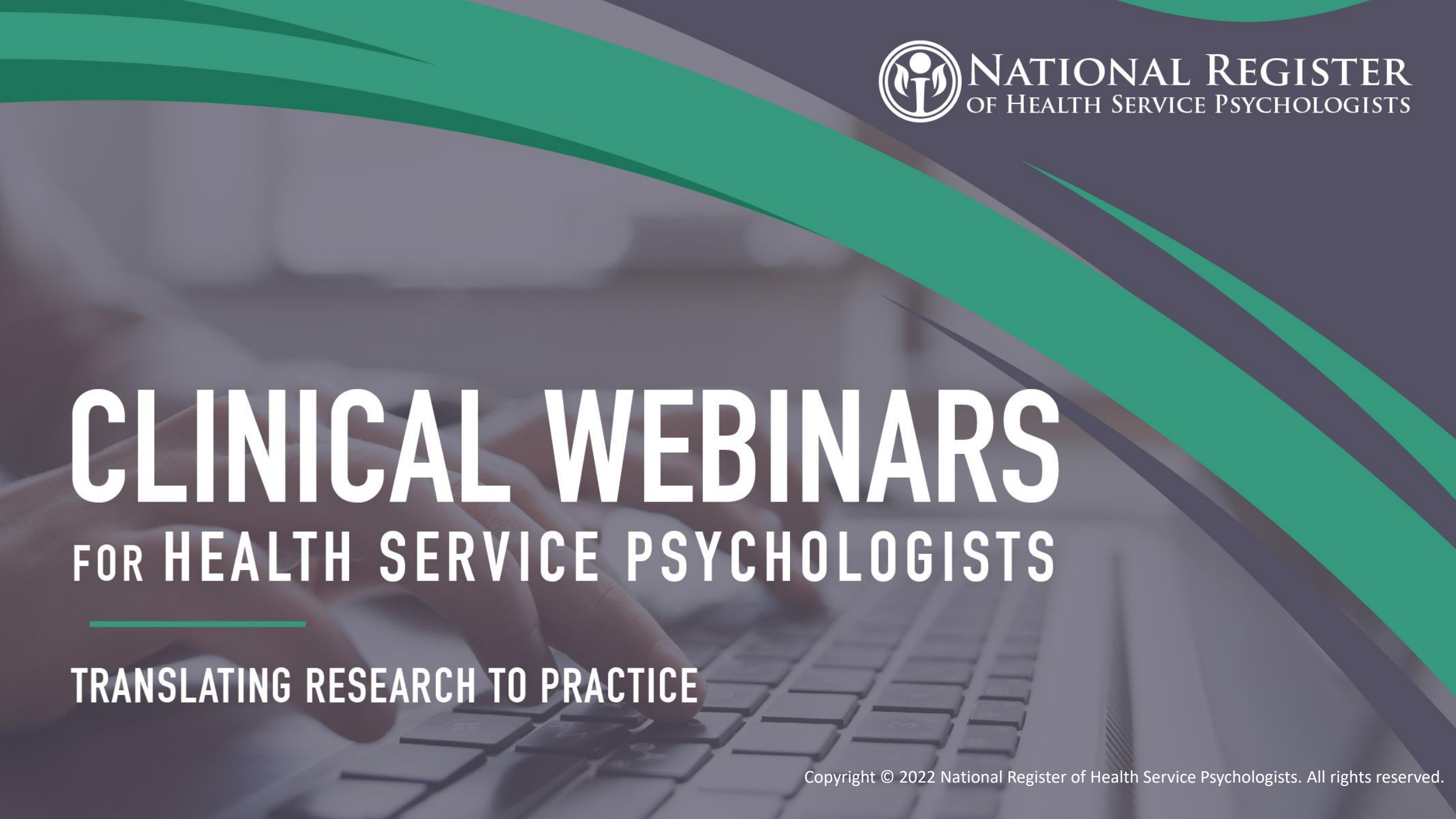

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CLINICAL WEBINARS

FOR HEALTH SERVICE PSYCHOLOGISTS

TRANSLATING RESEARCH TO PRACTICE

Treating Black Men Who Have Experienced Sexual Trauma

Vincent G. Walford, PhD, MPH

Webinar Tips for Attendees

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1 CE Credit, Instructional Level: Intermediate
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Vincent Walford, PhD, MPH

Vincent Walford, PhD, MPH, completed his undergraduate studies at Baylor University and obtained a Master's in Public Health from Morehouse School of Medicine, with a specialty in Health Education and Health Promotion. He pursued and completed his doctoral training in Counseling Psychology from Howard University and completed his clinical internship with the University of Houston Counseling Center. From there, he completed a post-doctoral Trauma Fellowship at the Michael E. DeBakey VA Medical Center. Currently, he is a staff Psychologist at University of Pennsylvania.

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Disclosures/Conflicts of Interest

- I have no conflicts of interest to disclose.

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Presentation Outline

- Learning Objectives
- Questions to think about
- Plight of Black Men
- Coping Strategies
- Statement of the Problem
- Case Study

Learning Objectives

- Identify the effects of sexual trauma with African American men and help-seeking behaviors of those survivors.
- Describe what factors help facilitate disclosure of sexual trauma experiences in African American male victims.
- Discuss issues facing African American men who self-identify as survivors of sexual trauma.

Content Warning:

Discussion of trauma and post-traumatic stress

Questions to Think About

- What are some stereotypes of black men?
- What are the cultural factors that cause black men to not disclose?
- What are your thoughts about access to care for black men?
- What are your concerns with working with black male survivors of sexual assault/trauma?

Plight of Black Men and Trauma

- Each year trauma accounts for 41 million emergency department visits, 2.3 million hospital admissions and 192,000 deaths across the nation (National Trauma Institute, 2014).
- Trauma has been identified as a major public health and medical issue, and Black males ages 18 and older are at a noticeably high risk for trauma exposure (Centers for Disease Control and Prevention, 2016; Davis et al., 2008; Fein, Wade, & Cronholm, 2013).

Plight of Black Men and Trauma Cont.

- Studies examining trauma exposure among community samples of Black males show that approximately 62% have directly experienced a traumatic event in their lifetime, 72% witnessed a traumatic event, and 59% have learned of a traumatic event involving a friend or family member (Afful et al., 2010; Centers for Disease Control and Prevention, 2016; Davis et al., 2008; Fein, Wade, & Cronholm, 2013; Kilpatrick et al., 2013; Substance Abuse and Mental Health Services Administration, 2014; Tolin & Breslau, 2007).
- Although many Black males who experience a traumatic event will go on with their lives without incurring lasting negative outcomes, others may experience traumatic stress reactions that lead to deleterious mental and/or behavioral outcomes (Cuff & Matheson, 2015; Roberts et al., 2011).

Men and Sexual Assault

- One in 6 men have experienced some form of unwanted or abusive sexual experiences before age 18 (Masho & Alvanzo, 2009).
- Males also make up 10% of the total population of those who have experienced sexual abuse (Masho & Alvanzo, 2009).

Limited Research on Rates of African American Men and Sexual Assault

- Possible Reasons for Lack of Disclosure
  - Stigma
  - Judgment
  - Masculinity
  - No one will believe them
  - In your own time think of some additional examples of why AA Male survivors are reluctant to disclose their sexual trauma.


Coping Strategies

Maladaptive Behaviors

- Avoidance
- Sleep Disturbance
- Increased Irritability
- Isolation and Distrust
- Substance Use
- What are some other maladaptive behaviors you have experience with this population?

(Richardson JB Jr, Wical W, Kottage N, Bullock C., 2020)

Healthy Coping Behaviors

- Spirituality
- Therapy
- Social Support (Formal/non-formal)
- What are some other coping skills you have seen in your practice?

(Richardson JB Jr, Wical W, Kottage N, Bullock C., 2020)

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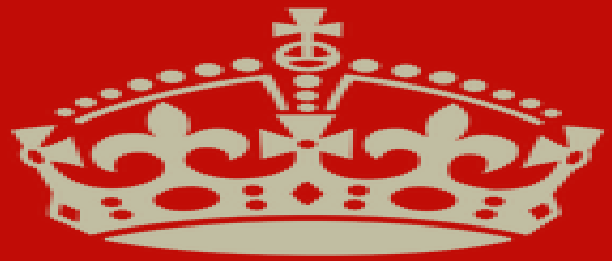
Statement of the Problem

- Research suggest that the prevalence rate for men experiencing sexual assault/trauma may be higher than once suggested however, men are less likely to disclose that they have experienced any sexual trauma (Crome, 2006)
- Symptoms of sexual assault/trauma: shame, rage or uncontrolled anger, confusion about their gender identity or masculinity, PTSD and difficulties in intimate relationships.

Counseling Recommendations

- Provide a safe environment
- Understanding the plight of African American men
- Endorse resiliency
- Process the experience of being a survivor
- Identify support systems



KEEP CALM AND LET'S GET TO WORK

Suggestions on working with Black Men and Sexual Assualt

- Rapport building
  - My Multicultural Self
- Identify Faulty Thoughts
  - Cognitive Distortions
- Cognitive Processing Therapy
  - In vivo Exposures

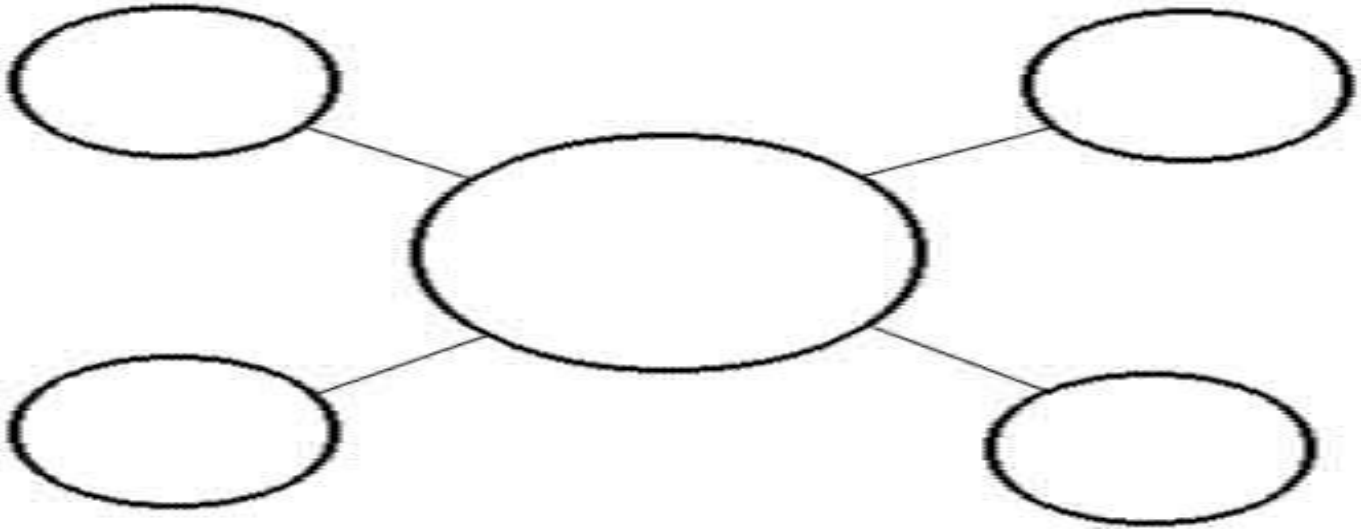
Rapport Building

- Share yourself
- Identity work
- Establish Trust
- Earn Respect from the client
- Build’s confidence for client to share
- Build’s familiarity
- Show Empathy

Circles of My Multicultural Self

This activity highlights the multiple dimensions of our identities. It addresses the relationships between our desires to self-define our identities and the social constructions that label us regardless of how we define ourselves.

Place your name in the center circle of the structure below. Write an important aspect of your identity in each of the satellite circles -- an identifier or descriptor that you feel is important in defining you. This can include anything: Asian American, female, mother, athlete, educator, Taoist, scientist, or any descriptor with which you identify.



1. Share a story about a time you were especially proud to identify with one of the descriptors you used above.

2. Share a story about a time it was especially painful to be identified with one of your identifiers or descriptors.

3. Name a stereotype associated with one of the groups with which you identify that is not consistent with who you are. Fill in the following sentence:

I am (a/an) _____ but I am NOT (a/an)_____.

(So if one of my identifiers was "Christian," and I thought a stereotype was that all Christians are radical right Republicans, my sentence would be:

I am a Christian, but I am NOT a radical rightwing Republican.

Identifying Faulty Thoughts

- Introduce Cognitive Distortions
- Identify stress thinking
- Discuss ways to combat distortions
- Useful Stuck Points

Cognitive Distortions

Cognitive distortions are irrational thoughts that can influence your emotions. Everyone experiences cognitive distortions to some degree, but in their more extreme forms they can be harmful.

Magnification and Minimization: Exaggerating or minimizing the importance of events. One might believe their own achievements are unimportant, or that their mistakes are excessively important.

> **Catastrophizing:** Seeing only the worst possible outcomes of a situation.

Overgeneralization: Making broad interpretations from a single or few events. "I felt awkward during my job interview. I am *always* so awkward."

Magical Thinking: The belief that acts will influence unrelated situations. "I am a good person—bad things shouldn't happen to me."

Personalization: The belief that one is responsible for events outside of their own control. "My mom is always upset. She would be fine if I did more to help her."

Jumping to Conclusions: Interpreting the meaning of a situation with little or no evidence.

> **Mind Reading:** Interpreting the thoughts and beliefs of others without adequate evidence. "She would not go on a date with me. She probably thinks I'm ugly."
>
> **Fortune Telling:** The expectation that a situation will turn out badly without adequate evidence.

Emotional Reasoning: The assumption that emotions reflect the way things really are. "I feel like a bad friend, therefore I must be a bad friend."

Disqualifying the Positive: Recognizing only the negative aspects of a situation while ignoring the positive. One might receive many compliments on an evaluation, but focus on the single piece of negative feedback.

"Should" Statements: The belief that things should be a certain way. "I should always be friendly."

All-or-Nothing Thinking: Thinking in absolutes such as "always", "never", or "every". "I *never* do a good enough job on anything."

Cognitive Processing Therapy (CPT)

- The preferred nonpharmacological treatment for PTSD is a trauma-focused cognitive-behavioral intervention such as **Cognitive Processing Therapy** (CPT).
- It combines exposing the client to the trauma by having him/her write a detailed description of it and reading it aloud to a therapist and identifying and challenging negative beliefs (“stuck points”) that are maintaining the client’s symptoms.

CPT Worksheets

- ABC Worksheets
- Challenging Beliefs Worksheet
- Patterns of Problematic Thinking Worksheet
- Safety Module
- Trust Module
- Power/Control Module
- Esteem Module
- Intimacy Module


CASE
STUDY

Background information

- Mr. S
  - 37-year-old African American male
  - Born Dallas, TX and raised in Columbus, GA
- Family History
  - Strained relationship with parents
  - Parents divorced (age of 12)
  - Left home at 16 years old
  - Oldest of three (Two half younger brothers)
- Education
  - Completed high school
  - Currently attending college and focusing on becoming a Licensed Chemical Dependency Counselor (LCDC)
- Religious Affiliation
  - Raised Baptist
- Work
  - Store Manager

Marriage and Family History

- First Marriage 1999-2001; Divorced in 2005
- Two boys (15 and 16) active
- Infidelity
- Second marriage 2005-2015; Divorced
- Two girls (10 and 11) not active
- Symptoms of PTSD (irritable, anger issues, defensive, isolation, etc.)
- Marital issues resulted in current legal issues

Background Information

- Trauma History
  - Physical Abuse (Father)
  - Emotional (Mother)
- Neglect (Homeless at 16 years old)
- Combat Trauma (Involving a female child who sustained a burn injury)
- Military Sexual Trauma (involving an older male colleague)

History of Maladaptive Behaviors

- Marijuana Use
- Alcohol Use
- Avoidance
- Sleep

Background history

- Mental Health History
  - Family history (aunt diagnosed with Bipolar disorder, father past suicide attempt, brother diagnosed with Schizophrenia)
- Suicide Attempts
  - 2004 (Gun) and 2015 (Rope)
- Initial Contact with services
- August 2014
- Presenting Concerns: anger related issues, irritability, and nightmares (war related)
- Past Mental Health Diagnosis
- PTSD, GAD and MDD

Presenting Problems

- Pending court case for an Aggravated Assault charge against his ex-wife (Anger Management)
- Indicated issues related to PTSD (combat trauma and MST)
- Symptoms of PTSD caused the demise of his 9 year marriage

Gold Standard Treatments for PTSD

- Individual therapies offered in the PCT Clinic
- Prolonged Exposure (PE) & Cognitive Processing Therapy (CPT)
- PE
- Individuals are encouraged to re-experience the traumatic event in a safe and supportive environment and, eventually, engage in activities they've been avoiding because of the trauma. (www.ptsd.va.gov)
- CPT
- Individuals learn how to identify, challenge and develop a more balanced thinking about the trauma. (www.ptsd.va.gov)

- Rationale for CPT over PE
- CPT works for complex trauma as well as simple trauma (Resick et al., 2003), while PE focuses on one trauma
- CPT has a lower dropout rate than PE, 32% vs. 44% (Jeffries et al., 2014)
- CPT best fit for the client

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CPT-C vs. CPT

- CPT-C omits use of trauma accounts
- The client non compliant with completing trauma accounts
- Faster decline in PTSD symptoms compared to CPT (Resick et al., 2008)
- Fewer dropouts then standard CPT (Resick et al., 2008)
- Researchers suggest that CPT-C may be the most beneficial symptom change with in the CPT protocol (Walter et al., 2014)

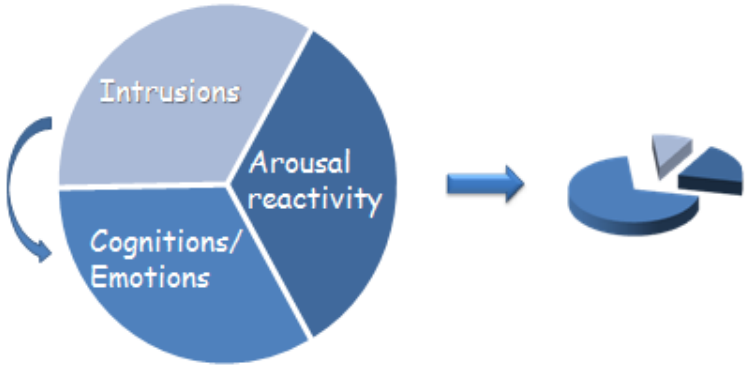
Diagnosis

- PTSD (Nightmares, anger, hypervigilance, negative thoughts about himself and others around him, avoidance of crowds and older males)
- MDD (Sadness, Hopelessness, Guilt, weight gain, irritability, uncontrollable crying, issues related to sleep)

Recovery vs. Non- Recovery

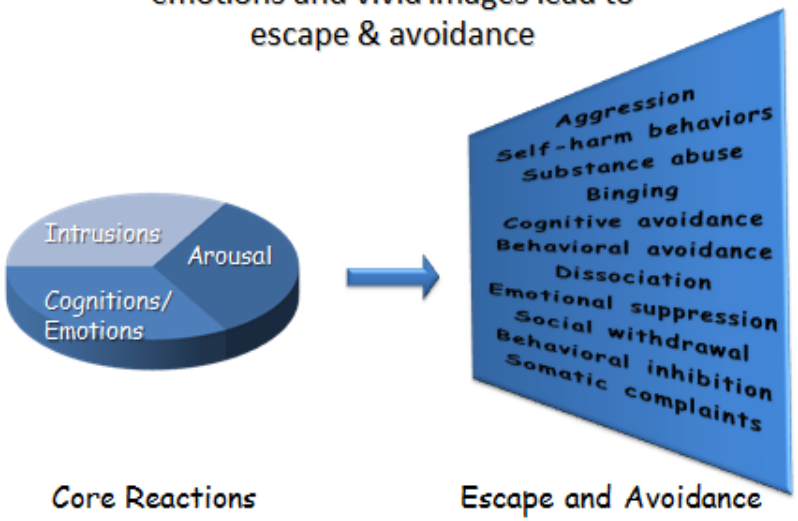
Recovery

In normal recovery, intrusions and emotions decrease over time and no longer trigger each other



Non-Recovery

However, in those who don't recover, strong negative emotions and vivid images lead to escape & avoidance



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Problematic Thinking that Perpetuates Symptoms of PTSD

• When an individual experiences a traumatic event that does not fit their beliefs, there are different ways that individuals may try to make their traumatic experience fit with their existing beliefs.

- Assimilation-changing your memories or interpretation of the event to fit with your pre-existing beliefs.
- "I ejaculated when I was raped so I must have liked it" and "If only I wasn't weak I wouldn't have been raped"
- Over- accommodating-altering one's beliefs about oneself and the world to the extreme in order to feel safer and more in control.
- "I can't trust older men" and "I can't be alone with my thoughts"
- One goal for treatment is to help the client accept what happened and to develop a balanced way of thinking about his traumatic experience.

Natural Emotions vs. Manufactured Emotions

•The CPT manual distinguishes between two kinds of emotions: Natural and Manufactured emotions

•**Natural Emotions**

•Feelings that follow naturally from the event and that would be universal: fear when in real danger, anger when being intentionally harmed, joy or happiness with positive events, or sadness with losses.

•Natural emotions have a natural course and are time limited

•**Manufactured Emotions**

•Emotions connected to our interpretation of the traumatic event

•The more that an individual continues to think about their traumatic event in these ways, the more manufactured feelings they are going to have

• EX: Anger (Allowing the rape to happen, viewing himself as weak, I should have fought back, assault to ex spouse, lashing out at coworkers and classmates)

Conceptualization of PTSD

•Previous Experiences

↓

•Attitudes/Beliefs Formed

↓

•Traumatic event

↓

•Stuck Points (Prevention of Natural Recovery)

↓

•Manufactured Emotions

↓

•Maladaptive form of coping

↓

•Avoidance and Substance Use

Course of Treatment

- Individual Therapy (CPT-C)
- Weekly Sessions
- 26 Sessions (12 CPT-C Protocol & supportive therapy)
- Goal of treatment: To assist the client in understanding the factors that create and maintain PTSD symptoms and to learn specific strategies that will help decrease PTSD symptoms.

Cognitive processing therapy-Cognitive

“PTSD is a whole-body tragedy, an integral human event of enormous proportions with massive repercussions.” Susan Pease Banitt

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CPT-C

Stage 1

- Discussion of trauma-related symptoms
- Explore impact of trauma

Stage 2

- Examining and Challenging unhelpful beliefs about the traumatic event

Stage 3

- Addressing issues commonly impacted by trauma: safety, trust, power and control, self-esteem and intimacy

Stage 1: (Sessions 1-3)

Session 1

- Provided an overview of PTSD symptoms, rationale of CPT, and discussed readiness to engage in treatment
- Asked client to write a one page "Impact Statement" describing the impact of his traumatic experiences on his thoughts and beliefs about himself, others, and the world

Session 2

- Reviewed Stuck Points and Stuck Point Log
- Reading, discussing and identifying Stuck Points found in the Impact Statement
- Introduced the A-B-C Worksheets

Session 3

- Reviewed homework (A-B-C Worksheets) with the client
- Introduced the trauma narrative and discussed issues related to avoidance

Assignment #1 Impact Statement

•“Why did this event occur? Well obviously he thought I looked good and being the perverted dude that he is he used his power of being a stronger to drug me and take advantage of me. He probably was picked on by some other guys and I was the lucky dude who he took his revenge out on. It was the beginning of me not believing in God because why would God let this messed up event happen to me. How this effected:

•Safety — I hate males that are older than me.

•Trust — I don’t trust any man that I don’t know

•Power and Control — I have none.

•Esteem — Esteem..what's that?

•Intimacy — I don’t care for sex sometimes and other times I hate it. I also will not do doggy style with women.”

Stuck Points

- “My family won’t understand my PTSD”
- “All older men are bad”
- “If only I wasn’t weak I wouldn‘t have been raped”
- “I must have enjoyed being raped because I ejaculated”
- “I am all alone and everyone will leave me”
- “I am pathetic and will always be alone”
- “If I am nice to someone I will get hurt”
- “I can't sit alone with my thoughts”
- “All people will screw me”

Stage 2 (Sessions 4-6)

Session 4

- The client did not bring the assigned trauma narrative to session;
- Reported having a “bad week,” experienced a panic attack and could not complete his assignments

Session 5

- The client did not complete his homework assignment
- Continued using A-B-C worksheets to help challenge is distorted beliefs
- Introduced the Challenging Questions Worksheets to aid in challenging stuck points

Session 6

- Completed Challenging Questions; the client focused on stuck points related to self-blame and hindsight bias
- Introduced the Problematic Thinking Patterns Worksheet

Stage 3 (Sessions 7-12)

Session 7

- Reviewed the client's completed Problematic Thinking Patterns Worksheets.
- Introduced the Challenging Beliefs Worksheet (CBW) and Safety Module

Session 8

- Discussed the Safety handout (Forgot Manual)
- Introduced the Trust Module

Session 9

- Discussed the Trust handout (Did not complete due to school obligations)
- Introduced the Power/Control Module

Session 10

- Discussed the Power/Control handout (Did not complete due to school obligations)
- Introduced the Esteem Module

Session 11

- Discussed the Esteem handout (Workbook Damaged)
- Introduced the Intimacy Module

Session 12

- Discussed the Intimacy handout (Did not complete due to school obligations)
- Compared Old and New Impact Statement
- Discussed continuing with therapy

Session 12: Impact statement #2

•“I am an unfortunate victim of someone else’s mental disorder. What he did hurt me physically, mentally and emotionally. I only blame myself for not saying something sooner. He will never know the amount of damage he has done to me. Damage that may never go away. Issues I have today may have been a bit better if I did talk about them but I cannot dwell on “what ifs.” I cannot say that things are cured but I am able to cope a little better. I did not bring this upon myself, however, it is up to me now to address it. I still do not care for older male or the smell of certain colognes. I still have nightmares. I’m still hypervigilant-but it’s a little better when I am with people. I know I can be happy again but attempting to see it is difficult.”

Continuation of therapy

Individual therapy

- Extension of CPT protocol
- Challenging Beliefs Worksheet

- In vivo Exposures Exercises (Avoidance)
  - Crowds, restaurants, stores, etc.

In Vivo Hierarchy

Situation or Activity	SUD
Going Fishing with friends	0
Walk dog in neighborhood w/daylight	10
Going to the grocery store at 6 am	25
Calling a friend	45
Sleeping without a nightlight	65
Crowded elevator	75
Go to a restaurant and sit in the middle during peak hour	85
Sexual Assault	100

Outcomes

- Decreased PCL-5 scores
- Improved mood (self report)
- Built social support
- Consistency
- More open with family and friends

Sessions 1-23 (PCL-5 Scores)

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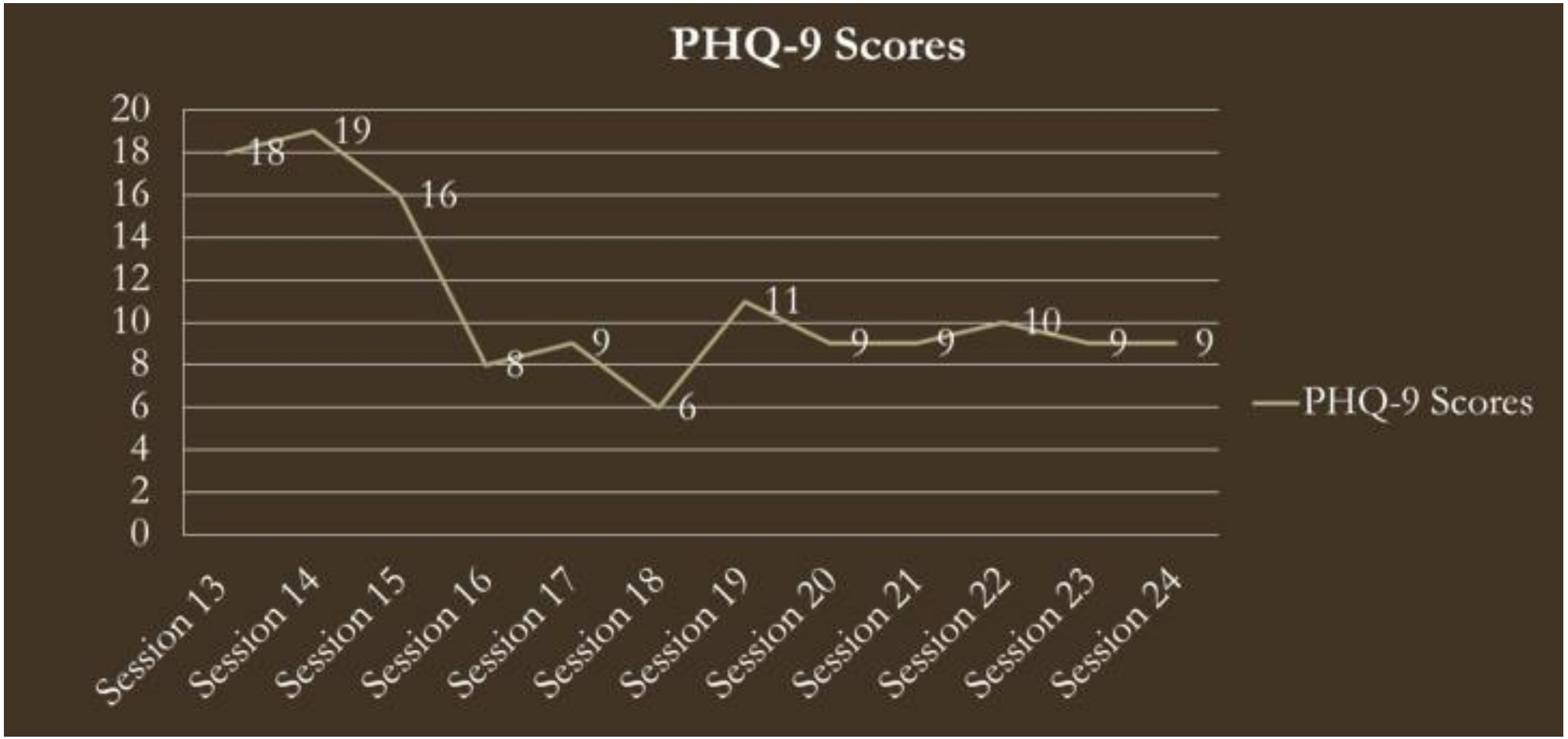
Session 12-20 (phq-9 scores)



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Emergent Issues Throughout Therapy

- Completion of assignments
- Avoidance (In vivo Exposure Exercises)
- Life and environmental stressors (family issue, finances, school, relationships, flooding of home)
- Rationale for treatment
- Validation of panic attacks

Cultural Considerations

Military Culture

•Lack of support from family

•Associates mostly with other black men

Spiritual Beliefs

•Raised Baptist

•Shamed by religious family

•Questions faith

•Hypocrisy

Gender

•Disclosing sexual assault to a male therapist

•Normalized experience

Age

•Similarity in age improved therapeutic rapport

Race/Ethnicity

•Similar in race different in upbringing

Termination

- Initially started as completion of CPT-C protocol
- Mutually agreed to focus on decreasing PTSD symptoms and address avoidance
- Discussed termination through the duration of treatment
- Ongoing discussion about future treatment planning

Lesson learned

- “There are wounds that never show on the body that are deeper and more hurtful than anything that bleeds.” Laurell K. Hamilton

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Q&A With Dr. Vincent G. Walford

- Dr. Sammons will read select questions that were submitted via the Q&A feature throughout the presentation.
- Due to time constraints, we will not be able to address every question asked.

National Register of Health Service Psychologists

Resources

• *Afful S, Strickland J, Cottler L, & Bierut L (2010). Exposure to trauma: A comparison of cocaine- dependent cases and a community-matched sample. Drug & Alcohol Dependence, 112(1/2), 46–53. [PubMed: 20599330]*

•*Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Injury Prevention & Control: Data & Statistics (WISQARS). (2015). Fatal injury reports, national, regional and state, 1981 – 2016. Retrieved from https://webappa.cdc.gov/sasweb/ncipc/mortrate.html*

•*Crome, Sarah. (2006). Male survivors of sexual assault and rape. Australian Centre For the Study of Sexual Assault, 2, 1-8.*

•*Cuff R, & Matheson FI (2015). Women, trauma & incarceration: What they say, how we work. Retrieved from http://content.govdelivery.com/accounts/USDOJBOPNIC/bulletins/111206c*

•*Curry, T.J., & Utley, E.A. (2018). She Touched Me: Five Snapshots of Adult Sexual Violations of Black Boys. Kennedy Institute of Ethics Journal 28(2), 205-241. doi:10.1353/ken.2018.0014.*

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Resources

•*Davis RG, Ressler KJ, Schwartz AC, Stephens KJ, & Bradley RG (2008). Treatment barriers for low- income, urban african americans with undiagnosed posttraumatic stress disorder. Journal of Traumatic Stress, 21(2), 218–222. [PubMed: 18404649]*

• *Fein J, Wade R, & Cronholm P (2013). Findings from the Philadelphia urban ace survey. Retrieved from http://www.instituteforsafefamilies.org/sites/default/files/isfFiles/Philadelphia%20Urban %20AC E%20Report%202013.pdf*

•*Jeffreys, M. D., Reinfeld, C., Nair, P. V., Garcia, H. A., Mata-Galan, E., & Rentz, T. O. (2014). Evaluating treatment of posttraumatic stress disorder with cognitive processing therapy and prolonged exposure therapy in a VHA specialty clinic. Journal of Anxiety Disorders, 28, 108–114.*

•*Kilpatrick DG, Resnick HS, Milanak ME, Miller MW, Keyes KM, & Friedman MJ (2013). National estimates of exposure to traumatic events and ptsd prevalence using dsm–4 and dsm–5 criteria. Journal of Traumatic Stress, 26(5), 537–547. [PubMed: 24151000]*

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Resources

- *National Trauma Institute. (2014). Trauma statistics. Retrieved from http://www.nationaltraumainstitute.org/home/trauma_statistics.html*

- *Masho, S.W., & Alvanzo, A. (2009). Helping-seeking behaviors of men sexual assault survivors. American Journal of Men's Health, (4) 3, 237-242.*

- *Motley, R., & Banks, A. (2018). Black Males, Trauma, and Mental Health Service Use: A Systematic Review. Perspectives on social work : the journal of the doctoral students of the University of Houston Graduate School of Social Work, 14(1), 4–19.*

- *Resick, P. A., Galovski, T. E., Uhlmansiek, M. O., Scher, C. D., Clum, G. A., & Young-Xu, Y. (2008). A randomized clinical trial to dismantle components of cognitive processing therapy for posttraumatic stress disorder in female victims of interpersonal violence. Journal Consulting and Clinical Psychology, 76, 243-258.*

- *Richardson JB Jr, Wical W, Kottage N, Bullock C. Shook Ones: Understanding the Intersection of Nonfatal Violent Firearm Injury, Incarceration, and Traumatic Stress Among Young Black Men. Am J Mens Health. 2020 Nov-Dec;14(6):155798320982181. doi: 10.1177/1557988320982181. PMID: 33356779; PMCID: PMC7768853.*

Resources

- *Roberts AL, Gilman SE, Breslau J, Breslau N, & Koenen KC (2011). Race/ethnic differences in exposure to traumatic events, development of post-traumatic stress disorder, and treatment-seeking for post-traumatic stress disorder in the United States. Psychological Medicine, 41, 71–83. [PubMed: 20346193]*

- *Substance Abuse and Mental Health Services Administration Trauma and Justice Strategic Initiative. (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach. Retrieved from http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf*

- *Tolin D, & Breslau N (2007). Sex differences in risk of ptsd. PTSD Research Quarterly, 18(2).*

- *Walter, K. H., Dickstein, B. D., Barnes, S. M., & Chard, K. M. (2014). Comparing effectiveness of cpt to cpt-c among u.s. veterans in an interdisciplinary residential ptsd/tbi treatment program. Journal of Traumatic Stress, 27, 438-445.*

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