evaluator	Comments
2	population.
3	I don't think I have seen a detailed approach to trauma work with Black adolescents like this before.

Each evaluator commented on this manual's ability to address the unique needs of Black American adolescents.

Table 5.

Feedback on Recommendations (Question 4)

To what extent does the manual appear to be culturally sensitive?	
Evaluator	Comments
1	I found the manual highly culturally sensitive and specified, in part, a brief overview of an African American Studies course, for those who never took such a class, bringing readers up to speed on the recurring themes and issues presented in working with AA families. I think someone from another culture (other than AA) who had never worked with an AA youth, but needing/wanting to provide TF-CBT for an AA client, would be highly prepared to do the work after reading this manual.
2	The manual appears to be culturally sensitive in providing research and appropriate means to intervene.
3	I think that the manual spoke to the Black experience and gave outsiders looking in, a guide to treatment.

Evaluators spoke to the issue of cultural sensitivity by commenting on the manual's ability to offer those unfamiliar with Black American culture or the nuances within it, a guide for clinical intervention.

Table 6.

Feedback on Recommendations (Question 5a)

Please feel free to provide any additional feedback on recommendation regarding the individual components/chapters (Chapter 1: Psychoeducation)	
Evaluator	Comments
(continued)	

Evaluator	Comments
1	I found this chapter to emphasize the necessity that education begin with the provider. To work effectively with AA youth, there is a need to be well versed in cultural phenomenon and weed out personal biases, while honoring individuality and with knowledge that each AA youth may relate to the black experience differently- in this way, mindfulness and empathetic examination on a case by case is highly necessary. I enjoyed the recommendations for integrating music therapy and dance, as trauma lives in the body.
2	Solid chapter on psychoeducation and important to include the impact oppression has on trauma and African American children and families.
3	Good recommendations

Evaluators offered feedback on Chapter 1 (Psychoeducation) of the manual. Though some commented more than others, overall, each acknowledged value and validity in its content.

Table 7.

Feedback on Recommendations (Question 5b)

Please feel free to provide any additional feedback on recommendation regarding the individual components/chapters (Chapter 2: Parenting Skills)	
Evaluator	Comments
1	Clinically I know authoritative parenting to consist of assertiveness and clear boundaries while still encompassing empathy and validation. In working with AA parents' validation of their resistance to these techniques and offering ample time to connect and for there to be an empathetic conversation about the resistance is important in gaining the parents trust, which is needed for successful treatment.
2	This is very important and helping the parents understands how their beliefs and behaviors are playing a role in the child's mental health concerns. It also is helpful in building their own self-knowledge and potentially aiding them in their own areas of growth and healing skills are helpful in this context. It also would be helpful to include the importance of how Post Traumatic Slave Syndrome plays a role in parenting of African Americans. I also appreciate the spirituality component of the chapter.
3	This can be one of the most challenging parts of working with youth, right?! Great that you are addressing cultural issues as they relate to Black parenting in therapy.

Related to Chapter 2: Parenting Skills, evaluators noted the need for addressing the specific needs of BA parents, how to work with these needs clinically, and the ways in which historical factors play into parenting styles.

Table 8.

Specific Feedback on Recommendations (Question 5c)

Please feel free to provide any additional feedback on recommendation regarding the individual components/chapters (Chapter 3: Relaxation Skills)	
Evaluator	Comments
1	To assess for the client's relationship to themselves/level of self-esteem, and an opportunity for the therapist to help transform any negative self-talk or devaluing of self-based on hair and culture. This could be a great time to introduce affirmations. I find that youth do very well with affirmation, which also introduce repetition and rhythm and pair well with meditation/breathing, song and dance.
2	Great chapter
3	Pretty basic. Not much to say on this chapter.

Though most evaluators did not have a lot of feedback on Chapter 3: Relaxation Skills, Evaluator 1 commented on the value of affirmations, meditation/breathing, song, and dance as useful relaxation tools with youth.

Table 9.

Specific Feedback on Recommendations (Question 5d)

Please feel free to provide any additional feedback on recommendation regarding the individual components/chapters (Chapter 4: Affective Expression & Modulation Skills)	
Evaluator	Comments
1	This chapter contained highly valuable information. Black girls and boys are often taught to be self-reliant and therefore, keep their emotions to themselves. This is a hindrance in future intimate relationships down the road as these youths do not cultivate the ability to learn how to be vulnerable with others and therefore not truly intimate many AA girls don't know about intimacy but they learn from music videos and pop culture how to appeal to men through

(continued)

Evaluator	Comments
1	their sexuality. There is a lot of repair work that can be done her b/t therapist and client. I think it is great to get explicit with youth in terms of teaching them how to ask for help and practice role-playing these scenarios.
2	Solid chapter
3	Not something we talk about too often, so I appreciate the points mentioned in this chapter.

Overall, the evaluators noted the value of the information contained within this chapter on affective expression and modulation skills (Chapter 4).

Table 10.

Specific Feedback on Recommendations (Question 5e)

Please feel free to provide any additional feedback on recommendation regarding the individual components/chapters (Chapter 5&7: Cognitive Coping & Processing)	
Evaluator	Comments
1	I appreciated the way this chapter validated the very real racial stressors that AA's experience and the importance of addressing a concern like being followed in the store as a true racial experience as opposed to paranoia or a trauma response. For youth, it is often easier to see their behaviors outside of themselves, so I believe the pre-trauma narrative exercises provided are highly useful.
2	Solid chapter
3	Good – not much to say about this one.

Again, some evaluators offered more feedback than others, but there appeared an overall consensus that Chapters 5& 7: Cognitive Coping and Processing were useful, particularly in addressing the impact of culturally specific stressors in relation to trauma.

Table 11.

Specific Feedback on Recommendations (Question 5f)

Please feel free to provide any additional feedback on recommendation regarding the individual components/chapters (Chapter 6: Trauma Narrative)	
(continued)	

Evaluator	Comments
1	The value of oral tradition is highly relevant. This chapter did a great service in offering options that could be used outside of the written word, in providing the trauma narrative. I think it's important that the therapist allow the client to choose which format will work best for them, empowering the client to make this their own and tell their story in their way.
2	Solid chapter
3	Good explanation of why oral tradition is prized in the Black community.

Evaluators described a sense of usefulness in Chapter 6: Trauma Narrative. Of those evaluators that offered specific feedback, they remarked upon the explanation on oral tradition and its cultural relevance.

Table 12.

Specific Feedback on Recommendations (Question 5g)

Please feel free to provide any additional feedback on recommendation regarding the individual components/chapters (Chapter 8: In-vivo Exposure & Mastery of Trauma Reminders)	
Evaluator	Comments
1	Involving the caregiver is highly valuable here. The manual touched on resourcing, without calling it that. Resourcing in the strengths and qualities necessary to gradually face trauma reminders, is an exercise that is uplifting for clients. Clients can also resource "mastery figures," spiritual figures, mentors, celebrities/writers, book or TV characters, that they believe possess the qualities they will need. The in-vivo exposure plan creates a measurable and structured way for clients to increase exposure that provides them with a level of certainty. It's important to encourage parents to validate their children before, during and after each exposure.
2	Great acknowledgement of real concerns instead of over-pathologizing clients. Appropriate means to work with clients in their environments if clinically appropriate.
3	If a patient is inpatient, how would exposure activities be done?

Evaluators commented on the need for greater inclusion of caregivers in the exposure portion of the manual and additionally pointed to the potential concern of execution amongst

youth within inpatient settings. Another evaluator commented on the chapter's ability to avoid pathologizing.

Table 13.

Specific Feedback on Recommendations (Question 5h)

Please feel free to provide any additional feedback on recommendation regarding the individual components/chapters (Chapter 9: Conjoint Child-Parent Sessions)	
Evaluator	Comments
1	This topic touched on the inclusion of supportive figures, other than bio parents, as equally viable when single parenthood and work-related or economic needs necessitate it so. This is important for therapists to accept and remember. The emphasis of talk around Black pride and stories of Blacks overcoming adversity is an important addition. The piece for Black males on how to manage interactions with law enforcement is highly, highly valuable. Very important for the parent or whoever the primary guardian is. This is important to recognize with African American families. Also, it is important to help the child and parent with means to work with their extended family as it relates to this topic. Great appreciation for gain familiarity with the historical and current sociopolitical context of the African American experience, as well as strengths.
2	Very important for the parent or whoever the primary guardian is. This is important to recognize with African American families. Also, it is important to help the child and parent with means to work with their extended family as it relates to this topic. Great appreciation for gain familiarity with the historical and current sociopolitical context of the African American experience, as well as strengths.
3	I'm sticking with my consideration of institutionalized youth. Who would their caregivers be or how would they involved?

Reviewers acknowledged the extended kin network that is often found in BA families and the importance of including those within that network. A shortcoming of this chapter, as one evaluator pointed out, was its inability to address this part of the manual with institutionalized youth.

Table 14.

Specific Feedback on Recommendations (Question 5i)

Please feel free to provide any additional feedback on recommendation regarding the individual components/chapters (Chapter 10: Enhancing Future Safety and Development)

Evaluator	Comments
1	I found this chapter to provide an inclusive summary of the information to be presented to youth and caregiver for ongoing discussion- as society and the media continue to give youth conflicting messages about what is inappropriate touch/language (e.g., Rev Run telling Amber Rose, "Dress how you want to be addressed," and therefore implying that it was her fault that she was harassed, while totally dismissing the concept of consent.) this is information the child will benefit from through continued conversations even after therapy has ended. The youth might even present a school project or start a school-wide campaign. Trauma therapy can empower youth and their caregivers how to break the silence
2	Great and important for healing and prevention.
3	Strong chapter. See my comment below, but I think that you might speak about safety in the context of youth that are institutionalized. This may pose some interesting challenges!

Evaluators offered feedback that pertained to this chapter's presentation of an opportunity for ongoing discussion and prevention as roles in recovery. Additional feedback by one evaluator posed inquiry as to how this chapter in the manual might work in an institutional setting.

Table 15.

Feedback on Recommendations (Question 6)

What are your overall impression of the resource manual?	
Evaluator	Comments
1	An excellent resource for those seeking clinical competency in treating AA youth/families and wanting to adapt the TF-CBT model to work with this population.
2	Very helpful and essential. I loved the manual overall, it is comprehensive and culturally specific and appropriate.
3	I'm sticking with my consideration of institutionalized youth. Who would their caregivers be or how would they involved?

Overall, evaluators found this manual useful and culturally competent, though one evaluator's feedback indicated greater salience had the manual included considerations for institutionalized youth.

Table 16.

Feedback on Recommendations (Question 7)

How could the manual be improved to make it more effective for BA clients who have experienced trauma?	
Evaluator	Comments
1	I think including case examples of dialogue and clinical style effectively used in actual sessions would increase the teaching power of the manual. In conjunction, providing actual examples of problems/ difficulties clinicians have run into in session and then trouble shooting and practice tips would make the manual even more applicable. The manual's theoretical offerings are paramount, and adding the practical applications component would only increase its value.
2	Include additional historical aspects and resources. The provider who facilitates this also has to have buy-in and be culturally competent with this population for the protocol to work well.
3	Maybe talk more about how Black children that are institutionalized might relate to this manual.

When queried about ways to improve this manual effectiveness for BA clients who have experienced trauma, evaluators suggested inclusion of more case examples, problem solving scenarios with trouble shooting tips, historical information, and suggestions for institutionalized youth.

The future evaluation of this intervention will be determined based on consensus between the evaluators as well as ongoing consultation with the dissertation's chair. Reference to the relevant literature decides which suggestions will be integrated into the final supplement of recommendations.

Discussion

The rate of trauma within Black American youth is astounding and raises appropriate cause for concern. Utilizing a well-established, evidence based treatment, TF-CBT, as a foundational building block to create a set of cultural recommendations, this supplemental resource aims to increase engagement and perceived relevance with Black American adolescents and their caregivers by addressing various ways to decrease trauma related symptoms. This was done by conceptualizing the contemporary and historical experiences and issues of Black Americans living in America.

Strengths of the Resource

This dissertation offers a contribution to the wealth of trauma literature that currently exists and an addition to the body of knowledge that supports culturally competent treatment for specific populations. The recommendations for TF-CBT developed in this dissertation offer strategies that will enrich cultural competence and salience to Black American youth and their caregivers. Additionally, the strong psychoeducational component, which is organic to the TF-CBT model and further underscored by the cultural specificity of this dissertation, might also offer a valuable resource to caregivers who do not identify with or share their child's Black American ethnicity by giving them a forum to receive psychological and cultural education that pertains to their child's experience as a trauma survivor of Black American descent, which can benefit the child's racial socialization – an issue that the caregiver might not have otherwise been able to provide. In addition to offering clinical recommendations for working with Black American youth, the manual offers a window into the dynamics of many Black American families. Though this is a clinical manual, the author addresses contemporary societal stressors that affect many modern-day Black American adolescent and their families. By providing

ultimate transparency and calling these issues (e.g., police brutality, rates of disproportionate bias) out by name and examining the ways in which societal stressors can affect mental health, clinicians are given permission, so to speak, to bring these “headliners” into the therapeutic hour. This manual provides an explicit reminder that Black American adolescent survivors not only need to address their interpersonal traumas, but likely address and learn how to manage a host of cultural stressors that are often faced day-to-day.

Weaknesses of the Resource

In review and consideration of the evaluator’s feedback this supplemental manual has a number of areas where it could be stronger. Specifically, by including more case examples, the manual could offer greater “teaching power” and a stronger resource for troubleshooting in clinical practice. Additionally, casting a broader net to include various settings (e.g., institutions such as jails, hospitals, group homes, etc.) might further increase relatability, as well as address common issues and provide problem solving tactics for those concerns and providers. Within any culture, traditions, ways of thinking, attitudes and behaviors have the potential to exist and presume without question, without knowing why we do the things that we do. In an effort to increase cultural salience, understanding, and resonance, it was recommended by one reviewer that a greater look at the historical factors that contribute to actions and beliefs of many Black Americans be examined in greater depth.

Limitations and Future Directions of the Resource

Despite the host of potential advantages these cultural recommendations might offer this dissertation is not without limitations. One such limitation lies around the heterogeneity of Black individuals living in America. For example, youth of Black American descent, whom do not identify with traditional values of Black American culture (e.g., mixed race youth who associate

with another predominant culture, youth who simply find another cultural group more relatable). Cultural and ethnic labeling is a useful way of grouping individuals categorically, but if a child does not relate to the label they have been marked with (viz., Black American), the applicability of the cultural recommendations generated within this dissertation might not be helpful. Further related to the heterogeneity of Black Americans is the fact that there exists a host of varied practices, traditions, beliefs, sexual orientation, genders, religions/atheism, and socioeconomic status within the community. With this being said, much of the available research is based on urban, low-income Black American youth or adults. The interventions suggested within this dissertation attempted to adjust for these varied experiences within Black culture, but the author readily acknowledges the difficulty in creating a manual that will speak to everyone within culture.

Another limitation of this supplement is its lack of empirical validity or reliability, as the recommendations of this manual have not been tested within a randomized trial. Conducting a RCT with Black American adolescents in conjunction with the TF-CBT manual (Cohen et al., 2006, 2016) would be a way to address this current limitation.

Informed by expert evaluators' feedback, future work with the treatment recommendations contained within this supplemental manual could be augmented by specific reference to Afrocentric theories, more detailed references to historical factors contributing to modern day concerns of the Black Americans, inclusion of various treatment settings (e.g., foster care, correctional facilities, psychiatric hospitals), and more case examples illustrating the interventions, as well as problem-solving techniques. Additionally, this supplemental manual only focused on interpersonal trauma, culturally motivated traumas, and community violence. It is well recognized that there are a host of other traumas that Black American adolescents might

experience (e.g., medical traumas, commercial sexual exploitation, war, etc.), however for the sake of providing a focused approach to treatment, the scope of trauma was limited.

Though this author did not attend a TF-CBT training, it is her intention to attend prior to publishing this manual. Thereafter, changes will be made to this supplemental training based on information gathered at the TF-CBT training.

From a more global perspective, this culturally specific supplement could be used alongside the TF-CBT manual (Cohen et al., 2006, 2016) to address the nation's disproportionate figures of trauma within Black American youth if it is found to be empirically valid and reliable. Settings and mediums in which this manual might be implemented disseminated include educational coursework or seminars aimed at increasing/raising awareness about cultural competency.

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APPENDIX A

Summary Table of Selected Literature

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
<p>Addis, M., Cardemil, E. V., Duncan, B., & Miller, S. (2006). Does manualization improve therapy outcomes? In J. C. Norcross, L. E. Butler, & R. F. Levant (Eds.), Evidence-based practices in mental health (pp. 131–160). Washington, DC: American Psychological Association.</p>	<p>evidence-based treatments, ethnic minorities, cultural adaptation, youth</p>	<p>Review; book chapter</p>	<p>Literature Review</p>	<p>Addresses need for cultural adaptation in manualized treatments; one-size-fits-all approach</p>
<p>American Academy of Child and Adolescent Psychiatry (2010). Practice parameter for the assessment and treatment of children and adolescents with posttraumatic stress disorder. Journal of American Academy of Child & Adolescent Psychiatry, 49, 414-430.</p>	<p>Practice parameter for the assessment and treatment of children and adolescents with posttraumatic stress disorder</p>	<p>Review</p>	<p>Online literature search</p>	<p>Early identification of posttraumatic stress disorder, gathering information from parents and children, and the assessment and treatment of comorbid disorders are key. There is also evidence to support trauma-focused psychotherapy, medications, and a combination of interventions in a multimodal approach.</p>

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
American Psychological Association Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. <i>American Psychologist</i> , 61, 271–285.	EBPP; APA guidelines	Practice Guidelines	Literature Review	APA 2005 Presidential Task Force on Evidence-Based Practice defines and discusses evidence-based practice in psychology (EBPP). In an integration of science and practice, the Task Force's report describes psychology's fundamental commitment to sophisticated EBPP and takes into account the full range of evidence psychologists and policymakers must consider. Research, clinical expertise, and patient characteristics are all supported as relevant to good outcomes. The report provides a rationale for and expanded discussion of the EBPP policy statement that was developed by the Task Force and adopted as association policy by the APA Council of Representatives in August 2005.
American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. <i>American Psychologist</i> , 58, 377–402.	Cultural Diversity, Research standards, Teaching methods; multicultural practice; APA guidelines	Practice Guidelines	Literature Review	This document was drafted by a joint Task Force of APA Divisions 17 (Counseling Psychology) and 45 (The Society for the Psychological Study of Ethnic Minority Issues). The specific goals of these Guidelines are to provide psychologists with: (a) the rationale and needs for addressing multiculturalism and diversity in education, training, research, practice, and organizational change; (b) basic information, relevant terminology, current empirical research from psychology and related disciplines, and other data that support the proposed guidelines and underscore their importance; (c) references to enhance on-going education, training, research, practice, and organizational change methodologies; and (d) paradigms that broaden the purview of psychology as a profession. These Guidelines address U.S. ethnic and racial minority groups as well as individuals, children, and families from biracial, multiethnic, and multiracial backgrounds. Thus, we are defining "multicultural" in these Guidelines narrowly, to refer to interactions between individuals from minority ethnic and racial groups in the United States and the dominant European–American culture. Ethnic and racial minority group membership includes individuals of Asian

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				and Pacific Islander, Sub-Saharan Black African, Latino/Hispanic, and Native American/American Indian descent, although there is great heterogeneity within each of these groups.
Bernal, G., Bonilla, J., & Bellido, C. (1995). Ecological validity and cultural sensitivity for outcome research: Issues for cultural adaptation and development of psychosocial treatments with Hispanics. <i>Journal of Abnormal Child Psychology</i> , 23, 67–82.	Ecological validity; cultural sensitivity; cultural competence; cultural adaptation	Conceptual	Literature Review	This article has two objectives. The first is to provide a culturally sensitive perspective to treatment outcome research as a resource to augment the ecological validity of treatment research. The relationships between external validity, ecological validity, and culturally sensitive research are reviewed. The second objective is to present a preliminary framework for culturally sensitive interventions that strengthen ecological validity for treatment outcome research. The framework, consisting of eight dimensions of treatment interventions (language, persons, metaphors, content, concepts, goals, methods, and context) can serve as a guide for developing culturally sensitive treatments and adapting existing psychosocial treatments to specific ethnic minority groups. Examples of culturally sensitive elements for each dimension of the intervention are offered. Although the focus of the article is on Hispanic populations, the framework may be

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				valuable to other ethnic and minority groups.
Bryant-Davis, T., & Ocampo, C. (2005). Racist incident-based trauma. <i>Counseling Psychologist</i> , 33, 479–500.	Racism; racism trauma	Conceptual		This paper identifies ways in which the trauma of racist incidents parallels the traumas of rape and domestic violence and argues that racist incidents can produce similar traumatic sequelae, particularly in clients of color.
Butts, H. F. (2002). The black mask of humanity: racial/ethnic discrimination and post-traumatic stress disorder. <i>Journal of American Academy of Psychiatry Law</i> , 30, 336–339.	Discrimination ; PTSD	Conceptual		Racial and ethnic discrimination produce psychic trauma, and African-Americans subjected to discrimination frequently respond with symptoms consistent with a diagnosis of PTSD.
California Evidence-Based Clearinghouse for Child Welfare. (2011). Rating of trauma-focused	TFCBT, Evidence for TFCBT	Web Reference/Review		TF-CBT received a "High Rating," meaning that it was designed, or is commonly used, to meet the needs of children, youth, young adults, and/or families receiving child welfare services. On a scale of 1-5, TF-CBT was rated a 1, meaning that it is well supported by research evidence on a scientific rating scale

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cognitive behavioral therapy. Retrieved from. http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/				
Cardemil, E. V. (2010). Cultural adaptations to empirically supported treatments: A research agenda. The Scientific Review of Mental Health Practice, 7, 8-21.	cultural adaptation; empirically-supported treatment; cultural competency	Conceptual	Literature Review	An important criticism of the EST movement is the fact that the overwhelming majority of treatments identified as well-established have limited evidence of their generalizability to participants from different cultural groups. One approach to addressing this limitation has been the development and evaluation of cultural adaptations of these treatments. Although the emerging evidence frequently documents the efficacy of cultural adaptations, many questions remain. In this article, Cardemil examines the several issues related to the development and evaluation of cultural adaptations of empirically supported treatments. Specifically, he addresses the following questions: (1) What information should inform whether and when to adapt an existing treatment for a particular racial, ethnic, or cultural group? (2) How should cultural adaptations be made to an existing treatment? And finally, (3) how should a culturally adapted treatment be empirically evaluated?
Carter, J. (1994). Racism's impact on mental health. Journal of the National Medical Association, 86, 543-547.	Racism; mental health	Conceptual		Racism negatively impacts mental health.
Carter, R. T. (1995). Race and racial	Race; racial identity; psychotherapy	Conceptual		Race and racial identity are integral components of identity. Offers greater

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
identity in psychotherapy: Toward a racially inclusive model. New York, NY: Wiley.				understanding of the construct of race, therapy, and the integration of the two
Carter, R. T. (2004). Disaster response to communities of color: Cultural responsive intervention (Technical Report for the Connecticut Department of Mental Health and Addiction [DMHAS]). Retrieved from http://www.dmh.state.ct.us	Disaster response; Haiti; Psychological First Aid	Conceptual		Advocates the utilization of Psychological First Aid in response to international health crises based on its cultural competence
Carter, R. T. (2005). Uprooting inequity and disparities in counseling and psychology: An introduction. In R. T. Carter (Ed.), Handbook of racial-cultural counseling and psychology: Theory and research (Vol. 1, pp. xv–xxviii). New York, NY: Wiley.	Racial-Cultural Psychology; race; psychology	Conceptual		Focuses on Racial-Cultural Psychology and how the construct of race impacts psychological and racial functioning

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
Carter, R. T. (2007). Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress. <i>The Counseling Psychologist</i> , 35, 13–105.	Racism, research, training, race-based traumatic stress	Conceptual		According to the report, people of Color have less access to and are less likely to receive needed care, and the care they ultimately receive is often of poor quality. The report identified a number of barriers that racial–ethnic people encounter in the mental health system including clinician's biases and utilization of culturally uninformed treatment. The report also stated that inequities also stem from historical and present struggles with racism and discrimination, which affect their mental health.
Carter, R. T., & Forsyth, J. M. (2009). A guide to the forensic assessment of race-based traumatic stress reactions. <i>Journal of the American Academy of the Psychiatry and Law</i> , 37, 28–40.	Racism based trauma; trauma; racism; treatment	Conceptual	Case Review	The existing body of research, as well as clinical experience, tends to support the notion that exposure to racism in various forms can cause psychological and emotional reactions that may rise to the level of trauma. It seems likely that experiences of race-based traumatic stress from discrimination or harassment of various types (e.g., housing, employment, service provision, interpersonal assaults, and racial profiling) are often involved in the development of the presenting problems or may contribute to the poor health of nondominant group members. Nevertheless, it is still rare for most, although perhaps not all, clinicians to perform routine assessments of patients for exposure to race-related experiences.
Cary, C. E., & McMillen, J. C. (2012). The data behind the dissemination: A systematic review of trauma-focused cognitive behavioral therapy for use with children and youth. <i>Children and Youth Services Review</i> , 34(4), 748–757.	TF-CBT Post-traumatic stress Depression Behavior problems	Empirical	Meta-analysis	Results show that there is a significant difference between the TF-CBT condition and comparison conditions in its ability to reduce symptoms of PTSD ($g = .671$), depression ($g = .378$) and behavior problems ($g = .247$) immediately after treatment completion. This difference held for PTSD at twelve months after treatment completion (.389) but did not hold for depression or behavior problems. There was not a significant difference between the TF-CBT condition and alternative active control conditions immediately after treatment completion. Therefore, TF-CBT is an effective intervention for the treatment of PTSD in youth.

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
Child Welfare Information Gateway. (2012). Chronic child neglect. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.	Policy, practice; child neglect	Conceptual		Review of policy, practices, and resources related to the child welfare system
Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. <i>Journal of the American Academy of Child & Adolescent Psychiatry</i> , 35(1), 42–50.	child sexual abuse; preschool children; treatment; parent interventions	Empirical	Pretreatment/posttreatment	Within-group comparison of pretreatment and posttreatment outcome measures demonstrated that while the NST group did not change significantly with regard to symptomatology, the CBT-SAP group had highly significant symptomatic improvement on most outcome measures. Repeated-measures analyses of variance demonstrated group \times time interactions on some variables as well. Clinical findings also supported the effectiveness of the CBT-SAP intervention over NST. Findings provide strong preliminary evidence for the effectiveness of a specific cognitive-behavioral treatment model for sexually abused preschool children and their parents.
Cohen, J. A., & Mannarino, A. P. (1998). Interventions for sexually abused children: Initial treatment outcome findings. <i>Child Maltreatment</i> , 3(1), 17–26.	Sexual abuse intervention, treatment sexual abuse children	Empirical	Pretreatment/Posttreatment	Results indicated that there was a significant group-by-time interaction on the Children's Depression Inventory and the Child Behavior Checklist Social Competence Scale, with the SAS-CBT group improving more than the NST group on both of these instruments. Clinical findings also suggested that SAS-CBT was more effective than NST in treating sexually inappropriate behaviors. Implications for clinical practice and future research are discussed.

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
Cohen, J. A., & Mannarino, A. P. (2008). Trauma-Focused Cognitive Behavioural Therapy for Children and Parents. <i>Child and Adolescent Mental Health</i> , 13(4), 158–162.	Trauma; posttraumatic stress; children; adolescents; cognitive behavioural therapy; parents	Review	Meta-analysis	The TF-CBT model described here is a flexible, evidence-based treatment for traumatised children. It has been tested in several completed and ongoing studies for children aged 3–17 years old who have experienced sexual abuse, traumatic grief, domestic violence, terrorism, disasters, and multiple traumatic events, and is currently being adapted and tested for use internationally.
Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. A. (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. <i>Journal of the American Academy of Child & Adolescent Psychiatry</i> , 43(4), 393–402.	posttraumatic stress disorder; child sexual abuse; trauma-focused cognitive-behavioral therapy; treatment; trauma	Empirical	Randomized control; Analysis of covariance	A series analyses of covariance indicated that children assigned to TF-CBT, compared to those assigned to child-centered therapy, demonstrated significantly more improvement with regard to PTSD, depression, behavior problems, shame, and abuse-related attributions. Similarly, parents assigned to TF-CBT showed greater improvement with respect to their own self-reported levels of depression, abuse-specific distress, support of the child, and effective parenting practices. This study adds to the growing evidence supporting the efficacy of TF-CBT with children suffering PTSD as a result of sexual abuse and suggests the efficacy of this treatment for children who have experienced multiple traumas.
Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). <i>Treating trauma and traumatic grief in children and adolescents</i> . Guilford Press.	Trauma; trauma treatment; children; adolescents	Conceptual		Treatment guidelines for working with children and adolescents who have experienced or witnessed traumatic event(s).

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
Cohen, J. A., Mannarino, A. P., & Iyengar, S. (2011). Community treatment of posttraumatic stress disorder for children exposed to intimate partner violence: a randomized controlled trial. Archives of pediatrics & adolescent medicine, 165(1), 16.	PTSD; intimate partner violence; IPV; children	Empirical	Randomized controlled trial conducted using blinded evaluators	Intent-to-treat analysis using last observation carried forward showed superior outcomes for TF-CBT on the total K-SADS-PL (mean difference, 1.63; 95% confidence interval [CI], 0.44-2.82), RI (mean difference, 5.5; 95% CI, 1.37-9.63), K-SADS-PL hyperarousal (mean difference, 0.71; 95% CI, 0.22-1.20), K-SADS-PL avoidance (0.55; 0.07-1.03), and SCARED (mean difference, 5.13; 95% CI, 1.31-8.96). Multiple imputation analyses confirmed most of these findings. The TF-CBT completers experienced significantly greater PTSD diagnostic remission ($\chi^2 = 4.67$, $P = .03$) and had significantly fewer serious adverse events. Community TF-CBT effectively improves children's IPV-related PTSD and anxiety.
Cohen, J. A., Mannarino, A. P., Kliethermes, M., & Murray, L. A. (2012). Trauma-focused CBT for youth with complex trauma. Child abuse & neglect.	Trauma-focused CBT; Complex trauma; Children; Adolescents; Evidence-based practice	Conceptual		Recent data from youth with complex trauma support the use of the above TF-CBT strategies to successfully treat these youth.
Cohen, J. A., Mannarino, A. P., Perel, J. M., & Staron, V. (2007). A pilot randomized controlled trial of combined trauma-focused CBT and sertraline for childhood PTSD symptoms. Journal of the American Academy of	stress disorders, posttraumatic AND randomized controlled trials	Empirical	Randomized controlled trial; Pretest/posttest	Both groups experienced significant improvement in posttraumatic stress disorder and other clinical outcomes from pre- to posttreatment with no significant group \times time differences between groups except in Child Global Assessment Scale ratings, which favored the TF-CBT + sertraline group. Only minimal evidence suggests a benefit to adding sertraline to TF-CBT. A drawback of adding sertraline was determining whether TF-CBT or sertraline caused clinical improvement for children with comorbid depression. Current evidence therefore supports an initial trial of TF-CBT or other evidence-supported psychotherapy for most children with PTSD symptoms before adding medication.

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
Child & Adolescent Psychiatry, 46(7), 811–819.				
Cohen, J.A., Mannarino, A.P., Knudsen, K. (2005). Treating sexually abused children: One year follow-up of a randomized controlled trial. Child Abuse & Neglect, 29, 135-145.	Child sexual abuse; Posttraumatic stress disorder; Trauma-focused cognitive-behavioral therapy; Treatment outcome	Empirical	Randomized controlled trial; Pretest/posttest ; Intent-to-treat and treatment completer repeated measures analyses were also conducted.	Intent-to-treat indicated significant group \times time effects in favor of TF-CBT on measures of depression, anxiety, and sexual problems. Among treatment completers, the TF-CBT group evidenced significantly greater improvement in anxiety, depression, sexual problems and dissociation at the 6-month follow-up and in PTSD and dissociation at the 12-month follow-up. This study provides additional support for the durability of TF-CBT effectiveness.
Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M. . . . van der Kolk, B. (2005). Complex trauma in children and adolescents. Psychiatric Annals, 35, 390-398.	child; adolescent; posttraumatic stress disorder; treatment; Practice Parameter	Conceptual		Various treatment approaches reviewed in the article show relief of symptoms, as well as improved social competence and emotion management. Requires adaptations for culturally and geographically diverse populations. Interventions should build strengths as well as reduce symptoms.

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
Copeland, W. E., Keeler, G., Angold, A., & Costello, E. J. (2007). Traumatic events and posttraumatic stress in childhood. <i>Archives of General Psychiatry</i> , 64(5), 577.	PTSD; trauma; longitudinal	Empirical	Longitudinal/ Multistage sample design	More than two thirds of children reported at least 1 traumatic event by 16 years of age, with 13.4% of those children developing some PTS symptoms. Few PTS symptoms or psychiatric disorders were observed for individuals experiencing their first event, and any effects were short-lived. Less than 0.5% of children met the criteria for full-blown DSM-IV PTSD. Violent or sexual trauma were associated with the highest rates of symptoms. The PTS symptoms were predicted by previous exposure to multiple traumas, anxiety disorders, and family adversity. Lifetime co-occurrence of other psychiatric disorders with traumatic events and PTS symptoms was high, with the highest rates for anxiety and depressive disorders. In the general population of children, potentially traumatic events are fairly common and do not often result in PTS symptoms, except after multiple traumas or a history of anxiety. The prognosis after the first lifetime trauma exposure was generally favorable. Apart from PTSD, traumatic events are related to many forms of psychopathology, with the strongest links being with anxiety and depressive disorders.
Daniel, J. H. (2000). The courage to hear: African American women's memories of racial trauma. In L. Jackson & B. Greene (Eds.), <i>Psychotherapy with African American women: Innovations in psychodynamic perspective and practice</i> (pp. 126–144). New York,	African American women; racial trauma	Conceptual		Narrative therapy facilitates the therapist's and client's understanding the effects of racism in African American women

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
NY: Guilford Press.				
Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. <i>Child Maltreatment</i> , 1(4), 310–321.	PTSD treatment; PTSD; children; sexual abuse	Empirical	Randomized controlled study; Pretest/posttest	Mothers assigned to the experiential condition described significant decreases in child externalizing bxs and increases in effective parenting skills; their children reported decreases in depression. Children assigned tot the experimental intervention exhibited greater reductions in PTSD symptoms than children who were not.
Deblinger, E., Mannarino, A. P., Cohen, J. A., & Steer, R. A. (2006). A follow-up study of a multisite, randomized, controlled trial for children with sexual abuse-related PTSD symptoms. <i>Journal of the American Academy of Child & Adolescent Psychiatry</i> , 45(12), 1474–1484.	child sexual abuse, follow-up, cognitive-behavioral therapy, posttraumatic stress disorder, childhood trauma	Empirical	Mixed model; Repeated analysis of covariance	Mixed-model repeated analyses of covariance found that children treated with TF-CBT had significantly fewer symptoms of PTSD and described less shame than the children who had been treated with CCT at both 6 and 12 months. The caregivers who had been treated with TF-CBT also continued to report less severe abuse-specific distress during the follow-up period than those who had been treated with CCT. Multiple traumas and higher levels of depression at pretreatment were positively related to the total number of PTSD symptoms at posttreatment for children assigned to the CCT condition only. Children and caregivers assigned to TF-CBT continued to have fewer symptoms of PTSD, feelings of shame, and abuse-specific parental distress at 6- and 12-month assessments as compared to participants assigned to CCT.

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
Deblinger, E., Mannarino, A. P., Cohen, J. A., Runyon, M. K., & Steer, R. A. (2011). Trauma-focused cognitive behavioral therapy for children: impact of the trauma narrative and treatment length. <i>Depression and anxiety</i> , 28(1), 67–75.	treatment outcome;child sexual abuse;PTSD;TF-CBT;externalizing behaviors;randomized trial;child anxiety;abuse-related fear	Empirical	Randomized controlled study; ANCOVA	Mixed-model ANCOVAs demonstrated that significant posttreatment improvements had occurred with respect to 14 outcome measures across all conditions. Significant main and interactive effect differences were found across conditions with respect to specific outcomes. Conclusions: TF-CBT, regardless of the number of sessions or the inclusion of a TN component, was effective in improving participant symptomatology as well as parenting skills and the children's personal safety skills. The eight session condition that included the TN component seemed to be the most effective and efficient means of ameliorating parents' abuse-specific distress as well as children's abuse-related fear and general anxiety. On the other hand, parents assigned to the 16 session, no narrative condition reported greater increases in effective parenting practices and fewer externalizing child behavioral problems at posttreatment.
Deblinger, E., Stauffer, L. B., & Steer, R. A. (2001). Comparative efficacies of supportive and cognitive behavioral group therapies for young children who have been sexually abused and their nonoffending mothers. <i>Child Maltreatment</i> , 6(4), 332–343.	Sexual abuse; nonoffending mothers; CBT	Empirical	Randomized controlled study; MANCOVA	Repeated measures MANOVAs indicated that compared to mothers who participated in the support groups, the mothers who participated in cognitive behavioral groups reported greater reductions at posttest in (a) their intrusive thoughts and (b) their negative parental emotional reactions regarding the sexual abuse. The children treated with cognitive behavioral therapy demonstrated greater improvement in their knowledge regarding body safety skills at posttest than did the children who received supportive therapy.

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
Deblinger, E., Steer, R. A., Lippmann, J. (1999). Two-year follow-up study of cognitive behavioral therapy for sexually abused children suffering post-traumatic stress symptoms. <i>Child Abuse & Neglect</i> , 23, 1371-1378.	Child sexual abuse, Treatment outcome, PTSD, Cognitive behavioral therapy, Follow-up.	Empirical	MANCOVA	A series of repeated MANCOVAs, controlling for the pre-test scores, indicated that for the three measures of psychopathology that had significantly decreased in the original study (i.e., externalizing behavior problems, depression, and PTSD symptoms), these measures at 3 months, 6 months, 1 year, and 2 years were comparable to the posttest scores. These findings suggest that the pre- to post-treatment improvements held across the 2-year follow-up period. The clinical and research implications of these findings are discussed.
D'Andrea, W., Ford, J., Stolbach, B., Spinazzola, J., & van, K. B. A. (April 01, 2012). Understanding Interpersonal Trauma in Children: Why We Need a Developmentally Appropriate Trauma Diagnosis. <i>American Journal of Orthopsychiatry</i> , 82, 2, 187-200.	Interpersonal trauma, childhood trauma, psychological distress	Review	Literature Review	Children exposed to interpersonal victimization often meet criteria for psychiatric disorders other than posttraumatic stress disorder (PTSD). This study suggests broadening current conceptualizations for children, focusing on the prevalence of a variety of psychiatric symptoms related to affect and behavior dysregulation, disturbances of consciousness and cognition, alterations in attribution and schema, and interpersonal impairment.
de Arellano, M. A., Danielson, C. K., & Felton, J. W. (2012). Children of Latino descent: Culturally modified TF-CBT. In J. A.	Trauma-focused CBT; Complex trauma; Children; Adolescents; Evidence-based practice	Conceptual	Literature Review	Chapter in book by authors of TF-CBT. Outlines the modification process of CM-TF-CBT (TF-CBT adapted for use with Latino youth and their families).

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
Cohen, A. P. Mannarino, & E. Deblinger (Eds.). Trauma-focused CBT for children and adolescents: Treatment of applications (pp. 253-279). New York, NY: Guilford Publications.				
DeGruy, J. D. (2005). Post traumatic slave syndrome: America's legacy of enduring injury and healing. Milwaukee, OR: Uptone Press.	Slavery, trauma, slavery psychological effects	Conceptual		Slavery has had spiritual, psychological, and emotional effects on people of African descent.
Edlynn, E. S., Miller, S. A., Gaylord-Harden, N. K., & Richards, M. H. (2008). African American Inner-City Youth Exposed to Violence: Coping Skills as a Moderator for Anxiety. American journal of orthopsychiatry, 78(2), 249-258.	community violence, African American youth, anxiety, coping	Empirical	Cross-sectional; Longitudinal	Youth and parents both reported on youth exposure to community violence and anxiety symptoms; youth provided self-reports of their coping strategies. Data were analyzed by using hierarchical multiple regression analyses. As predicted, avoidant coping showed a protective function on anxiety symptoms; contrary to predictions, approach coping was unrelated to anxiety. Implications for future research on contextually and culturally relevant coping are discussed.

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
Federal Interagency Forum on Child and Family Statistics. America's Children: Key National Indicators of Well-Being, 2013. Washington, DC: U.S. Government Printing Office.	Indicators of well-being; children; family			These child well-being indicators span seven domains: Family and Social Environment, Economic Circumstances, Health Care, Physical Environment and Safety, Behavior, Education, and Health. Racial and ethnic diversity has grown in the United States, and the composition of the population continues to change.
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 Preventative Medicine, 14(4), 245-258.	child development, neurobiology, stress, childhood abuse, domestic violence, substance, mental health	Empirical	Logistic regression analysis	Based upon logistic regression analysis, the risk of every outcome in the affective, somatic, substance abuse, memory, sexual, and aggression-related domains increased in a graded fashion as the Adverse Child Experiences (ACE) score increased ($P < 0.001$). The mean number of comorbid outcomes tripled across the range of the ACE score. The graded relationship of the ACE score to 18 different outcomes in multiple domains theoretically parallels the cumulative exposure of the developing brain to the stress response with resulting impairment in multiple brain structures and functions.
Finkelhor, D., & Dzuiba-Leatherman, J. (1994). Children as victims of	rates of violence; victims of violence	Empirical	Data collection; telephone survey	A quarter of the sample reported a completed victimization in the previous year and over half reported a completed victimization over the course of their lifetime. The victimization of children occurs at a greater rate than previously

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
violence: A national survey. Pediatrics, 94(4), 413-420.				reported and is misrepresented by national statistics
Finkelhor, D., Ormrod, R., Turner, H., & Hamby, S. L. (2005). The victimization of children and youth: A comprehensive , national survey. Child maltreatment, 10(1), 5-25.	violence; victims; crime; assault; sexual assault; juveniles; incidence	Empirical	Data collection; survey	More than one half (530 per 1,000) of the children and youth had experienced a physical assault in the study year, more than 1 in 4 (273 per 1,000) a property offense, more than 1 in 8 (136 per 1,000) a form of child maltreatment, 1 in 12 (82 per 1,000) a sexual victimization, and more than 1 in 3 (357 per 1,000) had been a witness to violence or experienced another form of indirect victimization. Only a minority (29%) had no direct or indirect victimization. The mean number of victimizations for a child or youth with any victimization was 3.0, and a child or youth with one victimization had a 69% chance of experiencing another during a single year.
Fitzgerald, M. M., & Cohen, J. (2011). Trauma-focused cognitive behavioral therapy. Handbook of child sexual abuse: Identification, assessment, and treatment, 199–228.	TFCBT; sexual abuse; child; assessment; treatment	Review/Conceptual	Meta-analysis	TFCBT is an evidence based treatment for children 3 - 17 that addresses emotional, behavioral, and adaptive functioning post trauma through a conjunction of treatment elements.
Gallup, G. H., Moore, D. W., & Schussel, R. (1995). Disciplining children in America: A Gallup poll report. Princeton, NJ: The Gallup Organization.	Neglect; abuse; discipline; child discipline; child rearing; fights between parents	Empirical	Data collection	

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
Hollar, M. C. (2001). The impact of racism on the deliver of health care and mental health services. <i>Psychiatric Quarterly</i> , 72, 337-345.	racism culture cultural competence best practices	Review		Comprehensive mental health care must include cultural competency. In the use of psychopharmacology cultural competence is increased by understanding molecular epidemiology and the impact of culture on compliance.
Huey, S. J., & Polo, A. J. (2008). Evidence-based psychosocial treatments for ethnic minority youth: A review and meta-analysis. <i>Journal of Clinical Child and Adolescent Psychology</i> , 37, 262–301.	Meta-analysis; cultural competence; evidence-based treatment; minority youth; adaptations	Review	Meta-analysis	This article reviews research on evidence-based treatments (EBTs) for ethnic minority youth using criteria from Chambless et al. (1998), Chambless et al. (1996), and Chambless and Hollon (1998). Although no well-established treatments were identified, "probably efficacious" or "possibly efficacious" treatments were found for ethnic minority youth with anxiety-related problems, attention-deficit/hyperactivity disorder, depression, conduct problems, substance use problems, trauma-related syndromes, and other clinical problems. In addition, all studies met either Nathan and Gorman's (2002) Type 1 or Type 2 methodological criteria. A brief meta-analysis showed overall treatment effects of medium magnitude ($d = .44$). Effects were larger when EBTs were compared to no treatment ($d = .58$) or psychological placebos ($d = .51$) versus treatment as usual ($d = .22$). Youth ethnicity (African American, Latino, mixed/other minority), problem type, clinical severity, diagnostic status, and culture-responsive treatment status did not moderate treatment outcome. Most studies had low statistical power and poor representation of less acculturated youth. Few tests of cultural adaptation effects have been conducted in the literature and culturally validated outcome measures are mostly lacking. Recommendations for clinical practice and future research directions are provided.

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
Hunt, K. L., Martens, P. M., & Belcher, H. M. (2011). Risky business: trauma exposure and rate of posttraumatic stress disorder in African American children and adolescents. <i>Journal of traumatic stress</i> , 24(3), 365-369.	adolescent, African Americans/psychology, ambulatory care, child, female, humans, male, medical records, prospective studies, questionnaires, regression analysis, risk factors, severity of illness index, stress disorders, post-traumatic/epidemiology, United States/epidemiology, urban population, wounds and injuries/psychology	Empirical	Descriptive analysis; Linear regression models	Being female and witnessing domestic violence was associated with more PTSD symptoms. Exposure to community violence and physical abuse increased the odds of clinically significant PTSD symptomatology by more than 2 times. The rate of PTSD (16%) was lower in the current study than in other same-age study populations (25%–40%).
Kaufman Best Practices Project (2004). Closing the quality chasm in child abuse treatment: Identifying and disseminating best practices: Findings of the Kauffman best practices project to help children heal from child abuse. Charleston	EBT, child abuse treatment	Review		Kaufman Best Practices advocates the use of evidence based treatment when treatment traumatized children and offers thorough review of three EBTs: Trauma Focused -CBT, Abuse Focused - CBT, and Parent Child Interaction Therapy

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
(SC) 7 National Crime Victims Research and Treatment Center.				
Kelly, S. (2004). Underlying component of scores assessing African Americans' racial perspectives. Measurement and Evaluation in Counseling and Development, 37, 28-40.	theoretical perspectives of race, African Americans, Racial perspective	Empirical	Principal component analysis with a varimax (octoganal) rotation	African American racial attitudes correlated in ways consistent with theory.
Kelly, S. (2006). Cognitive-behavioral therapy with African Americans. Culturally responsive cognitive-behavioral therapy: Assessment, practice, and supervision, 97-116.	CBT, African Americans, cultural competence	Conceptual		CBT if effective with African Americans, however cultural competence must be utilized by therapists to ensure efficacy

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
Kendall, P. C., & Beidas, R. S. (2007). Smoothing the trail for dissemination of evidence-based practices for youth: Flexibility within fidelity. <i>Professional Psychology: Research and Practice</i> , 38, 13–20.	youth; treatment; fidelity; adaptation; evidence-based practice; empirically supported treatment; flexibility within fidelity, treatment manuals	Conceptual	Literature Review	The role and implementation of evidence-based practice and empirically supported treatments has been hotly contested among researchers and practitioners. Using examples of and from various empirically supported treatments the authors offer suggestions for smoothing the pathway for dissemination of evidence-based practice with children and adolescents. The authors underscore that mediational analyses, treatment process studies, and the continued creation of flexible treatment manuals are important components of successful dissemination. Flexibility within fidelity is proposed as the preferred perspective that eases the transition and dissemination of empirically supported treatments from research clinics to service clinics.

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. <i>BMC Psychiatry</i> , 8, 70.	meta-analysis; LGB; sexual minority; risk factors; suicide; substance use; mental disorder	Review	Meta-analysis	<p>OBJECTIVE = To undertake a systematic review of the international research literature to establish whether LGB people are at higher risk of mental disorder, substance misuse, suicide, suicidal ideation and DSH than heterosexual people and to quantify this risk. METHOD = Authors conducted a systematic review and meta-analysis of the prevalence of mental disorder, substance misuse, suicide, suicidal ideation and deliberate self harm in LGB people. They searched Medline, Embase, PsycInfo, Cinahl, the Cochrane Library Database, the Web of Knowledge, the Applied Social Sciences Index and Abstracts, the International Bibliography of the Social Sciences, Sociological Abstracts, the Campbell Collaboration and grey literature databases for articles published January 1966 to April 2005. RESULTS = Of 13706 papers identified, 476 were initially selected and 28 (25 studies) met inclusion criteria. Only one study met all our four quality criteria and seven met three of these criteria. Data was extracted on 214,344 heterosexual and 11,971 non heterosexual people. Meta-analyses revealed a two fold excess in suicide attempts in lesbian, gay and bisexual people [pooled risk ratio for lifetime risk 2.47 (CI 1.87, 3.28)]. The risk for depression and anxiety disorders (over a period of 12 months or a lifetime) on meta-analyses were at least 1.5 times higher in lesbian, gay and bisexual people (RR range 1.54–2.58) and alcohol and other substance dependence over 12 months was also 1.5 times higher (RR range 1.51–4.00). Results were similar in both sexes but meta analyses revealed that lesbian and bisexual women were particularly at risk of substance dependence (alcohol 12 months: RR 4.00, CI 2.85, 5.61; drug dependence: RR 3.50, CI 1.87, 6.53; any substance use disorder RR 3.42, CI 1.97–5.92), while lifetime prevalence of suicide attempt was especially high in gay and bisexual men (RR 4.28, CI 2.32, 7.88). CONCLUSION = LGB people are at</p>

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
				higher risk of mental disorder, suicidal ideation, substance misuse, and deliberate self harm than heterosexual people.

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
<p>King, M., Semylen, J., Killaspy, H., Nazareth, I., & Osborn, D. (2007). A systematic review of the research on counseling and psychotherapy for lesbian, gay, bisexual and transgender people. Leicester: British Association for Counseling and Psychotherapy .</p>	<p>meta-analysis; LGB; sexual minority; risk factors; suicide; substance use; mental disorder</p>	<p>Review</p>	<p>Meta-analysis</p>	<p>OBJECTIVES = To undertake a systematic review of quantitative research and a thematic review of the qualitative literature in order to:</p> <ul style="list-style-type: none"> a) Review existing research on counselling and psychotherapy for LGBT people. b) Describe and evaluate the contribution of different research measures, techniques and designs used in this area. c) Identify future priorities for policy, practice and research. <p>METHODS = We undertook a systematic search for:</p> <ul style="list-style-type: none"> a) Quantitative studies of counselling or psychotherapy for LGBT people focusing on: The specific nature of therapies used in this group; Research instruments used to assess effectiveness and client-centred satisfaction; Effectiveness within experimental or quasiexperimental designs b) Qualitative studies of psychotherapy and counselling for LGBT people. <p>RESULTS = From 7,775 citations identified in the electronic search, 92 papers were obtained as potentially appropriate for the review. A further 18 potential papers were obtained for the review, identified from the grey literature, from hand searching of journals and reference lists, and from searching the Internet using the Google search engine. Thus, 110 papers in all were read and considered for inclusion, of which 22 papers were eventually retained in the review. Fourteen provided quantitative data and 10 qualitative data; two papers contained both quantitative and qualitative data. There were no trials evaluating the effectiveness of psychological interventions in LGBT people, nor were there any longitudinal follow-up studies of people who had received a specific service or therapy.</p>

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				Two papers provided quantitative data on transgender participants, but none provided qualitative data for this group. For simplicity, however, we use the abbreviation LGBT and clarify when findings are specific to particular sub-groups. CONCLUSIONS= Despite an extensive search, we identified relatively few papers for inclusion in the review. Therefore, although the findings are somewhat limited, they are based on the best available evidence. These studies reveal that affirmative talking therapies appear to help LGBT people to normalise their day-to-day experiences, face and counteract the homophobic nature of their early development and receive therapy that is appropriately focused on issues brought to therapy, rather than on their sexual identity.
Lau, A. S. (2006). Making the case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. Clinical Psychology:	cultural adaptation, evidence-based treatments, minority children and families, parent training	Conceptual	Literature Review	This article discusses a framework (a) for identifying instances where cultural adaptation of EBTs may be most indicated, and (b) for using research to direct the development of treatment adaptations to ensure community engagement and the contextual relevance of treatment content. Ongoing work in the area of parent training is highlighted to illustrate key issues and recommendations.

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
Science and Practice, 13, 295–310.				
Loman, L. A. (2006). Families frequently encountered by child protection services. A report on chronic abuse and neglect. St. Louis, MO: Institute of Applied Research. Retrieved from http://www.iarstl.org/papers/FEfamiliesChronicCAN.pdf	CPS, CPS intervention, families and CPS	Empirical	Data Collection	The role of CPS as a body of prevention versus respons is explored, however cost factors appear to affect implementation of this concept; Quality of assessments and CPS reports must also be reevaluated.
Macartney, S., Bishaw, A., & Fontenot, K. (2013). Poverty rates for selected detailed race and Hispanic groups by state and place: 2007–2011. American Community Survey Briefs, 11(2).	poverty rates United States, poverty by race, poverty by region	Empirical	Data Collection	By race, the highest national poverty rates were for American Indians and Alaska Natives (27.0 percent) and Blacks or African Americans (25.8 percent).

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
Margolin, G., & Vickerman, K. A. (2007). Posttraumatic Stress in Children and Adolescents Exposed to Family Violence: I. Overview and Issues. Professional Psychology: Research & Practice, 38, 6.	Complex trauma	Review	Literature Review	This article presents research related to family violence exposure and describes how the often repeating and ongoing nature of family violence exposure can complicate a PTSD diagnosis. In addition, recent literature indicates that children exposed to family violence may experience problems in multiple domains of functioning and may meet criteria for multiple disorders in addition to PTSD
Massachusetts Department of Education (2004). Massachusetts 2003 Youth Risk Behavior Survey Results. Malden, MA: Author.	adolescents; youth; LGB; risk factors; risk behaviors;	Empirical	Frequency Analysis; multivariate statistical analyses	The Massachusetts Youth Risk Behavior Survey (MYRBS) is conducted every two years by the Massachusetts Department of Education with funding from the United States Centers for Disease Control and Prevention (CDC). The survey monitors adolescent risk behaviors related to the leading causes of morbidity and mortality among youth and adults. These behaviors include tobacco, alcohol, and other drug use; behaviors related to intentional and unintentional injuries; high-risk sexual behaviors; poor dietary patterns; and lack of physical activity. The 2003 MYRBS was conducted in the spring of 2003 in 50 randomly selected public high schools across the Commonwealth. In total, 3,624 students in grades 9 through 12 participated in this voluntary and anonymous survey. Because of the high student and school response rates, the results of this survey can be generalized to apply to all public high schools across Massachusetts.
Okundaye, J. N. (2004). Drug trafficking and urban African American youth: Risk factors for PTSD. Child and Adolescent	Drug Trafficking, urban, African American, youth, PTSD	Empirical	Qualitative	For the children in this study, development of PTSD depends on moderation of avoidance or numbing of emotional response, by social support, and ability to cope. For these children, once exposure to traumatic events and violence related to drug trafficking activities in the neighborhood has been established, activities that identify, modify, enhance and optimize social support and relative

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Social Work Journal, 21(3), 285-302.				ability to cope become vital to our prevention and intervention efforts. These are the entry points of prevention and intervention currently lacking for children exposed to violence and trauma related to drug trafficking activities.
O'Callaghan, P., McMullen, J., Shannon, C., Rafferty, H., & Black, A. (2013). A Randomized Controlled Trial of Trauma-Focused Cognitive Behavioral Therapy for Sexually Exploited, War-Affected Congolese Girls. <i>Journal of the American Academy of Child & Adolescent Psychiatry</i> .	randomized controlled trial, posttraumatic stress, depression and anxiety, sexual exploitation, war and conflict	Empirical	Randomized controlled study; pretest posttest	Compared to the wait list control, the TF-CBT group experienced significantly greater reductions in trauma symptoms ($F_{1,49} = 52.708, p < 0.001, \eta^2 = 0.518$). In addition, the TF-CBT group showed a highly significant improvement in symptoms of depression and anxiety, conduct problems, and prosocial behavior. At 3-months follow-up the effect size (Cohen's d) for the TF-CBT group was 2.04 (trauma symptoms), 2.45 (depression and anxiety), 0.95 (conduct problems), and -1.57 (prosocial behavior). A group-based, culturally modified, TF-CBT intervention delivered by nonclinically trained Congolese facilitators resulted in a large, statistically significant reduction in posttraumatic stress symptoms and psychosocial difficulties among war-affected girls exposed to rape or sexual violence. Clinical trial registration information—An RCT of TF-CBT with sexually-exploited, war-affected girls in the DRC

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
Patton, G. C., & Viner, R. (2007). Adolescent health 1: Pubertal transitions in health. <i>Lancet</i> , 369 (9567), 1130-1139.	adolescence; youth; puberty; sexual orientation; development	Review	Literature Review	Puberty is accompanied by physical, psychological, and emotional changes adapted to ensure reproductive and parenting success. Human puberty stands out in the animal world for its association with brain maturation and physical growth. Its effects on health and wellbeing are profound and paradoxical. On the one hand, physical maturation propels an individual into adolescence with peaks in strength, speed, and fitness. Clinicians have viewed puberty as a point of maturing out of childhood-onset conditions. However, puberty's relevance for health has shifted with a modern rise in psychosocial disorders of young people. It marks a transition in risks for depression and other mental disorders, psychosomatic syndromes, substance misuse, and antisocial behaviours. Recent secular trends in these psychosocial disorders coincide with a growing mismatch between biological and social maturation, and the emergence of more dominant youth cultures.
Pierce, C. (1974). Psychiatric problems of the Black minority. In S. Arieti (Ed.). <i>American handbook of psychiatry</i> (pp. 512-523). New York, NY: Basic Books.	Microaggressions, racism, psychiatric effects racism	Conceptual		It is the sum total of multiple microaggressions by whites to blacks that has pervasive affects on the stability and peace of this world
Richards, M. H., Larson, R., Miller, B. V., Luo, Z., Sims, B., Parrella, D. P., & McCauley, C. (2004). Risky and protective contexts and exposure to violence in urban African	violence adolescents, juvenile delinquency, emotional trauma, adolescent psychology, African Americans	Empirical	Covariance; data collection	Exposure to violence partially mediated the relation of time in protective and risky contexts to delinquent behaviors, assessed with the Juvenile Delinquency Scale and the Child Behavior Checklist, and distress levels, assessed by a posttraumatic stress disorder (PTSD) score.

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
American young adolescents. Journal of Clinical Child and Adolescent Psychology, 33(1), 138-148.				
Rose, O. N., Green, K. J. E., & Klein, M. (2008). Righteous indignation: A Jewish call for justice. Woodstock, Vt: Jewish Lights Pub.	Social justice in Jewish communities	Book Chapter		This chapter discusses topics related to social justice, Jewish imperative, and Jewish traditions which impact the social systems within the communities. Deep rooted traditions and values, as well as commandments are discussed in regards to their impact on the justice of the Jewish communities as a whole.
Ross, S. L., & Turner, M. A. (2005). Housing discrimination in metropolitan America: Explaining changes between 1989 and 2000. Social Problems, 52, 152-180.	unfair housing, racial discrimination housing	Empirical	Data collection	Disparate rates of discrimination in rental and owner occupied markets persist, but have generally declined in comparison to years prior.
Roysircar, G. (April 01, 2009). Evidence-Based Practice and Its Implications for Culturally Sensitive Treatment. Journal of Multicultural Counseling &	Culturally sensitive treatment, culturally informed psychotherapy, evidence based treatment	review	literature review	This article explains the history and theories of several culturally sensitive treatment models. Author of this article assesses culturally adapted therapeutic models with evidence-based practices. Therapists can advance CST by designing and evaluating interventions that are culturally relevant, rather than remaining dependent on manualized treatments.

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
Development, 37,2.)				
Runyan, D., Wattam, C., Ikeda, R., Hassan, F., Ramiro, L., Krug, E. G., ... & Lozano, R. (2002). World report on violence and health. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R. Geneva: World Health Organization.	child abuse correlates, SES child abuse	Empirical	Data collection	SES is a correlate of child abuse and neglect.
SAMHSA (2008). Review of trauma-focused cognitive behavioral therapy. Retrieved September 2013 from. http://www.nrepp.samhsa.gov/viewintervention.aspx?id=135	TFCBT, review of TFCBT	Review		Summarized intervention and grouped into distinct parts: descriptive information, review of research and outcomes, related costs, and contact information

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
Saunders, B. E., Berliner, L., & Hanson, R. F. (2003). Child Physical and Sexual Abuse: Guidelines for Treatment. Final Report.	child abuse, child advocacy, counseling, counseling techniques, guidelines, mental health programs, sexual abuse	Review		Reviewed 24 treatment protocols and their classifications on the factors assessed. All other protocols were rated as having a sound theoretical basis in generally accepted psychological principles. Regarding the quantity and quality of the clinical/anecdotal literature describing the use of the protocol, five were assessed as having relatively little literature available about their use with abused children and their families, and eight were rated as having "Some" clinical literature that could be examined. The other protocols have substantial clinical literatures describing their use with abused children and their families. As for acceptance and use within the child abuse treatment community, nine protocols were judged as having "Some use," while five had only limited use. The other 10 protocols were rated as having wide acceptance by practitioners working with child abuse victims and their families. Specific to TF-CBT, it had sound theoretical basis, substantial clinical anecdotal literature, accepted in clinical practice, little risk for potential harm, and a "1" rating of clinical support.
Sedlak, A.J., Mettenburg, J., Basena, M., Petta, I., McPherson, K., Greene, A., and Li, S. (2010). Fourth National Incidence Study of Child Abuse and Neglect (NIS-4): Report to Congress, Executive Summary. Washington, DC: U.S. Department of Health and Human	child abuse; neglect	Empirical	Data collection; surveys	Black children had higher rates of overall maltreatment, overall abuse and physical abuse, as well as overall neglect in comparison to White and Hispanic children.

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
Services, Administration for Children and Families.				
Task Force on Promotion and Dissemination of Psychological Procedures. (1995). Training in and dissemination of empirically validated treatments: Report and recommendations. Clinical Psychologist, 48, 3–23.	evidence-based treatments; EST; EBT; training; culture	Review	Literature Review	APA Division 12 Task Force report on the training in and dissemination of empirically valid treatments. Provides recommendations for APA action. Helps to define empirically valid treatments.
U.S. Census Bureau. 2012. "CPS 2012 Annual Social and Economic Supplement." Accessed through CPS Table Creator: http://www.census.gov/cps/cpstablecreator.html data/	social factors united states; race economy united states;	Empirical	Data collection	Black children account for 35% of the nation's poor, as opposed to 12% of White children and are almost seven times more likely to experience ongoing poverty in comparison to their White counterparts.
U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families,	child maltreatment; CPS; child abuse	Empirical	Data collection	As in prior years, the greatest percentage of children suffered from neglect; , a nationally estimated 1,640 children died from abuse and neglect; CPS agencies provide services to children and their families, both in their homes and in foster care. For FFY 2012, 51 states reported 678,810 (unique count) victims of child abuse and neglect.

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
<p>Children's Bureau. (2012). Child Maltreatment 2011. Available from http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment</p>				
<p>U.S. Department of Health and Human Services. (2001). Mental health: Culture, race and ethnicity—A supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Public Health Office, Office of the Surgeon General.</p>	<p>ethnic minorities; health disparities</p>	<p>Report</p>	<p>Literature Review</p>	<p>This Supplement to Mental Health: A Report of the Surgeon General (U.S. Department of Health and Human Services [DHHS], 1999) documents the existence of striking disparities for minorities in mental health services and the underlying knowledge base. Racial and ethnic minorities have less access to mental health services than do whites. They are less likely to receive needed care. When they receive care, it is more likely to be poor in quality.</p>
<p>Vespa, J., Lewis, J. M., and Kreider, R. M. (2013). America's families and living arrangements: 2012.</p>	<p>families in America, households in America, living arrangements</p>	<p>Empirical</p>	<p>Data collection; surveys</p>	<p>Between 1970 and 2012, the share of households that were married couples with children under 18 halved from 40 percent to 20 percent; Sixty-six percent of households in 2012 were family households, down from 81 percent in 1970; Between 1970 and 2012, the average number of people per household declined from 3.1 to 2.6; Black children (55 percent) and Hispanic children (31 percent) were more likely to live with one parent than non-Hispanic White children</p>

Reference Citation	Keywords/ Note to self	Type (Review, Conceptual, Empirical)	Methodology/ Design	Major Findings
				(21 percent) or Asian children (13 percent).
Westen, D., Novotny, C., & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. <i>Psychological Bulletin</i> , 130, 631– 663.	EST; RCT; efficacy; generalizability; external validity	Review	Literature Review	This article provides a critical review of the assumptions and findings of studies used to establish psychotherapies as empirically supported. The attempt to identify empirically supported therapies (ESTs) imposes particular assumptions on the use of randomized controlled trial (RCT) methodology that appear to be valid for some disorders and treatments (notably exposure-based treatments of specific anxiety symptoms) but substantially violated for others. Meta-analytic studies support a more nuanced view of treatment efficacy than implied by a dichotomous judgment of supported versus unsupported. The authors recommend changes in reporting practices to maximize the clinical utility of RCTs, describe alternative methodologies that may be useful when the assumptions underlying EST methodology are violated, and suggest a shift from validating treatment packages to testing intervention strategies and theories of change that clinicians can integrate into empirically informed therapies.

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APPENDIX B

Email to Recruit Expert Reviewer

To Whom it May Concern:

I am currently a fourth-year-doctoral student attending Pepperdine University's doctoral program in Clinical Psychology. As part of my dissertation project I am developing a TF-CBT supplemental resource manual for use with Black American adolescents. The overarching goal of this dissertation project is to strengthen the resources available to clinicians working with Black American adolescent survivors of trauma. This will be done by making selective and directed adaptations to each of the components of the TF-CBT treatment model, whereby enhancing minority community engagement and improving the contextual relevance of treatment content. For the purpose of this research project, I am seeking out potential reviewers who have at least three years of licensure as a licensed mental health professional. Based upon your expertise in the area of CBT, TF-CBT, interpersonal trauma, *or* Black American adolescents I would like to invite you to participate as an expert reviewer of this culturally adapted resource manual. Your role as a reviewer would include the following:

1. Read and review the adapted resource manual designed to be used in conjunction with the standard TF-CBT treatment manual.
2. Provide revisions, suggestions, or comments based upon your expertise in this area, which will be carefully considered for incorporation into the final draft of the manual.

If you are interested in participating as an expert reviewer, please take a moment to complete and return the brief questionnaire and consent form attached to this email. Furthermore, if selected to review the manual, you will be compensated with a \$50 Amazon gift card (via email) after reviewing the manual and providing your written feedback. If you would like further information or have any questions, please feel free to contact me. Thank you for your time and consideration.

Sincerely,

Anthea A. Gray, M.A.

APPENDIX C

Qualification Form for Expert Reviewer

1. Please indicate the number of years you have been licensed and in what field(s) (i.e., licensed clinical psychologist, licensed marriage and family therapist, licensed clinical social worker, or other).
2. How many years of licensed clinical experience have you had in treating individuals with interpersonal trauma?
3. How many years of licensed clinical experience have you had in treating Black American adolescents and in what type(s) of setting(s)?
4. How many years of licensed clinical experience have you had in providing CBT?
 - Have you had any post-license clinical experience providing CBT to Black American adolescents/young adults?
5. How many years of licensed clinical experience have you had in providing TF-CBT?
 - Have you had any post-license clinical experience providing TF-CBT to Black American adolescents?
6. Have you had any specialized training in TF-CBT or CBT? If so, what type? Was it related to working with Black American individuals?

APPENDIX D

Informed Consent Form

PEPPERDINE UNIVERSITY
Graduate School of Education and Psychology

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

Protocol Title: Developing a supplemental resource for Trauma-Focused Cognitive Behavioral Therapists working with Black American adolescents.

I have been invited to participate in a research study conducted by Anthea A. Gray, M. A. (Principal Investigator) and Thema Bryant-Davis, Ph.D. (Faculty Advisor) at Pepperdine University, because I am a licensed clinician with expertise in either interpersonal trauma, CBT, TF-CBT, and/or Black American (BA) adolescents. My participation is voluntary. I have been advised to read the information below, and ask questions about anything that I do not understand, before deciding whether to participate. If I decide to participate, I will be asked to sign this form. I will also be given a copy of this form for my records.

PURPOSE OF THE STUDY

The purpose of the study is to strengthen the resources available to clinicians working with BA adolescent survivors of trauma. This will be done by making selective and directed adaptations to each of the components of the Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) treatment model and developing a supplemental resource that provides recommendations for TF-CBT therapists working with BA adolescents. Therefore, the goal is to develop a culturally sensitive resource manual that can be used in conjunction with the TF-CBT treatment model.

STUDY PROCEDURES

If I volunteer to participate in this study, I will be asked to review and provide qualitative feedback on the supplemental resource being developed through this research project. I will be emailed a copy of the supplemental resource manual and asked to complete an attached evaluation form. The evaluation form will include sections for providing written feedback regarding the supplement as a whole, as well as within each area of specific content. I am free to conduct my review at any time or place convenient to me. It is estimated that the duration of my participation will range between 1-2 hours. I will be asked to return the evaluation form via email so that the feedback can be considered for incorporation into the final draft of the supplemental resource. I will be offered the opportunity to have my contribution to the research project recognized in the supplemental resource, or I may choose to have my contribution remain confidential. The process mentioned within this paragraph is the sole procedural means of participation for this study.

POTENTIAL RISKS AND DISCOMFORTS

The participation of expert reviewers presents only minimal, foreseeable risks, such as boredom

or fatigue from completing the evaluation form.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

The primary goal of the TF-CBT recommendations for BA adolescents is to enhance the effectiveness of the treatment and increase retention of BA participants and their families by building upon the evidence based foundation of the seminal TF-CBT model. In doing so, the recommendations may serve to increase the cultural sensitivity of clinical providers and may establish greater resonance with BA participants and their families. By providing an increased understanding of the variables (past and contemporary) that contribute to an BA individual's unique experiences of trauma, providers will be better equipped to validate, normalize, empathize with, and address the unique needs of their BA clients and their caregivers.

PAYMENT/COMPENSATION FOR PARTICIPATION

I will receive a \$50 Amazon gift card for my time. The gift card will be given to me when I return the completed resource manual evaluation form via email. I may choose to have the gift card emailed to me or sent by mail.

CONFIDENTIALITY

The records collected for this study will be kept confidential as far as permitted by law. However, if required to do so by law, it may be necessary to disclose information collected about you. Examples of the types of issues that would require me to break confidentiality are if disclosed any instances of child abuse and elder abuse. Pepperdine's University's Human Subjects Protection Program (HSPP) may also access the data collected. The HSPP occasionally reviews and monitors research studies to protect the rights and welfare of research subjects.

Regarding confidentiality, email correspondence that contains dialogue between all participants, as well as requested forms for completion, will be stored electronically via the secured, password protected Pepperdine email server for three years total (viz., 2020), at which point the information will be deleted from the server.

SUSPECTED NEGLECT OR ABUSE OF CHILDREN

Under California law, the researcher(s) who may also be a mandated reporter will not maintain as confidential, information about known or reasonably suspected incidents of abuse or neglect of a child, dependent adult or elder, including, but not limited to, physical, sexual, emotional, and financial abuse or neglect. If any researcher has or is given such information, he or she is required to report this abuse to the proper authorities.

PARTICIPATION AND WITHDRAWAL

My participation is voluntary. My refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. I may withdraw your consent at any time and discontinue

participation without penalty. I am not waiving any legal claims, rights or remedies because of your participation in this research study.

ALTERNATIVES TO FULL PARTICIPATION

The alternative to participation in the study is not participating or only completing the items for which I feel comfortable.

INVESTIGATOR'S CONTACT INFORMATION

I understand that the investigator is willing to answer any inquiries I may have concerning the research herein described. I understand that I may contact Anthea A. Gray, M. A. (Principal Investigator), at xxxxx or by phone at xxxxx, or that I may contact Thema Bryant-Davis, Ph.D. (Dissertation Chairperson), at xxxxx or by phone at xxxxx, if I have any other questions or concerns about this research.

RIGHTS OF RESEARCH PARTICIPANT – IRB CONTACT INFORMATION

If I have questions, concerns or complaints about my rights as a research participant or research in general I can contact Dr. Judy Ho, Chairperson of the Graduate & Professional Schools Institutional Review Board at xxxxxx, xxxxx or xxxxx.

SIGNATURE OF RESEARCH PARTICIPANT

I have read the information provided above. I have been given a chance to ask questions. My questions have been answered to my satisfaction and I agree to participate in this study. I have been given a copy of this consent form.

Name of Participant

Signature of Participant

Date

SIGNATURE OF INVESTIGATOR

You have explained the research to the subjects and answered all of his/her questions. In your judgment the participants are knowingly, willingly and intelligently agreeing to participate in this study. S/he has the legal capacity to give informed consent to participate in this research study

and all of the various components. The subject has also been informed participation is voluntarily and that s/he may discontinue s/he participation in the study at any time, for any reason.

Name of Person Obtaining Consent

Signature of Person Obtaining Consent

Date

APPENDIX E

Evaluation Form

To: Expert Reviewer
From: Anthea A. Gray
Subject: Evaluation Form

Date: _____

Dear: _____,

Thank you so much for making the time and effort to review my dissertation, *Developing a supplemental resource for Trauma-Focused Cognitive Behavioral Therapists working with Black American adolescents*. Please record any feedback and recommendations you might have for this project within this document. As mentioned previously, your contributions (viz., feedback, comments, recommendations) to this project will not be cited explicitly, however your name will be mentioned – unless otherwise specified – within the “Acknowledgements” portion of my final manuscript.

Additionally, once you have emailed me back your completed Evaluation Form, I will promptly mail or email you the \$50 Amazon gift card. In your email, please include your preferred method for delivery of the \$50 gift card (i.e., preferred email address or preferred mailing address.)

Again, thank you for your participation!

Kind regards,

Anthea A. Gray, M.A.
Pepperdine University

Feedback and Recommendations

What did you find to be *most* helpful about the manual?

What did you find to be *least* helpful about the manual?

To what extent does the manual strengthen the relevance of TF-CBT for BA adolescents?

To what extent does the manual appear to be culturally sensitive?

Impressions, recommendations, or feedback regarding individual components/chapters:

- Chapter 1: Psychoeducation:
- Chapter 2: Parenting Skills:

- **Chapter 3: Relaxation Skills:**
- **Chapter 4: Affective Expression & Modulation Skills:**
- **Chapter 5: Cognitive Coping & Processing (Part 1):**
- **Chapter 6: Trauma Narrative:**
- **Chapter 7: Cognitive Coping & Processing (Part II):**
- **Chapter 8: In-vivo Exposure and Mastery of Trauma Reminders:**
- **Chapter 9: Conjoint Child-Parent Sessions:**
- **Chapter 10: Enhancing Future Safety and Development:**

Overall impressions of the resource manual:

How could the manual be improved to make it more effective for BA clients who have experienced trauma?

APPENDIX F

Supplemental Resource Manual

A SUPPLEMENTAL RESOURCE FOR TRAUMA-FOCUSED
COGNITIVE BEHAVIORAL THERAPISTS WORKING WITH
BLACK AMERICAN ADOLESCENTS

Chapter 1: Psychoeducation

Assessment and Awareness of Black American Culture

When working with Black American youth and their families - or any cultural group for that matter - the work starts before the first client interaction; it will be important for providers to familiarize themselves with the Black American culture (Williams, et al., 2014). Though the discussion of race and culture can be a difficult topic to broach in therapy, providers that share their understanding and experience working with Black American youth and families, as well as disclosing relevant information regarding their own culture has been found to increase the client's perception of empathy, engagement, and the working therapeutic alliance (Owen, Tao, Leach, & Rodolfa, 2011). Providers might also even consult with a peer, do some explorational journaling, or complete an implicit attitudes questionnaire, such as Harvard's Project Implicit at <https://implicit.harvard.edu/implicit/> to uncover any potential biases they might have towards Black Americans and or providing clinical treatment to Black Americans. Those whose questionnaire results indicate possession of cultural bias might try consultation and or supervision with an expert in Black American issues, family, and youth. One of the goals of these pre-treatment exercises is to avoid overpathologizing and misattributing clinical observations to common cultural experiences and norms (Chapman, Delapp, & Williams, 2014; Williams et al., 2014).

Clinical example: A Black American youth presents to treatment almost stoic and without emotion after witnessing her father being shot. Initially, the TF-CBT providers chalks her behavioral observations up to sheer psychopathology. After further investigation and recollection of "The Strong Black Woman" persona (Harrington, Crowther, & Shipherd, 2010),

the provider does not rule out a psychological dysfunction, but is now better able to fully conceptualize the youth's presentation.

Recognition of archetypal defense mechanisms, such as “The Strong Black Woman” (Harrington et al., 2010) or John Henryism (Buser, 2009) that developed in response to prolonged exposure to racism and microaggressions foster added value in the aesthetic of strength (Williams et al., 2014). Clearly this adaptive transformation to negative stimuli can be beneficial in some scenarios, but in the context of trauma psychotherapy - a highly personal, intimate activity that requires disclosure, trust, expression of negative emotion (e.g., fear, shame, humiliation) and vulnerability - once esteemed characteristics might now interfere with positive treatment outcomes (Williams et al., 2014). These values, which are often ingrained in many Black Americans, make this period of intervention critical. Considerable time should be spent developing the therapeutic alliance before treatment begins (Williams et al., 2014).

It will also be useful to consider the potential effects of historical traumas on Black Americas. Though a strong body of research related to intergenerational trauma has been outlined with specificity to individuals of Native American and Jewish heritage, authors such as DeGury (2005) have noted a process within Black Americans. In addition to identifying current cultural biases and racism (e.g., mass incarceration of Black men, police brutality) as contributing factors to Black American values, behaviors, and beliefs, DeGury (2005) points to historical circumstances (e.g., culture of fear associated with lynchings, Jim Crow law era, slavery) that maintain relevance long after their occurrence. Understanding Post Traumatic Slave Syndrome, a term coined by DeGruy (2005), as well as the general effects of historical trauma amongst individuals of African descent that were enslaved in America will broaden the

provider's conceptualization and overall approach to working with Black American youth and their caregivers.

As a reminder, it is important to consider the degree of heterogeneity within the Black American population, as within group experiences can vary considerably, so keep in mind that each client may or may not relate to traditional Black American values. Williams and colleagues (2014) suggest the utilization of pre-assessment measures that capture the varied experiences and values (e.g., ethnic identity, religiosity) within Black American culture. Using self-report measures, such as the Brief Religious Coping Scale (Pargament, Feuille, & Burdzy, 2011; Pargament, Smith, Koenig, & Perez, 1998) or the Multidimensional Inventory of Black Identity (Sellers, Rowley, Chavous, Shelton, & Smith, 1997), the provider will find themselves at a better vantage point to make individualized, cultural adaptations that this dissertation seeks to provide.

Orientation to TF-CBT

During the orientation portion of this introductory module, the provider will provide a general outline for treatment: session length, number of sessions, confidentiality and critical issues, rationale for treatment role of the therapist, role of the child, and role of the caretaker. Given common beliefs, stigma, and underutilization of mental health services in comparison to other cultural groups (Alvidrez, Snowden, & Kaiser, 2008; Barksdale & Molock, 2008; Dobalian & Rivers 2008), it will be useful to have an open dialogue regarding preconceptions of therapy. It will also be helpful to offer a period of questions and answers for both the youth and their caregiver to increase the collaborative nature of the protocol.

Normalization

The primary goal of this treatment component is to increase the youth and caretaker's understanding of trauma related symptomatology by normalizing their behavioral and emotional

experiences through psychoeducation (Cohen, Mannarino, & Deblinger, 2006). Though this module is designated at the start of the protocol, psychoeducation is provided throughout the whole of treatment (Cohen et al., 2006). Normalization is one of the key components of the psychoeducational module, as it offers trauma survivors and their caretakers an alternate framework to conceptualizing their seemingly abnormal experiences via education about the effects of trauma on all domains of functioning (e.g., emotional, psychological, behavioral, social). Through this process, youth and their caretakers are able to foster appropriate attitudes, cognitions, and beliefs about the trauma in an effort to mitigate negative affect, such as self-blame and guilt (Cohen et al., 2006). Specific to Black American youth and their caregivers, normalization may work to counterbalance archetypal perceptions of the emotionally and physically strong, self-reliant individual who might view symptoms associated with trauma as a reflection of weakness (Buser, 2009; Harrington et al., 2010; Poussaint & Alexander, 2000).

Therapeutic Alliance

Given psychoeducation's potential capacity to catalyze and develop the therapeutic relationship (Cohen et al., 2006; Williams et al., 2014), this component will be especially useful when practiced with Black American youth and their caretakers due to the history of non-disclosure with strangers (Tucker, 1999), as well as the common experience of mistrust experienced by this cultural group and medical/mental health service providers (Williams et al., 2014), particularly if the clinician's ethnicity differs from that of the Black American youth and their caretakers (Williams et al., 2014). Should the clinician's ethnicity differ from their clients, it is suggested that special attention be made to address those differences in an attempt to increase rapport, decrease institutional perceptions of mistrust, and subsequently increase the likelihood of treatment adherence (Williams et al., 2014). The potential consequence of not

speaking to cultural differences is dissolution of the therapeutic alliance (Constantine, 2007; Terwilliger, Bach, Bryan, & Williams, 2013).

Definition of Trauma

Another piece of the psychoeducation module is providing education which includes a definition of the trauma and the client's specific trauma (e.g., sexual abuse); prevalence of perpetration; who can be affected, potential emotional, behavioral, and cognitive effects; and how a trauma survivor and their caretakers can find help and symptom relief (Cohen et al., 2006). This information is transmitted orally, in-person but may also be supplemented through various medium. Illustrative handouts containing psychoeducative material may offer a quick reference guide to clients (Cohen et al., 2006). These handouts might also aid in ameliorating feelings of being overwhelmed by a deluge of information (Cohen et al., 2006) and appeal to youth and caregivers that prefer to digest information visually. This phase of treatment is also a good time to share the effectiveness - empirical and anecdotal based on personal, clinical experience - of this protocol with Black American youth and their caregivers (Cohen et al., 2006; Williams et al., 2014). Information could also be relayed through age appropriate books on the subject of trauma (Cohen et al., 2006).

Diagnostic Information

In addition to providing psychoeducation on the youth's trauma and its associated symptoms, the clinician should also provide clear diagnostic information using non-clinical language (Cohen et al., 2006). Given the history of misdiagnosis and over-pathology within the Black American community (Chapman et al., 2014), relating the diagnosis in a way that does not further marginalize the youth and their caretakers (Cohen et al., 2006) will be essential.

Treatment Components - What to Expect

During this portion of the psychoeducation module, the provider will outline the course of treatment: psychoeducation, parenting skills, relaxation, affective expression and modulation, cognitive coping and processing, trauma narrative, processing the traumatic experience, in-vivo mastery of trauma reminders, conjoint caregiver and youth sessions, and increasing/developing safety (Cohen et al., 2006). In an effort to help manage the potential sequelae of emotions that might arise as a result in response to some of the more emotionally demonstrative TF-CBT components, education on strategies and coping skills that facilitate these symptoms is suggested (Cohen et al., 2006). Because Black Americans often have an expansive system of support outside of their family of origin, the provider should encourage the youth and their caregiver(s) to call upon those external supports (e.g., church peers, higher power, neighbors, etc.) during their treatment (Billingsley & Caldwell, 1991; Ruggles, 1994; Williams et al., 2014). The therapist's recommendation and encouragement to seek external support might increase treatment adherence, treatment outcomes (Williams et al., 2014), and increase the likelihood of sustainability when the TF-CBT protocol concludes.

Afrocentric approach. As suggested by Williams and colleagues (2014) in their cultural adaptation of Prolonged Exposure Therapy with Black Americans, the TF-CBT model might also be augmented by an Afrocentric approach that is infused with traditional Black American tenants and values, such as resilience, faith, family and social support, and hope (Azibo, 1992; Jackson & Sears, 1992). Utilization of an Afrocentric approach should be based on the client's background and interest in this approach - much of which can be gathered via clinical interview and or the previously mentioned assessment measures that evaluate racial identity.

Black American youth tend to display higher treatment outcomes and satisfaction when frequent, consistent, and interactive interventions are used (Bandy & Moore, 2011). Such interventions are reviewed below.

Music therapy. Within the Black American community, music – historically and currently – functions as a bridge to awareness, understanding, emotional healing, and connectedness (Armstrong & Ricard, 2016; Dutton, 2001). Music therapy might offer youth with PTSD and other trauma-associated symptoms a safe, non-threatening means of exploration, versus the traditional talk-therapy, which might be experienced as confronting or awkward (Ciardiello, 2003; Carr, d’Ardenne, Sloboda, Scott, Wang, & Priebe, 2012). Rap music, as well as spoken word poetry are specific types of rhythmic interventions whose messages often mirror the cultural experiences of the youth – a process which facilitates self-reflection and problem resolution (Day-Vines & Day-Hairston, 2005).

Spirituality. Spirituality, hope, and participation in positive activities act as protective factors for many Black Americans (Bryant-Davis, 2013; Logan, 2001; Marques, Lopez, & Mitchell, 2013), providing a greater sense of life satisfaction (Marques et al., 2013). For many Black American families the Black Church serves as the epicenter for not only religious, but also civic engagement - providing resiliency and hope to its parishioners (Harley, 2011). As mentioned prior, if religion is an important part of the client’s life, encouragement to seek support through their center of faith is advisable. In session and out of session exercises that utilize faith-based interventions, as well as language laden with spiritual vocabulary might be useful if the practice is of interest to the client and the client’s family.

Dance. The significance of dance in Black American culture reflects an intrinsic cultural orientation toward physical expressiveness, creativity, and movement through challenging

situations (Farr, 1997; Vinesett, Price, & Wilson, 2015). Since bodily connection can be a particularly sensitive activity with trauma survivors, it is suggested that the youth start with small movements (Levine & Land, 2015). Throughout this process, it will be important for the provider to normalize any difficulty with movement and offer psychoeducation on any potential reluctance (e.g., shyness, wanting to protect their bodies that may have been harmed by another, fear of vulnerability) (Levine & Land, 2015). Levine and Land (2015) further suggest an activity referred to as *shadow movements* in which the provider mimics the youth's activity in an effort to increase awareness through reflection. If the caregiver(s) would like to join in this activity, they may also provide reflection to the youth's movement. When the youth is ready to increase their range of motion and movement, allow them to pick their favorite music, and move how they like. The youth is then encouraged to label their movement with words (Levine & Land, 2015) using culturally syntonic language. The fusion between mind and body that occurs in expressive movement is thought to provide insight into the ways in which the body has responded to trauma and stored the trauma narrative within the body (Levine & Land, 2015; Ogden, Minton, & Pain, 2006). As the youth's capacity for self-awareness and self-expression increases, gradually and intuitively their bodies and minds will unhinge their responses to trauma (Levine & Land, 2015; Ogden, Minton, & Pain, 2006).

Chapter 2: Parenting

The primary goal of the parenting module is to improve the overall quality of the caregiver and child relationship that might become strained as a result of the youth's traumatic experience (Cohen et al., 2006). In an effort to attain these goals, Cohen and colleagues (2006) highlight various parenting techniques and tools that might help them better manage their child's symptomatology, as well as support the growth and lessons their child has obtained during TF-CBT.

As a general review of the TF-CBT parenting module, it is suggested that activities such as praise, selective attention/ignoring, rewards, and consequences be implemented into one's parenting practices (Cohen et al., 2006). These are implemented utilizing instruments such as worksheets, role plays, observation, and practicing new skills with youth (Cohen et al., 2006). Cohen and colleagues (2006) parenting techniques will not be reviewed in this chapter, as the goal of this dissertation is to offer a culturally specific supplement to fill in potential gaps within the seminal TF-CBT model. Thus, the interventions discussed in this chapter are concepts that might augment the original protocol.

African American Parenting Practices and Styles

Though any cultural group's parenting practices and values can be difficult to generalize, African American parenting has often been characterized as “no-nonsense parenting,” a descriptive term used to describe a theoretically authoritative style of parenting (Baumrind, 1967, 1991; Brody & Flor, 1998) marked by parental affection, caring, and encouragement (Mandara, 2006; Tamis-Lemonda, Briggs, McClowry, & Snow, 2008). As a point of information, the parenting literature operationalizes “authoritative” in numerous ways: a punitive style of communication and overall relation to the youth, using harsh parenting tactics and discipline, or

being intrusive (Tamis-Lemonda et al., 2008). However, this style of parenting within African American culture is sandwiched by numerous shared cultural beliefs that include an emphasis on achievement and effort (Hurd, Moore, & Rogers, 1995); showing respect for others through compassion, helping others, and being honest (Hurd et al., 1995); having a strong sense of spirituality and connectedness to one's faith community (Harley, 2011; Hurd et al., 1995); development of self-reliance in a world in which they will face culturally related adversity and discrimination (Hurd et al., 1995; Tamis-LeMonda et al., 2008); education (Hurd et al., 1995; West-Olatunji, Sanders, Mehta, Behar-Horenstein, 2010); acceptance and management of the ebbs and flows of life, resiliency, and persistence (Hurd et al., 1995); and self-respect and cultural pride (Hurd et al., 1995; Tamis-Lemonda et al., 2008). Infusion of the aforementioned African American values, as well as the unique values of your client(s), into this parenting module should be made whenever possible.

Parenting Discussion - Psychoeducation and Inquiry

Though the caregiver might be totally receptive to the parenting module, there might be others that are challenged by this component of the TF-CBT model. Offering another individual parenting tips can certainly be a precarious scenario, particularly if the provider is of another cultural group (e.g., without children, different age range, single, not-African American). Questions and comments that might arise when working with an African American parent might include:

- *“You don’t have kids, how are you going to tell me how to raise mine?”*
- *“No offense, but you’re not African American. I really don’t think you can relate to what we’re dealing with.”*
- *“We’ve been spanking our kids for generations, I don’t get how this psychology mumbo-jumbo is going to work.”*
- *“I don’t want to make my kid soft.”*
- *“Time outs? ‘We’ don’t do those in our culture.”*

Regardless of the parent's degree of receptivity, begin the module with comprehensive psychoeducation on the purpose for this module and goals of the suggested interventions. Additionally, offer recognition and appropriate discussion of any explicit and or perceived cultural differences between provider and caregiver(s) (Williams, Malcoun, Sawyer, Davis, Nouri, & Leavell Bruce, 2014). Normalization of common African American parenting styles and practices should also occur within this period. After thorough psychoeducation, an open discussion related to the parent's parenting values and practices should follow. The provider should offer normalization, validation, supportive research, and a sense of cultural awareness (Williams et al., 2014) to instill a sense of hope within the caregiver. Based on the generated discussion, as well as the caregiver's level of openness, the clinician can tailor the parenting interventions accordingly. General adaptations using common African American values have been provided within this supplemental chapter.

Clinical Example:

Caregiver - "I raise my kids like my grandmother raised me - with tough love. That used to work with my kid, but ever since he was abused, I feel like I don't know what I'm doing anymore."

Provider - "Many parents experience feelings of helplessness when something like this happens to their child. You've been using a 'tough-love' approach with your son, just as your ancestors used for years. I don't want you to change that if it's working. I just want to help you tweak some things. I know spirituality and family is important to you, so whatever we do we'll make sure those things are represented and I'll get your feedback before we move along. And just remember, if you feel uncomfortable with anything I suggest, please let me know so we can discuss and make changes that are congruent with your values."

Depending on the African American caregiver's values, some of TF-CBT's suggested parenting interventions (Cohen et al., 2006) might pose an initial challenge, as many African American caregivers parent with greater authoritative features of parenting in comparison to other cultural groups (Mandara, 2006). Implementation of interventions such as time-out and selective attention, might be looked upon as taking a hands off approach and could be difficult initially. Encourage the African American to try the suggested exercises, allow space for processing and discuss barriers to intervention, and discuss the youth's receptivity to the intervention. It will be important to share this intervention strategy with individuals within the family of origin's extended network of support (e.g., individuals at centers of worship, extended family members, fictive kin - family friends, neighbors, etc.).

Ethnic Socialization

Ethnic socialization is defined as the installation of ethnic pride by educating African American youth on their respective cultural concerns, information, values, traditions, history (Hughes, Bachman, Ruble, & Fuligni, 2006; Hughes, Rodriguez, Smith, Johnson, Stevenson et al., 2006). It is generally considered an important practice amongst African American families and communities, as it can help prepare youth for experiences of ethnic bias and injustice (Hughes et al., 2006; Hughes & Johnson, 2001). In a literature review of ethnic socialization practices, Hughes and colleagues (2006) found that across some studies, ethnic socialization was associated with increased self-esteem, greater coping abilities when confronted with experiences of prejudice and discrimination, and fewer externalizing behaviors. To this author's knowledge there is no research that studies the correlation of trauma related symptoms and racial socialization, however this practice might offer some potential benefits to trauma survivors, particularly if the related trauma has racial undertones (e.g., police brutality, hate-crime,

colorism). Racial socialization practices might also offer caregivers an added opportunity to connect and engage with their youth after their traumatic experience.

It is encouraged that caregivers get creative with this module. Some suggested ethnic socialization practices include exposure to African and African American culture through the arts by going to free exhibits at local museum; making and wearing Afrocentric jewelry and fashion attire; wearing traditional African American hairstyles; and even engaging in African American traditions such as going to the barbershop together. Caregivers might also speak to youth about the historical salience of African and African American music, literature, and books from different eras; educate on cultural leaders and figures, eat traditional foods, watch ethnic movies and read ethnic literature, and expose youth to productive and successful individuals in the community (e.g., police officers, teachers, health providers, civic groups, etc.) (Umaña-Taylor & Fine, 2004).

Spirituality development. For many African American families, spirituality and religiosity plays an integral in everyday living (Harley, 2011). A sense of spirituality can also offer a protective value when used as trauma coping mechanism (Bryant-Davis & Wong, 2013). If the youth's family holds religion and spirituality in high regard, activities that increase one's connectedness to their higher power or their own spirit/soul this intervention could be particularly useful. Such activities might include saying prayers with one another, guided meditations, yoga practice, deep breathing exercises, going to church/place of worship, creating relationships with members at centers of worship, going on walks together, spending time in nature, playing with animals, making dinner together, and even volunteering.

Chapter 3: Relaxation

The chronic stress that a trauma survivor experiences may experience can create a host of physiological responses in the body that relaxation strategies can be particularly useful in amelioration of symptoms (Cohen, Mannarino, Deblinger, 2006). The body's reactivity to trauma, can reveal itself somatically and behaviorally in a number of ways: increased heart rate - active and resting - and blood pressure (Brownley, Hurwitz, & Schneiderman, 2000; Buckley & Kaloupek, 2001; Cohen et al., 2006), poor sleep (Charuvastra & Cloitre, 2009), poor weight regulation and obesity due to increased cortisol levels (Danese & Tan, 2014), anxiety related aggression (Marsee, Weems, & Taylor, 2008), hyperactive sympathetic and parasympathetic nervous systems that affect threat appraisal and processing (Buckley & Kaloupek, 2001), thus resulting in hypervigilance, mistrust, and an increased startle response, and other somatic complaints (e.g., irritable bowel syndrome, chronic pain, and chronic fatigue) (Afari et al., 2014). Trauma related stress may be even greater within Black American adolescents due to the added experience of racial discrimination (Gaylord-Harden & Cunningham, 2009). The physiological sequelae are of particular concern to Black Americans - a population that experiences greater health issues in comparison to European Americans (Taylor et al., 2005). In relation to European Americans, Black Americans have higher rates of diseases, such as cardiovascular disease, diabetes II, asthma, and certain cancers (Betancourt, 2006). The Centers for Disease Control notes that these health disparities could impact Black American's quality of life and rates of mortality (2005). It is believed that some of the contributing factors to these ongoing health disparities are the social and economic inequalities between the two cultural groups (Jackson & Knight, 2006). In an effort to cope with chronic stressors, such as race related discrimination, poverty, and limited access to resources, many Black Americans have

come to rely on unhealthy coping tools, such as smoking, emotional eating, eating nutrient depleted foods, and inactivity, which increases the likelihood for medical issues such as diabetes, obesity, and cardiovascular concerns - health issues that are prominent within the Black American community (Betancourt, 2006; Din-Dzietham, Nembhard, Collins, & Davis, 2004). These significant health disparities increase the importance of the offered relaxation strategies within this chapter. It is by practicing the suggested relaxation strategies that reduces internal states of over-activity and gives the adolescent an opportunity to feel at ease by using healthy, accessible coping tools.

Offering psychoeducation on the potential for physical signs of trauma to the adolescent to increase awareness and normalize their experience might be of utility (Cohen et al., 2006). Psychoeducation and normalization of physical signs of trauma might be especially useful to Black American youth to assuage the stigma of mental health issues that lingers amongst some Black Americans (Alvidrez, Snowden, & Kaiser, 2008).

The placement of this module towards the former half of the protocol is far from happenstance. The introduction to relaxation strategies early on in treatment was done so to (1) facilitate the reduction in current physiological symptoms and (2) prepare and empower the adolescent with coping skills for the physiological symptoms that *might* appear as a result of later modules that involve exposure or trauma processing. Cohen and colleagues (2006) note that not all adolescents will find utility in the relaxation training module, as some will be more comfortable with discussing their trauma than others. For those adolescents, it is suggested that the treatment be weighted in the development of cognitive and emotional expressive skills that might increase their ability to communicate their experiences in a manner that does not create psychological dysregulation (Cohen et al., 2006).

During session, the therapist can offer an introduction to each of the following relaxation strategies, followed by a demonstration, and in-session practice. To get the optimal benefits from these exercises, it is suggested that the adolescent practice regularly throughout the week with their caregiver, if possible, and alone.

Mindfulness

Mindfulness involves an encouragement of being in the present and simultaneously encouraging awareness of one's environment and ultimately one's body (Siegel, Germer, Olendzki, 2009). Though there are many well established health and psychological benefits to utilizing non-pharmacological and alternative relaxation strategies (Davis & Hayes, 2011; Greenberg & Harris, 2012; Thompson, Arnoff, & Glass, 2011), there are less supporting its efficacy within Black American youth (Black Milam, & Sussman, 2009; Robinson, Droege, Case, & Jason, 2015). When considering mindfulness-based interventions, it is important to consider potential barriers to acceptance and implementation amongst Black American adolescents. Though there are a wide range of values and traditions within the Black American culture, religion and prayer are common systems of beliefs and practices that are interwoven and deeply ingrained into daily living (Saghal & Smith, 2009). When introducing a mindfulness based activity to an Black American youth, it will be important to assess their familiarity with the practice and explore any potential conflicts the practice might have with their religious faiths. Added psychoeducation on mindfulness - paying extra attention to the fact that it is not a religion - is also suggested. Should the therapeutic recipient come from a particularly religious background, utilization of culturally salient language might increase receptivity to the exercises.

Potential ways to introduce mindfulness based relaxation interventions to an individual with high religiosity:

- Replace mention of traditional Eastern leaders with the adolescent's faith (if the two are not mutually exclusive). For example, "Buddha says ..." might be replaced with, "Jesus says" or "Allah says."
- Replace the word "meditation" with "relaxation," to avoid misappropriation of general beliefs that meditation is a religion
- Integrate faith based examples that utilize literature of the youth's respective faith throughout the exercises.
- Offer education on what mindfulness is and its origins (Siegel et al., 2009)

Texture & Touch. During this activity, adolescents are encouraged to describe all aspects of their hair in as detailed manner as possible. This suggested activity is something that can not only be used as a mindfulness activity, but also an activity that promotes cultural acceptance, as hair is an integral part of Black American identity and culture (Patton, 2006). In this exercise, adolescents are encouraged to describe the texture of their own hair. Due to boundary issues and promotion of healthy boundary setting, it is strongly recommended that adolescents ask before they touch the hair of another individual or have another touch their hair. It might be a better suggestion to have therapist encourage the adolescent to describe the textures, touch, feel, smells of their own respective hairs.

Cooking. In this exercise, the adolescent will be instructed how to make a peanut butter sandwich using the principles of mindfulness. If the adolescent is allergic to peanut butter, feel free to substitute with any other foodstuff with a similar texture. The adolescent will be asked to describe the smells of the peanut butter, the texture of the bread, describe the feel it as it is spread

across the bread, share how the sandwich feels in their mouth upon the first bite, and so forth. If the adolescent has the opportunity to eat with caretakers, this is an activity that can be done with others and can make mealtime a mindful, family experience.

Walking. If the adolescent lives in a safe neighborhood, walking quietly with intention by noticing the sights, sounds, and environment is a good way of connecting with the environment, moment, and staying present. If the adolescent does not live in a safe area, an opportunity to do mindful walking in doors or simply “being still,” are an equally valuable alternatives.

Prayer

Though trauma may bring about a conflicted relationship with religion, for many religiosity and spirituality can be a great source of comfort and invite a sense of relaxation (Bryant-Davis et al., 2012; Harper & Pargamet, 2015). Finding a quiet space to pray can be particularly calming. A conversation with one’s respective religious leader, such as Jesus or Allah might also be comforting. An example of a conversation - written or verbal dialog - with one’s higher power might sounds like this, “Hello Higher Power, Today I had a bad day. I felt really scared when I was at school today. I pray that you hold my hand today and remind me that you are always with me, especially when I am scared.”

Breathe & stretch!

A regular yoga practice offers many emotional and physical benefits (Felver, Butzer, Olson, Smith, & Khalsa, 2015; Kaley-Isley, Peterson, Fischer, & Peterson, 2010). The marriage of physical movement and diaphragmatic breath works to encourage persistence, patience, presence and the ability to traverse through difficult poses - a practice that can be used in everyday life to navigate difficult situations and emotions. This strong physical component is

particularly relevant to Black Americans, as bodily movement is a culturally salient form of expression. Similarly, to mindfulness and meditation practices, it will be useful to offer psychoeducation on the practice of yoga (Felver et al., 2015), its potential benefits, and invite an open discussion surrounding the individual's preconceived notions about the practice. It might also be useful to explain that yoga is a practice intended for all ethnicities. If at all possible, it is recommended that an instructor of Black heritage lead the group to dispel preexisting notions that yoga is only meant for certain races. The term yoga might even be substituted with the term "Breathe and Stretch" in an effort to detach any preconceived notions about the practice of yoga. Yoga teachers exercising their practices alongside youth survivors as an adjunct treatment intervention with Black American youth should utilize and have experience utilizing trauma informed practices. Resources to consider before practicing might include *Overcoming Trauma through Yoga* (Emerson & Hopper, 2011) and *The Body Keeps Score* (Van der Kolk, 2015).

Nightly Routine

Nighttime can be a particularly challenging time for adolescents who have experienced a trauma (Brown, Mellman, Alfano, Weems, 2011; Sadeh, 1996). Introduction to a nightly routine can be especially useful, particularly for the adolescent that has difficulty falling asleep. The nightly routine might also provide a sense of control by offering the adolescent regularity.

Gratitude lists. Inclusion of a gratitude list in the adolescent's nightly routine, is a way of closing the day by celebrating the positives and is congruent with many religious practices of staying in gratitude – a practice that might be relevant to many Black American clients. Even after a particularly symptomatic day, creating five things that the adolescent is grateful for can create a shift - minor or major - in affect or perspective (Froh, Kashdan, Ozimkowski, & Miller, 2009). The prevailing message of the exercise is that despite all of the seemingly negative things

that might be going on in life, there is always - no matter how seemingly small - something to be grateful for. For those individuals who are more comfortable with prayer, an activity might be a conversation with one's creator expressing gratitude might also work.

Movement Based Expression and Music

Dance is a powerful, culturally relevant way of expressing emotion and expending energy. A mindful dance practice also speaks to the transgenerational trauma that adolescents of Black American descent have experienced, as dance mimics tribal healing rituals by restoring the severed connections from one's tribes (Harris, 2007). Dance therapies further work to facilitate connection by tending to symptoms of dissociation by guiding the adolescent to be in tune with the music, rhythms, and moment that the music brings (Pierce, 2014). Allow youth to select the type of music they would like to listen to, however some suggested music to listen to includes songs by Janella Monáe, Solange, Kirk Franklin, Yalonda Adams, and Black based music with drums. If the youth feels uncomfortable dancing, they may simply listen to a song of their choice as a means of relaxation. In this case, ambient music such as sounds of the ocean or birds may be relaxing.

Chapter 4: Affective Expression & Modulation

The affective expression and modulation component develops adolescents' ability to build an efficient and effective skill-set to express and manage emotions (Cohen et al., 2006) in a manner that is appropriate to their environment and congruent with their internal experience. The goals of this module are more likely attainable when organic developmental processes (Eisenberg & Spinrad, 2004) and ethnic and cultural variables are factored into the adolescent's overall conceptualization (Ogbu, 1981). Though research surrounding emotional expression within the Black American culture is underdeveloped (Nelson, Leerkes, O'Brien, Calkins, & Marcovitch, 2012), the available literature suggests that the messages and expectations within the Black American community surrounding affect expression could be informed by several factors: (a) low socioeconomic status (Bocknek, Sanderson, & Britner, 2009), (b) neighborhood violence (Cunningham, Kliwer, & Garner, 2009), (c) current and historical experiences of discrimination, racial bias, dehumanization, and microaggressions (Dovidio, 2001; Garcia Coll, et al., 1996; Goff, Jackson, Di Leone, Culotta, & DiTomasso, 2014), (d) religious beliefs, (e) within-group expectations, and/or (f) gender roles (Woods-Giscombè, 2010). It is through these shared cultural experiences that informs parenting styles and subsequently, the way in which emotional expression is packaged and presented to children.

Though Black American caregivers' approach to developing a young person's conception of affective expression often varies by gender, parenting literature suggests that there is a general sentiment of discouragement related to self-disclosure and verbal expression of emotion, particularly fear and sadness (Markus & Kitayma, 1991; Nelson et al., 2012). Unfortunately, these cultural tendencies could be interpreted as might "shutting down," guardedness,

aggression, having poor self-awareness/insight, having poor treatment compliance/engagement, or being emotionally “numb” – interpretations that could certainly impair the therapeutic alliance and ultimately treatment outcomes (i.e., trauma symptom reduction). Alongside these messages are values of independence and emotional control, which are instilled at an early age to prepare Black American youth for the societal challenges that lie ahead of them (Dodge McLoyd, & Lansford, 2005; Hughes et al., 2006).

Education

Affective expression in the Black American community. At the outset of this module, common perceptions of affective expression and cultural justifications for their existence within the Black American community should be shared with the youth and their caregiver.

Psychoeducation on this topic will be instrumental in normalizing caregiver’s current practices of teaching youth about emotional expression and minimizing the risk of a caregiver’s feeling like “bad parents” – an experience that might jeopardize engagement in the therapeutic process.

Discussion: Emotions in Black culture. In this activity, the TF-CBT provider will engage the AA youth and their parents in dialogue about what emotional expression means in Black culture. Some topics that are to be included in this activity include: (a) messages that were shared about emotional expression in their home and (b) level of comfort in sharing publicly about emotions.

Discussion: Consequences of emotions. This intervention encourages the AA youth and their parents to develop a discussion about the consequences of emotional expression. For example, the TF-CBT provider might ask, “What might happen to you if you say that you are scared at school?” The youth and the parent(s) might also discuss the consequences of not expressing their feelings.

Activity: Developing an emotional vocabulary. Because many Black Americans have not received messages that open communication of one's affective experience is culturally acceptable, it may not be outside of the realm of possibility that language to express those experiences is underdeveloped. As such, educating youth and parents on different types of emotions will be a useful tool inside and outside of therapy.

- Present a feelings chart that features an Black American; discuss what each feeling means
- Have the youth listen to a song and share their emotional response using the feelings chart as a guide for recognition
- Watch a television show or video clip that features Black Americans and have the youth identify and label the character's affect
- Ask the youth to come up with culturally syntonc language that might replace standard psychological terms that describe affective states. For example, the adolescent expresses discomfort with the word "depressed." The youth would be prompted to come up with other words for "depression."

Asking for Help

Though self-reliance is a highly valued characteristic in Black Americans, it might conflict with stereotypical perceptions of strength (e.g., John Henryism, Strong Black Woman, *see below*) within the Black American community. As a result, Black Americans might find it difficult to ask for and receive help when it is needed. Because asking for help regarding emotional issues might be an underused practice, there also runs the possibility of simply not knowing how or feeling uncomfortable with doing so. Offering psychoeducation on the potential consequences of not talking about one's problems (e.g., health issues, psychological symptoms) will facilitate the topic's resonance. Have fun with this activity and role play!

How to Ask for Help

- Can I talk to you for a sec?
- Would you mind if I grabbed your ear for a second?

- I'm having an issue – do you have a few minutes to talk?
- I don't know what to do about this. Do you have any suggestions?
- I'm struggling right now. Can you help me?
- Have you ever felt _____? What did you do?

Affective Expression – Adolescent Males

Many Black American boys receive overt messages to conceal their emotions (Goodey, 1997; Harrison, 2015) from self and others. Standards of acceptable and appropriate gender based affective expression for Black American males are filtered through numerous channels that include the media, family, and friends (Harrison, 2015). Such messages might be as explicit as, “Black males don't cry” (Goodey, 1997; Harrison, 2015) or receiving negative reinforcement in response to emotional expression. The thought behind these emotional guidelines, so to speak, stems from a common cultural belief within the Black American community that Black males will be perceived as threatening (Stevenson, Herrero-Taylor, Cameron, & David, 2002); face oppression, safety issues, and discrimination – more so than AA females - in society (Demo & Hughes, 1990; Dodge et al., 2005; Hughes et al., 2006); and that any action or behavior that gives the illusion of “weakness” (i.e., over emotionality), could increase the youth's vulnerability to the aforementioned environmental threats (Nelson et al., 2012).

Goodey (1997) posits that those Black American male youth that are not taught about healthy expressions of emotions have the potential to adopt hyper-masculine, stereotypical traits, such as bravado and fearlessness that could subliminate into aggression towards others or the self. As Harrison (2015) notes, escaping one's genuine emotional experience is all too easily replaced with templates for Black American maladaptive coping skills that are readily found in the media, as well as the Black American community.

Affective Expression – Adolescent Females

Jezebel. Mammy. Superwoman. Welfare Queen. Strong Black Woman. Angry Black Woman.

These six descriptors are labels that have been superimposed onto Black American females over the course of American history and have likely shaped how others perceive them to the present date. These findings are exemplified in a multiethnic survey in which Black American female youth (ages 5-14) were viewed as more adult-like and less innocent than white girls – specifically, that Black American girls needed less support, less protection, less nurturing, less comfort, are more independent, are more educated about adult subjects, including sex (Epstein, Blake, & González, 2017). It will be useful for the provider to familiarize themselves with these findings and self-assess for any personal biases to increase a positive therapeutic relationship with the youth and their caregiver.

In addition to the ways that others perceive them, the aforementioned paradigms of Black American females – on some level – may be internalized and have the potential to influence the way Black American females view themselves and thus, express themselves. For example, many of these stereotypical archetypes were born out of a necessity for survival (Mullings, 2006). For young girls, the cascade of scantily clad women in music videos and the roles of Black American women portrayed in film as “Jezebels” might be sources of confusion on how to present themselves and what is acceptable behavior in a relationship or from a partner/romantic pursuit. Though the paradigm and cartoonish portrayal of being a Mammy is certainly negative, a very true reality is that young Black American girls may find themselves assuming caretaking roles if they come from a single-parent household or working-class family. There is nothing wrong with caretaking, but with it often comes a personal sacrifice – to mental, social, and physical wellbeing – when one is constantly putting the needs of others before their own. In a review of traits and behaviors that Black American women associated with the Superwoman Role, many

felt an *obligation* to help others (Woods-Giscombè, 2010). Specific to the Superwoman and Strong Black Woman labels, at times these roles can be adaptive as Black American women throughout history have been called to assume the head of household and carry multiple roles (Woods-Giscombè, 2010). Again, this paradigm has carried Black American women, their families, and communities through challenging times (Banerjee & Pyles, 2004; Woods-Giscombè, 2010), but can also be counterproductive in that the roles might prevent from getting help, manage stress, engage in romantic relationships (e.g., difficulty with trust and vulnerability), exercise self-care, and how they report challenging issues (Woods-Giscombè, 2010).

Exercise: Black American Female Paradigms – Are they Helpful or Hurtful

1. Offer psychoeducation on the meaning and history of Black American female stereotypes (e.g., Sapphire, Jezebel, etc.)
2. Discuss how each have served the client's
3. Discuss how each have hurt the client's

Black American Communication Styles – Implications for Therapy

When working with Black American youth and their caregivers it will be important to consider styles of communication and expression that are common within the community. An understanding of such will foster engagement and decrease the likelihood for overpathology.

Common Features of Black American Communication Styles (Elliott, 2010)

- | | | |
|--|---|--|
| • Animated and passionate | • <i>Eye contact</i> – Direct when speaking and might be less direct when listening | • Physical touch (e.g., a hand on the back or arm when addressing someone) |
| • Directness and confrontation if something is bothersome or needs to be addressed | • Varied volume and pitch (e.g., very loud to quiet) | • Grand gestures |

Ethnic/cultural discrimination

This chapter not only encourages and educates affective expression related to the youth's respective trauma, but also discrimination. Hammond (2012) found that Black American males that talked about their experienced microaggressions and experiences of prejudice were less likely to experience depression in comparison to those that kept things to themselves. Though it might seem too early to speak with youth at an early age about discrimination, it is quite likely they will experience cultural bias. In support of these notions, Goff, Jackson, Di Leone, Culotta, & DiTomaso (2014) found that white female undergraduate students viewed children equally innocent until age nine when at that point, they started to look at black children as less innocent at age ten. The consequences of explicit and implicit cultural bias (Dovidio, 2001), as well as dehumanization (Goff et al., 2014) might manifest in the judicial system (Poe-Yamagata & Jones, 2007), at school, or socially. When encouraging youth to talk about their cultural injustices, it is important to tell them to be mindful that not everyone will be receptive to such discussion. Though a shared experience of discrimination with other Black Americans may at times offer an individual comfort, other instances may bring about varied responses. This is largely in part to the fact that everyone experiences these situations differently. For example, if a youth approaches a peer and says, "This woman just clutched her purse when I walked by her. It made me feel terrible!" His friend might say, "Yeah, that happens to everyone. You need to get over that mess and get used to it." In other words, a shared experience, might illicit invalidation.

Interventions with Racial Discrimination

- Educate on common emotions in response to discrimination & microaggressions
- If the resources are available practice and study art expression – take a look at Black American male artists and
- Encourage youth to put their experiences into song (e.g., hip-hop, spoken word, reggae, rock). Look to what's already out there for examples.
- Keep a feelings chart readily available at all times

poets to see how they channel their
experiences

Chapters 5 & 7: Cognitive Coping & Processing

Consistent with the foundations of cognitive behavioral theory (Beck, 1976; Ellis, 1962), the goal of Cohen and Colleagues (2006) Cognitive Coping and Processing component is to offer the youth and their caregivers psychoeducation on the relationship between thoughts, feelings, and behaviors (i.e., the cognitive triangle); apply the cognitive triangle to the youth's unhelpful thinking styles and beliefs; and reframe those unhelpful thoughts and beliefs in a way that allows for greater functionality and less symptomatology. This supplemental chapter aims to conceptualize and reframe unhelpful cognitions in a way that is culturally congruent.

Many aspects of the cognitive behavioral approach are in line with Black American culture and make it a complementary modality for conceptualization and intervention. For one, the collaborative nature of cognitive behavioral therapy (CBT; Kelly, 2006) leaves room for all parties to participate and offer valuable feedback, making both client(s) and provider experts in their respective experiences and contributions (Breismeister & Schaefer, 1998). The active inclusion of all parties may work to dismantle the Black American family's commonly held beliefs about mental health and foster the therapeutic alliance. Additionally, respect and recognition of each party's value can empower (Hays, 1995; Kelly, 2006; Van Wormer & Davis, 2008) the youth and their caregivers in the wake of a traumatic event. Empowerment is furthered by the strengths based approach of the CBT model that works to identify and mobilize individual strengths, social supports, and skills (Sayers & Heyman, 2003). Installation and organization of the youth and caregiver's internal and external resources facilitates an awareness of a locus of control by giving the youth and their caregivers the opportunity to change their ways of thinking (Hays, 1995; Van Wormer & Davis, 2008) - a practice that aligns with many Black Americans experience of using resources to challenge adversity and face that adversity on

a macro (i.e., historical) and micro (i.e., everyday) level. It is important to recognize that while the pivotal role of self in this model may engender feelings of empowerment and mastery for some Black Americans, a lack of recognition to include one's higher power, religious or spiritual community, and family may prevent total resonance and create treatment resistance. For example, some religious Black American - youth and or caregivers - might present to the Cognitive Coping and Processing sessions with statements such as, "The Devil put those thoughts in my head" or "God wanted all of this to happen. I don't have anything to do with it." In this case, it might be useful to frame the youth/caregiver's strengths as a *piece* of the therapeutic process and change that works alongside religious or spiritual entities, family and fictive kin, and other supportive communities.

Example (provider) – "You have so many strengths that are going to help you through this process. You are so curious and open to learning about TF-CBT. I know your mom works a lot, but I know that your neighbors and cousins have all been looking out for you. You also have faith in a higher power - that's huge! These are things that will really be helpful to you throughout this process."

Validating Ethnic Stressors

It is further important to consider the climate of racial tensions, discrimination, and the youth's respective environment when working within this module (Laszloffy & Hardy, 2000; McNair, 1996). Though awareness of Black American culture and therapist/client cultural differences is important throughout the whole of treatment, this phase proves itself no different (Hines & Boyd-Franklin, 1996; Kelly, 2006). Should the youth present with seemingly pathological behaviors or cognitions, take a moment to review and discuss the cognitions in light of current and historical racial factors.

Example (youth):

Youth - "I keep thinking that someone is following me."

Provider - "Where were you when you felt this way?"

Youth - "I was at the drugstore, but sometimes I feel this way at home when I think about the guy that attacked me."

Provider - "I want to talk about all of this, but first let me ask you - who was following you in the drugstore?"

Youth - "The manager. He made me feel like I was a criminal."

Therapist - "I know that we've been working on modifying our thoughts and beliefs, but it sounds as though the store manager was actually following you in the store. I know you and your parents have spoken about the challenges some men of color have faced in the community these days and I just want you to know that you're not just making this feeling up. It sounds like you've done your reality testing and this situation seems to have occurred. Let's go back to that other cognition you mentioned earlier."

Given the impact of cultural influences, whether family, friends, community, environment, or history, on cognitions, awareness and delivery of a culturally mindful practice will help decrease over pathologizing and increase the collaborative nature of CBT (Beck, 1976; Gonzalez-Prendes, Hindo, Pardo, 2011). Due to the high prevalence of abuse and maltreatment within AA youth, it will be important to remember that due to the relative frequency of interpersonal and community violence within many AA communities, particularly low-SES populations (U.S. Department of Health and Human Services, 2012; Sedlak, Mettenburg, Basena, Peta, McPherson, & Greene, 2010) the youth and their parents may not see their experiences as maladaptive or worthy of treatment, despite evidence for the contrary. Also,

unhelpful thinking styles respective to trauma and negative cognitions about Black American culture, might even be normalized and validated by family, peers, and societal influences, such as the media (Coltraine & Messineo, 2000).

Example (youth):

Thought - "It seems like all of my friends have boyfriends that hit them. I know it's not right, but it just feels normal. It's kind of cool, because we can talk about it all when it happens. Besides, it's like the songs and and friends tell me - stick by your man, no matter what."

Behavior - "I don't leave my boyfriend and he keeps hitting me."

Feelings - "I feel bad about myself."

Example (youth's caregiver):

Thought - "I feel bad that my daughter is going through this, but I was raped, my mother was raped. It runs in our family."

Behavior - "I don't really know how to answer this, but I guess I could say that I'm not as supportive as I could be."

Feelings - "I feel helpless that I can't protect my daughter from this cycle of abuse. I feel like a bad mom"

Example (youth):

Thought - "He told me that because I was so dark, this was the only kind of love I could get. I wish I was light and pretty. A lot of rap songs only put light skinned girls in their videos, so maybe he was right."

Behavior - "I've started smoking weed and drinking more to forget about it all."

Feelings - "I feel ashamed."

The potential danger of ingesting the aforementioned influences lies in the youth's and caregiver's absorption and internalization of the externally generated negative beliefs, resulting in a fatalistic and external locus of control (Hines, 1998). Additionally, those youths who have received and withhold negative concepts of their racial identity tend to have greater levels of personal distress (Kelly, 2006), which could further complicate their trauma related symptoms and overall treatment if not addressed. Being mindful and discussing these potential influential variables in session may also increase rapport (Kelly, 2006).

Easing into Cognitive Coping & Processing

In an effort to familiarize the youth and their caregivers (in separate sessions) with this component and increase their level of comfort, it is suggested that an exercise where identification, labeling, and restructuring of another's unhelpful cognition be conducted before each discloses their own personal trauma-related cognitions (Cohen et al., 2006).

Pre-trauma Narrative Exercises:

- Watch movies or Youtube clips that feature Black Americans and have the youth/caregiver identify the characters' unhelpful thoughts. Later have the youth provider alternative, more helpful cognitive replacements.
- Have the youth/caregiver select their favorite song and scan the song for unhelpful cognitions and then create more helpful, accurate song lyrics as replacements.
- Review and discuss healthy cognitions, as evidenced by challenging adversity with words, that popular Black American authors and poets, such as James Baldwin, Langston Hughes, and Maya Angelou have written about in their literature. The youth/caregiver might also choose other figures, such as comic book characters, athletes, and entrepreneurs/inventors that have worked through adversity.

Application of Cognitive Coping and Processing

After the youth has displayed competence in the pre-trauma narrative exercises and completed their trauma narrative (see the following chapter), the provider will help the youth apply the principles of this module to their personal story to shape those thoughts into adaptive, more realistic ways of thinking. As suggested by Cohen and colleagues (2006), this intervention can be approached by review of the youth's trauma narrative— paragraph by paragraph, identification and discussion of the unhelpful cognitions, and generation of more helpful and realistic ways to frame their thoughts.

Exploration of the caregivers' unhelpful thinking and behaviors related to their child's trauma should be done in a separate session (Cohen et al., 2006). In this session, the provider and caregiver might review the ways in which those cognitions are unhelpful to them (as a caregiver), to the youth, and their household/family. Subsequently, the provider guides the caretaker to identify the ways in which more adaptive ways of thinking might better serve their child, themselves, and their household/family.

Take Home Points

- Reflect upon and validate cultural experiences and climate of the current/historical Black American experience.
- Think about the person's respective community - what messages are they receiving about their trauma and culture? Where are these messages coming from?
- In what ways are the youth's cognitions about their trauma affected by their ethnic identity or experiences as an Black American? Does the youth have the awareness or language to articulate these cognitions?

Chapter 6: Trauma Narrative

During this sixth phase of the TF-CBT protocol, the youth assembles a detailed recollection of their trauma related memories into a collective narrative. The overall process can be likened to gradual exposure therapy in which the youth's traumatic experience is recounted incrementally, becoming more detailed and likely, more distressing over time. Embedded within this component lies multiple goals: (a) decrease negative thoughts and associations surrounding the traumatic event (Cohen, Mannarino, & Deblinger, 2006), (b) desensitize trauma related reminders (Deblinger, McLeer, & Henry, 1990), (c) reduce psychological and physical hyperarousal (Deblinger et al., 1990), (d) reduce PTSD symptoms, (e) increase overall well-being and level of functioning, and (f) provide a template for the provider to see where the unhelpful thinking styles existed, what unhelpful thoughts were creating the most distress, and points of intervention for reconstruction and clarification (Cognitive II). Though voicing and sharing memories is a vital pathway to attaining the TF-CBT goals, the trauma processing component needs to be coupled with a psychological deconstruction, integration, and exploration of the remembered events into a meaningful, cohesive collection of the once fractured emotionally charged segmented memories (Pennebaker, 1993; Pennebaker & Francis, 1996). Another goal of this treatment module is to remind youth that this is but one event in their life that fits within the narrative of their life as a whole and is not a defining moment(s) (Cohen et al., 2006). For those children with multiple traumas, Cohen and colleagues (2006) suggest creating a timeline or relating one's life in chapters, so that the youth can see that life has not been entirely negative.

Prior to the commencement of this component, it will be of utmost importance to offer psychoeducation about what lies ahead in this leg of treatment and what the goals of treatment are (Cohen et al., 2006). It will also be useful to educate the caregiver on any potential adverse events that might arise (e.g., children may want to stop coming to therapy as this phase approaches, increase in symptomatology). Also, explain that it is important they communicate with the therapist, so that they may revisit the implementation of coping tools (e.g., relaxation) and or titrate the exposure to increase manageability (Cohen et al., 2006). Keep in mind that the caregiver may become the person that the child wants to share with, so the caregiver should also be comfortable (Cohen et al., 1996). Additionally, have joint sessions to show the child that the parent can tolerate negative emotions (Cohen et al., 2006). The caregiver may also share their experience of the trauma and how they felt upon hearing their child's incident. Lastly encourage the parent not to "correct" the child's book - not, unless the details are creating a negative impact (Cohen et al., 2006).

The narrative style that is characteristic of this module is complementary with the African American community in that theirs is a history deeply rooted in oral tradition going back to the continent of Africa. These oral communications have survived and carried African Americans through challenging times and offered hope, explanation, and meaning through difficult times. Urban African American youth notably use oral communication of sidewalk games in which messages about African American culture and pre-adult issues are carried in rhyme, handclapping games, and rhythmic jump rope games (Saloy, 1998). Saloy (1998) notes that once these sidewalk games and songs are in place they replace the use of nursery rhymes, thus signifying a developmental marker in growth. The same might be true for other oral mediums in that they are developmentally appropriate. For example, the stories and prose of sidewalk games

might be developmentally appropriate for children whereas the messages contained within raps might be more developmentally congruent with adolescents.

In an effort to incorporate a developmentally and culturally appropriate medium of expression African American youth and this module, a number of activities might be used:

Spoken word. Spoken word is a style of poetry that allows the author to transpose thought, feeling, and emotion through personal, verbal, and physical expression. The vessel by which spoken word is carried may be through poetry, storytelling, slam poetry, rap, and stand-up comedy (Five Tips, n.d.). The heightened sense of emotionality of this expressive artform is intensified by the use of facial expression, physical gestures, verbal intonations and inflections, rhyming, eye contact, projection, enunciation, and repetition (Five Tips, n.d.).

Music Therapy. Music therapy is a creative form of intervention that ignites and channels self-expression, curiosity, learning, and improvisation to illicit change in emotional, cognitive, and social wellbeing in youth (Francis, 2011; Tervo, 2001). Though music therapy can be implemented in numerous ways (e.g., learning how to play an instrument, listening to music), for the sake of this intervention, the task will be to create a song that tells the narrative of the youth's experience. The genre may be of the youth's selection. Though many youth might enjoy Hip Hop, other African Americans might like Heavy Metal – just ask!

Giving testimony. Though there are various types of religious affiliation within the African American community, many might be able to relate to the concept of “giving testimony,” which is when people speak about their peaks and valley's of their journey and share it with their congregation and God, who give witness to the share. In this activity, the youth might give testimony by creating a sermon, religious song, or speech that speaks to their traumatic experience.

Tapestry. Given the history and salience of oral tradition within the African American community, it might be useful to present and frame this exercise as the creation of a tapestry with each piece of the youth's trauma story serving as a thread of the final masterpiece. The youth should start this activity by writing their favorite memories and personal strengths on different fabrics to illustrate the fact that within darkness there is also beauty. Creating a tapestry using brightly colored fabrics with pieces of the youth's story is a wonderful way of bringing this metaphor to life. As the tapestry comes together the youth, caregiver, and therapist can work with one another to see that these pieces signifying a range of experiences and memories - both positive and negative - come together to form something beautiful and can be made meaningful.

Chapter 8: In-Vivo Exposure & Trauma Mastery

Fear and avoidance are adaptive responses that facilitate safety by serving as alerts to present or impending danger (Christopher, 2004). However, when an individual begins to perceive innocuous cues (e.g., the dark before bedtime, certain aromas) as threatening because of an association with the youth's respective trauma, then the fear has become maladaptive – pathology ensues (Meulders, Van Daele, Volders, & Vlaeyen, 2016; Rau & Fanselow, 2009). It should be explicitly stated that those youth who have a fear or avoidant response to an actual or current threat should not attempt to blunt or discard their natural response to danger. Instead, steps to keep ensure safety should be developed – a point that will be covered in greater detail in the last module of this dissertation. This chapter addresses treatment considerations and approaches for trauma survivors that experience psychological or behavioral issues in response to innocuous trauma reminders (e.g., a thought, memory, or encounter with something that reminds them of their trauma) *or* in response to avoidance of those innocuous trauma reminders (Cohen, Mannarino, & Deblinger, 2006).

Efficacy

Exposure therapies are considered an efficacious treatment for the amelioration of fear and anxiety (Barlow, Raffa, & Cohen, 2002). Though research related to the efficacy of treatment protocols that utilized exposure therapy, specifically in-vivo exposure, in predominately Black American populations is limited, existing literature has noted a reduction in anxiety symptoms (Carter, Sbrocco, Gore, Marin, & Lewis, 2003; Friedman et al., 2003; Williams, Chambless, & Steketee, 1998). Foa and colleagues also found a decrease in depressive and PTSD symptoms when using a treatment protocol that included in-vivo exposure in a sample that featured 43.6% Black American female assault survivors (Foa et al., 2005).

Exposure therapies have also been found useful in school based initiatives. In a study featuring Black American school children with anxiety, the youth experienced a decrease in anxiety symptoms (Ginsburg & Drake, 2002).

Decreased symptomatology has also been found in various TF-CBT treatment outcome studies that utilize the in-vivo exposure component with Black American youth. Jaycox and colleagues (2010) found diminished PTSD symptoms in Black American adolescent students, who were survivors of Hurricane Katrina. TF-CBT has also been effective with Black American youth in the foster care system. One pilot study found TF-CBT useful in improving Traumatic Stress Symptoms, Behavioral/Emotional Needs, and Child Strengths (Weiner, Schneider, & Lyons, 2009) – assessment domains within the Child and Adolescent Needs and Strengths measurement, which measures the severity and type of psychosocial and psychological factors that might impact treatment decisions and outcomes (Lyons, Griffin, Fazio, & Lyons, 1999).

Assessment and Additional Normalization

Though it may seem superfluous at this stage of treatment, reassessment of avoidant behaviors is suggested. The provider should inquire with both the youth and their caregiver. In reviewing the utility of exposure therapies in the treatment of Black Americans with obsessive compulsive disorder (OCD), secrecy was highlighted as a potential perpetuating factor of the disorder and barrier for help-seeking/treatment (Hatch, Friedman, & Paradis, 1996). Hatch and colleagues (1996) posited that Black Americans might hide their obsessive compulsive symptoms in greater proportion to White populations due to perceptions about that particular disorder. Though youth survivors of trauma may not present with obsessive compulsive symptoms, they certainly might present with anxious or other psychological symptoms or behaviors that they might try and hide for a number of reasons. One potential reason why a

youth may hide – intentionally or unintentionally – their avoidance is due to the erroneous belief that avoidance is a healthy and seemingly effective coping tool (see Psychoeducation section below for more on this topic). Also, a youth’s disclosure surrounding fears or avoidant behaviors might be influenced with how *their* symptoms are portrayed by the media (Hatch et al., 1996) or spoken about in their community. For example, Hatch and colleagues (1996) found that their Black American OCD participants had trouble sharing their obsessive compulsive symptomatology because they had only seen White people with OCD discussed about in the media. Having only seen OCD portrayed within ethnically White populations, the Black American women within Hatch and colleague’s study (1996) came to believe that OCD was a disease for White people, thus making their experience as Black Americans culturally atypical or as one participant explained, “OCD negated her identity as an Black American” (Hatch et al., 1996, p.312). In an effort to further normalize a fearful response and avoidant behaviors post trauma, the provider might list examples of common responses and include culturally related fears and avoidant behaviors as well.

- Fear or avoidance of an entire cultural group that resembles the perpetrator
- Fear response or avoidance when confronted with smells, sounds/songs, places, or situations that remind the youth of their trauma
- Increased symptomatology around the time of year the trauma occurred.

Psychoeducation

Avoidance. The subject of avoidance and the utilization of healthy coping behaviors is particularly salient as it relates to Black Americans, as they are likely to encounter more social stressors (Vigna, Hernandez, Kelley, & Gresham, 2010), such as in-group conformity pressure, stereotype threat, discrimination than youth of European descent (Contrada et al., 2000), as well

as out-group conformity pressure (i.e., acculturation/assimilation). Because of the potentially greater, daily exposure to culturally related stressors, a standard, generic template for coping might develop (Vigna et al., 2010). Related to this point, Scott and House (2005) found that individuals who had greater negative attributions (e.g., feeling powerless and defeated or as though things will never change) to cultural stressors engaged in more avoidant, unhelpful coping styles. By contrast, those who felt a sense of mastery or greater sense of control over their cultural stressors practiced more direct, problem focused coping (Scott & House, 2005). It should be noted that problem focused coping is *not* characterized by self-directed coping (e.g., not asking others for help, not bringing a spiritual element into the problem-solving process, counting on one's self to figure things out). Molock, Puri, Matlin, & Barksdale (2006) noted that this kind of coping style as a risk factor for suicidal ideation in Black American high school students – communal religious coping was found to be a protective factor. Though this chapter relates to in-vivo exposure of the trauma related stressor, Slavin, Rainer, McCreary, and Gowda (1991) so poignantly note that consideration and inclusion of the Black American experience cannot be excluded when treating stress and developing coping models for Black American youth. When working with Black American youth, their experience of people of color in the United States, as well as their overall worldview, cannot be viewed apart from the trauma that has brought them into treatment – culture and trauma must be addressed in tandem. Some ways in which the provider might explore the ways in which the youth and their caregiver face cultural adversity or stressors is provided here below.

Facing Cultural Stressors Head-on

- Provide a vignette that illustrates an Black American youth experiencing discrimination. Discuss with the character might feel and what they can do to feel empowered
- Ask for a personal example in which the youth witnessed or was the survivor of a discriminatory practice or cultural stressor – how did they feel, what did they do to cope?

- Develop a list of coping tools the youth might use when faced with these kinds of stressors
- If the youth's stressor involves a verbal exchange or dialogue with another person, develop a list of quick responses to keep at the ready!

Though the subject of avoidance has been covered in the Psychoeducation component of this dissertation, it will be important to offer supplementary psychoeducation on avoidant behaviors in this section of the treatment due to its paradoxical nature and as mentioned previously, potential for not being disclosed in an earlier phase of treatment. There is a strong likelihood that youth and their caregivers alike might understand avoidance strategies as harmless. If something is bothering you – simply stay away from it, right? Some Black American clients might even use biblical scripture or their faith as an act of avoidance. For example, instead of seeking communal support or help, clients might say, “This too shall pass.” In these situations, highlight the strength and hope in the recited passage or belief and encourage the client to use their faith in conjunction with more active, problem-focused coping styles. It is important that clients understand the psychological properties and process of avoidance. By avoiding an innocuous cue, distress might be temporarily avoided, but in the long-run, that avoidant behavior is reinforcing (Meulders, et al., 2016; Rau & Fanselow, 2009). It is by facing these fears in a series of planned, controlled, increasingly anxiety provoking exposures that one's unhelpful thoughts affixed to that trauma reminder are released and a sense of mastery over that trauma reminder is attained (Williams, et al., 2014).

It might also be useful to engage the youth in this component by easing them into the intervention with a non-trauma related example that illustrates not only an avoidant behavior, but also the consequences of avoidance.

Example

Provider: “You said that you were afraid of dogs, right?”

Youth: “Yes.”

Provider: “Ok. That’s a fairly common fear. So, tell me what happens when you see a dog.”

Youth: “My grandma has one. I get *really* scared and my heart starts pounding every time I see it. It sucks because I have to go to my grandma’s house every weekend. I love my grandma, but I got to the point where I didn’t even want to visit her, because of her dog so I told my mom not to take me there anymore.”

Provider: “I bet! And dogs are everywhere, so I’d imagine it’s not so fun to feel scared so frequently.”

Youth: “Nope! It’s annoying, but I don’t like feeling scared so I’m staying away from anything with a tail!”

Provider: “So it sounds like your fear of dogs is starting to affect you more and more. You started off just having a feeling about the dog, then your body started telling you that it was scared by giving you little hints such as a rapid heart rate. Now, your fear is telling you that you might want to avoid the dog altogether. Your fear is now potentially interfering with your relationship to your grandmother. See how that works? Your fear started off with a thought, turned into behavioral symptoms, and then avoidance altogether. It sounds like your fear has made your life a little limited and cut out an important relationship from your life. And by staying away, did your fear of dogs go away?”

Youth: “No. I’m still scared of dogs and now I don’t see my grandma because of it.”

When addressing this topic as it relates to the client’s trauma, it will be useful to consider cultural factors that might contribute to their avoidant behaviors. For example, the use of dogs in the Civil Rights Movement was often used in a negative fashion against Black Americans.

Invalidation of contributing cultural variables might be perceived as microaggressions, invalidating to the youth and their caretakers, and potentially cause a fissure in the therapeutic relationship and treatment outcomes (Williams et al., 2104). A way to assess for culturally avoidant related behaviors is to (1) simply ask or (2) familiarize one's self with the historical context of the Black American client's experience as it pertains to their specific trauma/circumstance (Suite, La Bril, Primm, & Harrison-Ross, 2007; Williams et al., 2014). Additionally, the provider must also understand that many Black American clients might present with cultural mistrust (Ashby, 1986; Bronstein, 1986; Ridley, 1984), a term that refers to the thoughts and feelings held by many Black Americans about their White counterparts and is a by-product of historical and current events that have perpetuated feelings of mistrust at the workplace, the education system, social interactions, politics, law enforcement, and the judicial process (Terrell & Terrell, 1981; Whaley, 2001). This cultural mistrust – which may even be validated collectively within the client's respective Black American family and community – may serve as reinforcement for avoidant behaviors. Explicit acknowledgement and validation of the Black American client's potential reasons for being mistrustful in certain situations is vital. However, the consequences of any culturally related avoidance behaviors should subsequently be explored after that validation. Has preexisting (i.e., prior to the trauma) cultural mistrust alongside trauma related avoidant behaviors contributed to psychological symptoms or social impairment? For example, if a youth begins staying home from school and is now fearful of *all* White children because she has been beaten up by her White peers at school, it will be important to validate the youth and family's concerns about racism, acknowledge the history of discrimination within the United States educational system, and explore the consequences of avoidance for this youth.

Cultural Traumas

Up until this point, this chapter has regarded cultural social stressors as just that – stressors. Though unrecognized as an index trauma by the DSM-5 (American Psychological Association, 2013), there is burgeoning research that identifies acute or chronic cultural stressors as traumatic events that could meet criteria for a mental health disorder, such as post traumatic stress syndrome (PTSD; Carter, 2007; Chou, Asnaani, and Hofmann, 2012). The correlation between cultural and traditionally recognized index traumas (e.g., natural disaster, assault) is illustrated by Bryant-Davis & Ocampo (2005), who relate the sequelae of domestic violence with a culturally-related trauma: both share the potential for self-imposed/externally imposed feelings of shame; psychological symptoms, such as avoidance and hypervigilance; and survivors of both might also receive advice to thwart future victimization/racism by speaking, dressing, or acting a certain way – advice that indirectly imposes a spirit of blame onto the survivor. Offering added evidence for the psychological gravity of cultural traumas, Bryant-Davis and Ocampo (2005) further note that when an individual does their best to comply with self/super-imposed false standards of safety and the cultural discrimination/bias continues, the PTSD symptoms might not only persist, but also increase. In working with individuals who have/are experiencing clinical symptoms surrounding past or current cultural traumas, it is important to validate their experiences and offer psychoeducation explaining this occurrence. If appropriate and safe, these cultural traumas might also be addressed in the in-vivo exposure.

In-vivo Exposure

After the clients display a strong understanding of avoidance, education on in-vivo exposure is in order. In-vivo exposure is direct confrontation of an object, situation, or circumstance that elicits a fear response or avoidant behavior (American Psychological

Association, n.d.; Smith, Duax, & Rauch, 2013). In a process referred to as habituation, the client's reactions to their identified fear(s) decrease as a result of repeated exposure (APA, n.d.). As the client is repeatedly exposed to variables (e.g., places, people, scenarios, etc.) associated with their fear, their associations pertaining to their primary fear will begin to decrease or even relinquish in a process called extinction (APA, n.d.). This process has the potential to be incredibly empowering and offer the installation of a sense of accomplishment and self-efficacy over thoughts and feelings (APA, n.d.; Cohen et al., 2006; Williams et al., 2014). Though much of the cognitive processing was done in previous modules, this behavioral intervention also offers an opportunity to unpair unhelpful thoughts and feelings and replace them with more positive, beneficial associations with trauma reminders (APA, n.d.).

This particular intervention, though challenging and anxiety provoking (Williams et al., 2014), can be likened to the collective Black American experience of moving through emotionally, physically, spiritually, and mentally depleting moments in time – “And still I rise” (Angelou, 1978). Using literature, such as Maya Angelou, or another Black American experience or person of the youth's choice might be used to provide salient examples of resilience. When speaking about resilience with Black American clients, an open discussion should be had to ensure the clients have not misunderstood overcoming adversity to mean application of John Henryism (Buser, 2009) or the Strong Black Woman (Harrington, Crowther, Shipherd, & 2010) personas. These cultural defenses are often sought-after character traits in the Black American community and have helped many Black Americans navigate microaggressions and racially challenging circumstances (Buser, 2009; Williams et al., 2014). However, wearing an impenetrable armor of emotional strength denies any potential emotionality in response to hardship (e.g., it doesn't matter what you do to me, I'm unaffected, I just push on). What TF-

CBT (Cohen et al., 2006) and this dissertation encourages is the unapologetic recognition of trauma related sequelae and an opportunity for change.

In-Vivo Therapy in Practice

At this juncture of the treatment, the youth has a number of tools in their toolbox to facilitate the implementation of this intervention. Identification of the youth's fear, which is creating avoidant behaviors or negative affect is the first step of this intervention (Cohen et al., 2006). In the following step, the youth will develop an in-vivo exposure plan alongside his/her caregiver. This in-vivo exposure plan is essentially a graded exposure in which the youth ranks all of the places, things, situations, etcetera associated with that fear in order of their difficulty (i.e., a fear hierarchy; APA, n.d.). The youth may also use the relaxation strategies that they learned in previous modules to manage uncomfortable emotions that might have been elicited from the exposure *after* they have completed their exposure task (Cohen et al., 2006). In addition or in lieu of traditional relaxation strategies, the provider may discover that the youth finds external coping strategies more useful – a finding that is consistent with a significant amount of Black American coping literature (Boyd-Franklin, 2003).

Examples of external coping strategies

- Visit, call, or text a member of kin support network
- Listen to uplifting or personally meaningful music (e.g., gospel)
- Write and practice recitation of poetry in a powerful, rhythmic way (i.e., spoken word)
- Become an advocate for community issues or a topic of choice
- Listen to a free faith-based or spiritual podcast (if the youth has internet access)
- Practice writing and delivery jokes
- Engage in prayer or have a conversation with God
- Practice expressive dancing
- Exercise, stretch/yoga, or work-out in a community gym (e.g., boxing, swim)
- Practice a skill, such as cooking
- Write a gratitude list

Though these exposures might be challenging – for the youth to complete and caregiver to observe, if the youth is struggling – it is essential that the exposures go uninterrupted to increase the likelihood of positive outcomes (Cohen et al., 2006). Utilization of a coping tool during the exposure would be counterproductive and provide no symptom reduction, as the youth would come to associate their coping behavior as the conductive agent for exposure completion, versus the desired goal: belief that the exposure is safe (Rauch & Foa, 2006). Seemingly innocuous coping strategies, such as deep breathing that might “help” the youth “get through” the exposure, are referred to as safety behaviors, as they keep the individual from experiencing undesirable affect or facilitate the avoidance of anxiety (Rauch & Foa, 2006). Cohen and colleagues (2006) also suggest that the caregivers offer the youth a reward after each completed session (Cohen et al., 2006). Though many Black American families are of economic fortitude, there is also a significant portion of the population that falls within the lower socioeconomic status. In this case, it might be useful to reward the youth with free/low-cost activities.

Examples of rewards

- Make the youth their favorite dish
- Allow the youth to watch a few extra minutes of television
- Attend a high school sporting event (e.g., volleyball, football, basketball, tennis)
- Offer affection if the youth is open to receiving this kind of reward
- Make a trip to the library to check out DVDs or books
- Take a trip to a museum – kids are often free!

Sample In-Vivo Exposure Plan

Identified trauma reminder: The holiday season – the time of year that the client was abused

- Week 1: Discuss stories, positive memories, read books, etc. related to holiday time
 - Spend 10 minutes talking about the holiday season on Monday with Mom
 - Spend 20 minutes talking about the holiday season on Tuesday with Dad
 - Spend 30 minutes talking about the holiday season on Wednesday with Mom
 - Spend 40 minutes talking about the holiday season on Thursday with Dad
 - Spend 50 minutes talking about the holiday season on Friday with Mom
 - Spend 60 minutes talking about the holiday season on Saturday with Dad
 - Spend 70 minutes talking about the holiday season on Sunday with both caregivers

- Week 2: Participate in holiday related activities
 - Spend 10 minutes writing holiday cards on Monday
 - Spend 20 minutes listening to holiday music on Tuesday
 - Spend 30 minutes making holiday foods on Wednesday with caregivers
 - Spend 40 minutes listening to holiday music on Thursday
 - Spend 50 minutes making holiday foods on Friday with caregivers
 - Spend 60 minutes watching a holiday movie/television episode on Saturday
 - Spend 70 minutes watching a holiday movie/television episode on Sunday
- Week 3: Have a mock holiday celebration
 - Have a tree decorating (if they celebrate Christmas and a tree is available/accessible for purchase) party on Monday with family
 - Make a present/draw a picture for someone in your family on Tuesday
 - Have a holiday dinner after school on Monday with family on Wednesday-Saturday
 - Have a holiday dinner party after school with gift exchange with family on Sunday

When creating the in-vivo exposure plan alongside the caregiver, it will be important to, again, factor in cultural considerations and environmental factors that might inhibit the youth from moving up the fear hierarchy. Some questions for the provider to ask the caregiver might include:

- Does the youth live in a neighborhood that is safe for this exposure activity?
- Does the youth have access to all of the resources necessary for this activity?
- Do any of the items on the plan conflict with any religious beliefs?

To further the potential efficacy of the in-vivo exposure, the caregivers might share the plan with their child's teachers or siblings, so they might be on board with the plan (Cohen et al., 2006). Given the extended system of support that is often typical within Black American communities (White, 2004), it is further recommended that those identified individuals – aunts, cousins, neighbors, church community, etcetera – also be included if it is safe to share and the plan supports their knowing.

COMPONENT 9: CONJOINT SESSIONS

Though the content of conjoint sessions with the youth and their caregiver might vary, the scaffolding of this TF-CBT module provides an open forum for education, discussion, and review of the youth's trauma narrative (Cohen, Mannarino, & Deblinger, 2006). This chapter also provides a general synopsis of factors to consider when working with Black American families, as well as a treatment planning guide.

Working with Black American Families – A Brief Review

Since common characteristics of families that identify with Black American culture have been discussed in depth in previous chapters, this section will simply fold those concepts into this module to create a strengths based (Boyd-Franklin, 2006; Harrell & Rowe, 2014), culturally mindful module. To summarize the previously mentioned treatment considerations, here below is a quick reference guide for providers working with Black American families.

- Gain familiarity with the historical and current sociopolitical context of the Black American experience (Williams et al., 2014, Wilson & Stith, 1991)
- Keep in mind common Black American parenting styles, awareness of traditional parenting styles and the interventions prefaced with psychoeducation will be integral. More detailed information related to this subject can be found in the Parenting chapter of this dissertation.
- Recognize that notable strengths of Black Americans include, but are not limited to having a kinship network, adaptable family roles, strong religious orientation, and achievement (Hill, 1972, 1999a)

- Consider the heterogeneity of Black Americans and intersectionality of diversity. A person within the Black American cultural may identify with many cultural groups (Harrell & Rowe, 2014)
- Become aware of different Black American styles of communication (i.e., vernacular and body language) to avoid overpathology and increase engagement (Sue & Sue, 1990; Wilson & Stith, 1991)
- Explore your own personal biases, which have the potential to impact treatment outcomes and the therapeutic alliance (Harrell & Rowe, 2014)
- Thoughtful disclosure of the provider's cultural values and discussion of the clients' culture (i.e., historical and current stressors) could strengthen the therapeutic alliance by revealing a sense of empathy, transparency, and openness (Harrell & Rowe, 2014; Owen, Tao, Leach, & Rodolfa, 2011; Williams et al., 2014)
- Be mindful of your language – try using the term “counseling” in exchange for more clinical terms such as psychotherapy (Thompson, Bazile, & Akbar, 2004)

In addition to the aforementioned considerations, it is also important that the provider consider the caregiver's potential mental health concerns and how those issues might impact treatment engagement and outcomes. Risk factors associated with mental health issues, make the Black American population particularly vulnerable to mental health issues. As reviewed in the In-vivo Exposure chapter, many Black Americans have experienced cultural traumas that might cause or contribute to the development of mental disorders or symptomatology, such as post traumatic stress disorder (PTSD; Bowen-Reid & Harrell, 2002; Carter, 2007) and or impact the way in which an individual attributes cognitive appraisals to stress and everyday concerns (Harrell, 2000). It has been estimated that Black Americans are 20 times more likely to endorse

psychological symptoms in comparison to individuals of European descent (U.S. Department of Health and Human Services Office of Minority Mental Health, 2016) and it is believed that Black American women are at even greater risk for developing mental illness (Ward, Clark, & Heidrich, 2009), due to risk factors that include lower socioeconomic status (i.e., diminished access to resources, living in poverty, greater likelihood for exposure to violence), chronic health conditions, the burden of bearing multiple roles (e.g., single parent household) and stress surrounding the experience of multiple minority status (e.g., gender, Black American, sexual orientation, etc.) (Artinian et al., 2007; Neufeld, Harrison, Steward, & Hughes, 2008; Schnieder, Hitlan, & Radhakrishnan, 2000). Despite the rate of mental illness within the Black American community, treatment seeking is markedly low due to numerous variables that may include historical and contemporary unethical, biased, discriminatory, and sociopolitical factors contributing to cultural mistrust of health care (Rusert, 2009; Whaley, 2001). When looking at potential treatment barriers specific to Black American women, researchers have found a preference for help from informal supports and religious leaders (Abrams, Dornig, & Curran, 2009; Neighbors, Musick, & Williams, 1998), a belief that family issues should be kept in the family – “don’t air your dirty laundry” (Alvidrez, 1999), and a need to preserve archetypal conceptions of strength (e.g., the Strong Black Woman) (Neal-Barnett & Crowther, 2000) and portrayals and beliefs about self-reliance (Matthews, Nelesen, & Dimsdale, 2005; Mays, Caldwell, & Jackson, 1996). It has been estimated that approximately 52.5% of Black American households are led by single-women, thus making these variables particularly salient when working with Black American female caregivers (Hofferth, Stueve, Pleck, Bianchi, & Sayer, 2002). In addition to factoring these considerations into your conceptualization and work with clients, it may also be useful to consider using greater flexibility in terms of scheduling, as a

caregiver, particularly those of a single-household may find it difficult to get to session on time due to work demands. Despite numerous internal strengths and external supports, the prevalence rate of mental health issues and exposure to traumas within the Black American community may make the youth's caregiver more vulnerable to mental health concerns. Though this module can offer numerous positive learning and sharing opportunities, the youth's presentation of his or her trauma narrative might evoke negative affect within the caregiver, who has a mental illness or trauma history. In this case, it should be communicated to the caregiver the overall importance of not being emotionally effusive (e.g., uncontrollable sobbing, visible expressions of rage) during the youth's trauma narrative (Cohen et al., 2006). In an effort to relate the importance of appropriate emotional restraint, the provider might point out the caregiver's role as an exemplar of strength. Not an emotionally impenetrable parent figure, but an empathetic, Black American human that can tolerate and compassionately cradle the youth's honesty, vulnerability, and courage. If the provider senses that the caregiver will not be able to maintain emotional composure – for any reason – during the trauma narrative, the exercise should be forgone (Cohen et al., 2006). Given the high prevalence rates of trauma and mental health concerns within the Black American community, as well as common reticence for mental health treatment, it might be useful to approach the topic in a non-pedantic, five-pronged approach:

1. Stress that this discussion is not to make the caregiver the “patient,” but that this is a standard procedure done with all caregivers given the number of risk factors (share them) within the Black American community.
2. Highlight the potential benefits of mental health treatment, as it relates to the youth's treatment outcomes and the wellbeing of the caretaker.

3. Validate the coping skills and strengths of Black Americans – Point out that while those coping skills may be useful to some at certain times, others may need additional help.
4. Dispel any myths - without validating experiences of inequity - about mental health treatment.
 - a. If comfortable and appropriate, share a time in which you, as the provider, have sought mental health treatment and share barriers/your thought process surrounding your decision to get that help
5. Casually offer a list of provider's within the parent's price range.

Session Participants - Who's Invited?

TF-CBT (Cohen et al., 2006) was originally developed with the youth and their parents in mind for inclusion – a theoretical design that might complement many Black American households. However, as discussed in greater detail within previous modules of this dissertation, many Black American families place high value on kinship bonds and as such, have an extensive network of family with individuals that may or may not be biologically or legally related (Hill, 1972, 1999a). This extension of family augments the primary family unit in that it contributes a wealth of resources, such as spiritual support, financial assistance, facilitation of logistics (e.g., picking up one's child from school, teaching one's child a sport), is amassed and makes the family stronger (Hill, 1972). Additionally, various life circumstances within an Black American parent's social stratosphere, such as single-parenthood or having an inflexible work schedule, could shift significant parental responsibility to another trusted individual, such as a grandmother, aunt, or even an older sibling. The malleability of roles within families is noted by Hill (1972, 1999a) as a common value within Black American homes. Though assessment of

safety should undoubtedly trump all, comments from youth such as, “My big sister is like my mom – she walks me to school, helps me with my homework, cooks my dinner” should be understood within cultural context. In cases where the primary caregiver has distributed *significant* parental responsibility to other individuals, it is suggested that the adult adjunct caregivers also attend these conjoint sessions, as therapy should involve the entire family system (McCollum, 1997).

Session structure. The suggested framework for a standard session is a 60-minute session that is divided into three parts: (a) 15 minutes with the youth, (b) 15 minutes with the caregiver(s), and (c) 30 minutes with the youth and their caregiver(s) (Cohen et al., 2006). The placement of the sessions typically commences after the Cognitive Processing of the Trauma Narrative, but depending on the client’s needs, the sessions may begin at any point (Cohen et al., 2006). The first session may begin with an introduction to the conjoint sessions and general orientation, as well as agenda setting. Thereafter, the provider and clients will set the agenda for the following week at the end of each session (Cohen et al., 2006).

Education. Cohen and colleagues’s (2006) model is loosely designed, which allows for individualization. Depending on the family’s background, interests, and needs, the education portion of the program will be different. Though a thorough clinical assessment and application of clinical intuition will be vital, these education sessions embody the essence of a true cognitive behavioral treatment, as they are collaborative nature (Beck, 1979, 2011) and simply ask the family what they might like to learn about. General topics for education should be specific to the youth’s trauma. Potential conjoint session topics might include: boundary setting, healthy relationships (platonic and friendships), self-care, substance abuse and drug refusal skills, effective communication styles, conflict resolution skills, how to trust in the wake of trauma,

safety planning. Culturally specific education related to Black Americans will also be beneficial: how to manage interactions with police enforcement.

Because a strong cultural identity and racial socialization around cultural pride and societal hostility have been found to be a correlate of psychological health amongst Black Americans (Jackson-Gilfort, Liddle, Tejada, & Dakof, 2001), as well as report less substance behaviors (Belgrave et al., 1994, Stevenson, Reed, Bodison, & Bishop, 1997), this is a wonderful time to provide ethnic socialization – a construct that was reviewed in the Parenting module. This portion of the dissertation discusses ways in which ethnic socialization can be utilized in the conjoint sessions. Though history has often focused on negative traits of Black Americans, a shift towards positive strengths is recommended (Harrell & Rowe, 2014). Topics that may be covered might be covered alongside caregivers are listed here below.

- Exercises that encourage Black pride, such as what do you like about your hair and complexion
- Have caregivers share a story of a family member that overcame social injustice or personal trauma
- Identify contributions (e.g., inventions, music, medicine, etc.) of Black Americans throughout history

In a study within Black American male adolescents, the authors found that they were more engaged with discussions related to anger, alienation, respect, and transition from boyhood to manhood (Jackson-Gilford et al., 2001). In addition to the topics identified above, topics that might be discussed with Black American males might include the following.

- How to manage interactions with police enforcement
- Identify activities that might decrease feelings of anger (e.g., martial arts, boxing, speaking with a pastor, talking to a supportive male figure, etc.)
- Identify activities that might decrease experiences of alienation (e.g., extracurricular activity)
- Have caregivers share some of the challenges males in their family experienced when transitioning from boyhood to adulthood

Though much of the available research that relates to Black Americans and particularly Black American youth includes subjects that are from low-income social economic status, it is important to remember that Black Americans are not a homogenous group (McCollum, 1997). For example, experiences of Black Americans in middle and upper socioeconomic groups may have different experiences than those in lower socioeconomic groups. Furthermore, Harrell and Rowe (2014) highlight that there is diversity within diversity, in other words an intersectionality of diversity thus, cultural should be conceptualized holistically. Also, identification to a specific cultural group may co-exist, exist within a hierarchy (e.g., one might identify as an Black American male first and *then* a gay male), or switch their primary cultural identification depending on the setting.

Trauma narrative. In addition to covering various educational topics, the conjoint sessions offer a space to discuss and process the youth's trauma in a semi-structured, planned manner by sharing the youth's trauma narrative. After the youth has written and processed their trauma narrative with the provider in previous modules, they will write a list of questions for their caregiver to address in the conjoint sessions (Cohen et al., 2006). The provider will then share those questions with the parent and discuss how to answer them (Cohen et al., 2006). When the provider and caregiver are reviewing the youth's trauma narrative in private, the caregiver can ask unfiltered questions and be as emotionally expressive as needed (Cohen et al., 2006). During the conjoint session, the youth will read their trauma narrative, ask their caregivers their questions, and the caregiver can respond. If appropriate and agreed upon prior to the session, the caregiver may also share their feelings related to the trauma (Cohen et al., 2006). If the caregivers in attendance decide that they do not want to hear the trauma narrative or feel that they will not be able to maintain emotional composure in front of the youth, this portion of

the module can be eliminated (Cohen et al., 2006). In lieu of this intervention, additional education modules may be added. In addition, it should be suggested that the caregiver do additional work, perhaps outside of TF-CBT to increase comfortability with hearing their child's trauma, as the goal of this particular module is to increase the youth's ability to discuss their trauma with their caregiver (Cohen et al., 2006) and eliminate feelings of shame and increase openness to strengthen the family relationship.

Chapter 10: Enhancing Future Safety & Development

“Education is the most powerful weapon which you can use to change the world.” – Nelson Mandela

As the youth and their caregivers move through the TF-CBT protocol, they become equipped with numerous resources to help better manage innocuous fears and unhelpful thinking patterns that pertain to their respective trauma(s). In addition, TF-CBT also offers valuable tools to help clients prepare for the future through the installation of safety skills, education, and mind/body awareness. Though education and promotion of safety skills about abuse and intimate partner violence are recommended within all families, youth that are survivors of trauma are particularly viable recipients of these resources.

Though this module has the potential to increase feelings of self-efficacy and empowerment in the youth and the caregivers, poor placement in the treatment protocol might increase feelings of self-blame, guilt, or even compromise the youth’s candor when working through the trauma processing module (Cohen, Mannarino, & Deblinger, 2006). As such, it is suggested that this module be placed after the cognitive processing and in-vivo modules (Cohen et al., 2006). However, this is not a resolute recommendation and certain exceptions to this can be made if the youth is in immediate or ongoing danger (e.g., living in a dangerous neighborhood, going to school with an aggressor) (Cohen et al., 2006). In these situations, carefully planned execution of education and safety planning may be introduced earlier in the treatment (Cohen et al., 2006).

Education

The primary goal of this module, is to instill and develop well-informed conceptions of various forms of abuse in the youth and their caregivers in an effort to increase the clients’

awareness, as well as promote proper labeling and handling of abusive behaviors (Cohen et al., 2006). For many caregivers, discussion of these topics can be difficult. Navigating through the potential awkwardness and discomfort of these topics can be ameliorated by identifying other behaviors and concepts that caregivers socialize their youth towards early in childhood (Cohen et al., 2006). Additionally, education clarifies any preexisting or false conceptions about abuse that might inadvertently perpetuate aggressions, by allowing them to go unnoticed. Though education and safety skill building cannot completely eradicate childhood violence, both can play a pivotal role in prevention (Cohen et al., 2006; Leeb, Paulozzi, Melanson, Simon & Arias, 2008; Niolon et al., 2017).

Dissemination of educational materials and participation of informative discussions should be given to both the youth and their caregivers. Though a frank discussion is encouraged, there are various ways in which the caregiver might broach these topics with youth. Here below are a list of potential approaches:

1. Watch a movie featuring a predominately Black American cast that touches on emotional, physical, sexual abuse; community violence, or intimate partner violence. After discussing the different types of abuse/violence, go through the movie and have a discussion about the occurrences violence within the movie.
2. Read a psychoeducational, age-appropriate book on childhood violence that includes Black Americans characters.
3. Listen to music that speaks about different types of violence and use it as a complementary discussion piece or segue into a larger discussion on violence.

Types of Abuse and Violence & Specific Safety Skills

Psychological Abuse

Coined “the most challenging and prevalent form of child abuse and neglect,” (Hibbard, Barlow, MacMilan, & Committee on Childhood Abuse and Neglect, 2012, pp. 372), the terms psychological and emotional abuse/neglect are often used interchangeably to describe aggression characterized, but not limited to, intimidation, verbal insults, physically threatening gestures, verbal threats, withholding, shunning, and or isolation (Hibbard et al., 2012; Spinazzola et al., 2014). Spinazzola and colleagues (2014) note that this form of abuse is often viewed as, contextually, less detrimental in comparison to physical or sexual abuse, however survivors of emotional abuse can experience even *greater* mental health problems, particularly if experienced in conjunction with physical or sexual abuse. Despite the many misconceptions surrounding the potential gravity of this form of abuse, the rate at which it occurs is considerably high. In an analysis of 5,616 youth with histories of emotional abuse/neglect, physical abuse, and sexual abuse, an astounding 62% experienced comorbid emotional abuse/neglect and 24% experienced emotional abuse/neglect as a standalone construct (Layne, Briggs-King, & Courtois, 2014; Spinazzola et al., 2014). This high frequency rate might relate to the difficulties surrounding detection, as there are no physical indications of psychological aggression, and the absence of social taboo that physical and sexual abuse often carry (Spinazzola, 2014).

As reviewed in previous modules, assaults based on the individual’s cultural group can be psychologically detrimental and contribute to psychopathology (Bryant-Davis & Ocampo, 2005; Carter, 2007), as well as shape the way in which the way in which individuals encode and assign cognitive attributions to everyday stressors (Harrell, 2000; Thompson, 2002). It will be important to educate Black American clients on the potential for psychopathology as the

incidents may become so commonplace that Black Americans might become accepting of cultural biases/discrimination as “normal. Education on culturally related traumas may also validate and normalize any negative affect that may arise in response to cultural stressors and put things into context.

There might be times when providers are confused about an Black American’s pathological response to cultural insults and ask themselves, “Well you use the n-word with your friends” or “You make fun of each other’s color all of the time, why are you offended when a person of another ethnic group uses the same language?” The utilization of culturally self-deprecating humor to progress through and manage psychologically and physically challenging times has been a common coping tool utilized by Black Americans throughout history as a means of developing emotional strength, while simultaneously acting as a mature defense mechanism (Erickson & Feldstein, 2007; Lefcourt & Davidson-Katz, 1991; Lewis, 1994). This self-depreciative humor is often bundled within a verbal exchange of “put downs” against another (e.g., a slight towards one’s ethnic phenotypic features, family, economic circumstance, etc.). This verbal dance between individuals is often referred to as the dozens, signifying, telling “yo mama” jokes, capping, or joning (Lewis, 1994). Though many comedians, actors, and musicians have used this enduring cultural coping strategy and made it economically profitable and entertaining, Cecile Brown is quoted as saying, "The dozens, capping, are forms of survival ... Being able to keep cool and not take insults personally are things that allow black people to be so effective. (Lewis, 1994).” Lewis (1994) notes that the origin of the dozens is not clear, but suspects that it might relate to the days of slavery in which field slaves were unable to physically assault house-slaves, who were generally lighter skinned and considered of higher status in the slave hierarchy. The only way to “get at them” was through verbal assaults, which were

commonly directed towards the house slave's parents; if the degradation worked – the assaults would increase (Lewis, 1994). Lewis (1994) suspects that the term “the dozens” might be in reference to the house slave's mothers, who were one of many (one of dozens) women used for sex by their masters.

Self-deprecating language is also representative of Black Americans turning a negative experience into something less harmful. Evidence of this can be found by many Black American's utilization of the term “nigga” in dialogue, media, and music. Historically, the term “nigger” was used pejoratively to describe an individual of a lowly class of poor intelligence (deCoy, 1967). For many Black Americans, the term still carries its original connotation and conjures images of as persecutory acts, such as lynchings and threatening acts, such as burning crosses on lawns that the word was often paired with to justify acts of violence and discrimination. Though some Black Americans – on a conscious or subconscious level – may use the term as a means of reminding other Black Americans that they will always be at the bottom of American society (Kennedy, 2002), the term can also be used to express endearment or as a pronoun. Other Black Americans hold onto the word as a symbol of survival, strength, and resilience – a reclamation of sorts. In a discussion exploring the continued use of the “n-word,” Coates (2013) highlights the perspective taken by some by noting, “Whitey may have more money and live better and all that, but here's one place where we hold the cards; here's one place where we have the power. We can call each other ‘nigger’ and you can't.” Though the utilization of the “n-word” within group remains controversial, it is important to understand the history and its place in modern day Black American vernacular and culture. When used within group, the term can carry less emotional bite, however when used by another ethnic group, the experience can evoke a range of negative emotions of the Black American recipient (Kennedy,

2002). So is it emotional abuse? If the client experiences psychological symptomatology as a result of it – even if it is a culturally acceptable form of humor or dialogue – yes. However, be careful not to label the behavior as such without the client’s buy in, as they might see the humor as culturally innocuous.

Safety Skills

- Learn characteristics of supportive, healthy relationships
- Disparaging that relate to one’s color or other ethnic features can be very harmful and hurtful. Though many comedians or peers within Black American culture may make light of these issues, they can certainly become abusive and you do not have to tolerate them.
- Set emotional boundaries
- Become familiar with the concept “trust your gut” – if something feels inappropriate, it probably is
- Practice assertiveness training

Sexual Abuse

The scope of acts that fall within the definition of sexual abuse might include coercing a minor to participate in sexual activity that includes touching and non-touching behaviors such as fondling, penetration, exposure, voyeurism, exhibitionism, or viewing pornography (Leeb et al., 2008).

Due to the secretive nature of this type of abuse, it often goes unreported, however some figures indicate that as many as 62,939 cases of child sexual abuse were reported in 2012 (Childhood Maltreatment, 2012)

When thinking about the stereotypical child abuser or molester, one often refers to stereotyped images depicted by the media. These images might conjure up an odd social misfit or an individual of European descent. In a review of sexual offenders, Greenfeld (1997) found that 99% of sex offenders that committed single sexual assaults were male and 6 out of 10 times

they were of European descent. Though these stereotyped images may be true in some instances, many molesters look “normal” and fly under the radar of suspicion by capitalizing on these widely held misconceptions. Offenders can be of different ethnic backgrounds, including Black American males and females. In addition to stereotypical attributes, other common misconceptions of child abusers is that they are all aggressive. Again, this may be true in some cases, but they can also be very manipulative and engage in common tactics or “grooming” behaviors to lure minors into engagement by buying the youth gifts or using play, threats, or other non-aggressive techniques to ensure the youth does not tell and keep them in victimhood (National Child Traumatic Stress, Network, Physical Abuse Collaborative Group, 2009). These grooming behaviors are often confusing to both the minor and their caregivers, as they are not aggressive and present – superficially – as “nice” and “caring” behaviors. Though many Black Americans tend to have a large support network, it should be up to the caregiver to assess and check in with the youth about their level of comfort with an individual. Just because the caregiver is cordial with an individual in the kin network, does not mean the youth will be.

Safety Skills

- Review the difference between appropriate and inappropriate secrets
- Provide education on the medical terminology for genitalia
- Check to see if those within your social support network are registered sex-offenders or display any of the grooming behaviors listed above
- Educate on safe and unsafe touching
- Check in with the youth about their feelings towards individuals in the family’s network of support; be cognizant of any resistance to visiting/spending time with those individuals
- Discuss who the child will inform if they are sexually abused

Physical Abuse

Though the definition of physical abuse varies by state, the broad definition encompasses the utilization of physical force that might include, hitting, kicking, shaking, burning, that may or may not result in a residual physical mark (e.g., welt, cut, bruise) or injury (e.g., broken bone) (Child Welfare Information Gateway, 2007). The aggressor's intentions (e.g., "It's only abuse if I meant to hurt my kid.") are not a qualifier for physical abuse and as such, planned or seemingly controlled corporal punishment that results in injury can be qualified as physical abuse (Child Welfare Information Gateway, 2007). The prevalence of physical abuse is considerably high. In 2007, approximately 149,000 cases were reported in the United States, the District of Columbia, and Puerto Rico (National Child Traumatic Stress, Network, Physical Abuse Collaborative Group, 2009). It is further suggested that the highest frequency of victimization occurs between the ages of 4-7 and 12-15, with the youngest being most vulnerable to catastrophic injuries (US Department of Health and Human Services, Administration on Children, 2007).

The utilization of corporal punishment has been a common practice of addressing disobedience in American culture (Greven, 1991). However, as research exploring parenting practices, psychological effects of corporal punishment, and laws pertaining to child safety percolate, its utilization takes on a far different tone with the potential for significant consequences today than it might have in generations past (Caselles & Milner, 2000; Child Welfare Information Gateway, 2007; Gershoff, 2008). The practice of corporal punishment within Black American culture finds its historical origins in American slavery as a means by which mothers would inflict upon youth to steer their children against wrongdoing in an attempt to escape greater punishment from slave owners (Dyson, 2014). Because of the long withstanding tradition of corporal punishment within many Black American families, its utilization is often remarked upon in dialogue as a source of folly or humor (Dyson, 2014).

Some Black Americans might even validate their implementation by referencing supportive biblical passages, such as Proverbs 13:24 - “He who spares the rod hates his son, but he who loves him is careful to discipline him.” (Dyson, 2014). Despite the cultural value many Black Americans have placed on corporal punishment and its long withstanding utilization across numerous generations, utilization – particularly with trauma survivors – cannot continue.

Safety Skills

- Identify healthy communication skills
- Discuss who the youth might contact in case they witness or experience physical abuse
- If the youth lives in a dangerous neighborhood and is at risk for being subjected to physical abuse (e.g., being jumped, robbed, etc.):
 - Do not talk to strangers
 - Do not take rides from strangers
 - Keep your money in your pocket – don’t wave it around for others to see
 - Run and scream if someone begins following you
 - Do not take shortcuts
 - Keep your “eyes to yourself” when walking through rough parts of the neighborhood
 - Come straight home
 - Let caregiver know what time you expect to be home
 - Text/call caregiver when you arrive home
 - Run and scream if someone begins following you
- If the youth lives in a dangerous neighborhood and is at risk for *witnessing* violence:
 - Do not sit close to windows and have a safe place to hide if gunshots are heard (if neighborhood is known for drive-bys)
 - Check in with youth daily to see what they’ve been exposed to and how they’re handling it
 - If the youth lives in a home where there is domestic violence, develop a safety plan: find a room to hide and lock the door, call 9-1-1
- Practice conflict resolution skills
- Model non-aggressive discipline

Neglect

Willful or non-willful failure or inability to fulfill a child’s basic physical, such as shelter, meals, clothing, education, access to medical care, and emotional sustenance is defined as neglect (Child Welfare Information Gateway, 2007). In 2015, an estimated 75.3% cases of neglect were reported to the Child Protective Services (Child Welfare Information Gateway, 2017). Also

from that sample, of the 1,640 youth that died from maltreatment, an astounding 70% passed away as a result of neglect (Child Welfare Information Gateway, 2017).

It is important to consider that in some cases of neglect, might be a result of accessibility or access to resources. Many Black Americans living in poverty or in rural areas may have difficulty accessing healthcare or medicine for transportation or economic reasons. Caregivers might also be mistrustful of healthcare providers and be reticent to send their child to a medical/mental health professional (Whaley, 2001). Though government programs have insured many Black Americans, there are still approximately 15.9% of Black Americans, in comparison to 11.1% of individuals of European descent who did not have insurance in 2014 (Agency for Healthcare Research and Quality, 2014). If this is the case, take the precautionary steps to afford access. If there are cultural explanations (e.g., certain religions may not advocate vaccinations) for neglectful behaviors, offer an adequate level information for the caregiver to make an informed decision and avoid mislabeling behaviors as negligent.

Safety Skills

- Provide education on who a youth might contact in case of neglect
- Connect caregivers with social workers or community organization that might better provide information and resources to increase accessibility barriers

Intimate Partner Violence

The Centers for Disease Control and Prevention defines intimate partner violence (also known as domestic violence) as a “serious, preventable public health problem” (Niolon et al., 2017, p.7; Breiding, Chen, & Black, 2014) that entails physical, sexual, or psychological aggression by a current or former partner (Niolon et al., 2017). In an age where social media and electronic communication bear great influence on the lives of many youth, it is important to note that

intimate partner violence can be conducted in-person *and* from a distance, whether through social media, text-messaging, phone calls, emails, etc. In addition, this type of violence is not mutually exclusive to any one particular sexual orientation (e.g., same-sex, heterosexual, etc.) or identify (e.g., transsexual, queer, etc.); furthermore, it does not require sexual intimacy (Niolon et al., 2017).

Though there may be some reticence to bring up this topic with youth, it should be noted that intimate partner violence can occur during adolescence when youth begin dating (Niolon et al., 2017). In fact, Smith and colleagues (2017) estimate that approximately 8.5 million American women (7%) and 4 million men (4%) reported involvement in an act of physical violence, forced sex-act, or psychologically threatening behavior (e.g., stalking) at the hands of an intimate partner in their lifetime and that their first encounter with these violent acts by that partner occurred before the age of 18. The high prevalence of teen domestic violence (TDV) was further echoed in a national survey of American high school students. Of those who reported dating, 10% experienced physical dating violence, 11% experienced sexual dating violence within the past 12 months (Kann et al., 2014). In another survey reviewing dating behaviors of teenage youth, those that dated within the past year, 21% of girls and 10% of boys reported physical violence, sexual violence, or both from a dating partner (Vagi, Olsen, Basile, & Vivolo-Kantor, 2015). In another study, it was found that almost 3.5 million women (3%) and 900,000 men (1%) in the U.S. report that they first experienced stalking before age 18 (Smith et al., 2017). In another study, almost as many as 17% of high school students in Kentucky report stalking, many of them saying that they were afraid of a former boyfriend or girlfriend (Fisher et al., 2014). Many Black American youth have been socialized – directly or indirectly – to take on the “Strong Black Woman” or John Henry personas. The youth might say, “I’m too strong for

that – no body is ever going to beat me up. That doesn’t happen to Black people.” However, individuals that identify as Black American are at even greater risk for intimate partner violence, as evidenced by supportive prevalence rates. Multiracial women 57%, 45% non-Hispanic Black women lifetime prevalence; 42% multiethnic, 40% non-Hispanic Black (Smith et al., 2017). These rates of early occurrence support the notion that early education on healthy relationships is pivotal in the prevention of intimate partner violence. As stated by the CDC, the “goal is to stop IPV before it begins.”

Some Black Americans in unhealthy relationships might find have more traditional child rearing attitudes and believe that “grown folks business” is not the concern of children. They might find themselves asking, “What do my relationships have to do with my child” or “I make sure we don’t fight until my kid is asleep.” Well, there is overwhelming support that suggests that stable and healthy relationships (i.e., between parent and child, parents and their intimate partners, and parents and other adults) and environments are essential in the prevention of child maltreatment and offer a healthy template for social interactions and healthy standards for relationships (Breiding et al., 2014; Smith et al., 2017; Schofield, Lee, & Merrick, 2013).

Safety Skills

- Model healthy relational styles
- Educate on healthy, supportive, nurturing relationships
- Discuss warning signs of intimate partner violence

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APPENDIX G

IRB Approval Letter



Pepperdine University
 24255 Pacific Coast Highway
 Malibu, CA 90263
 TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: February 28, 2017

Protocol Investigator Name: Paul Perales

Protocol #: 16-12-454

Project Title: Developing a supplemental resource for Trauma-Focused Cognitive Behavioral Therapists working with lesbian, gay, and bisexual adolescents.

School: Graduate School of Education and Psychology

Dear Paul Perales:

Thank you for submitting your application for exempt review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations 45 CFR 46.101 that govern the protections of human subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Since your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chair

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives

Mr. Brett Leach, Regulatory Affairs Specialist



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Malibu, CA 90263
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cc: Dr. Lee Kels, Vice Provost for Research and Strategic Initiatives

Mr. Brett Leach, Regulatory Affairs Specialist