***TRAUMA-INFORMED ANNOTATED BIBLIOGRAPHY***

\*Denotes I/DD addressed within the article

**Journal Articles**

***Trauma-Informed conceptual discussion***

**\*Ballan, MS & Sormanto, M (2006). Trauma, grief and the social model: Practice guidelines for working with adults with**

 **intellectual disabilities in the wake of disasters. *The Review of Disability Studies: An International Journal*, 2(3): 78-96.**

The authors provide an overview practice response following traumatic events in the life’s of people. They then discuss the paucity of existing literature on assisting adults with intellectual disabilities following a traumatic event or death. Proposing the social model as a narrative for responding to people with ID, they then provide guidelines for what should be included in the model.

**Becker-Blease, KA (2017). As the world becomes trauma-informed, work to do. *Journal of Trauma & Dissociation*, 18 (2): 131-**

 **138. doi: 10.1080/15299732.2017.1253401.**

The author makes the argument that trauma-informed care is a very broad construct which can be confusing and which is applied without a measure of consistent, evidence based treatment/systems. She critiques potential biases in TIC systems, i.e.: that the model becomes part of the status quo, that the model does not attend to conflicts of interest, that scholarship is inconsistent on definitions of TIC and how trauma is defined. She notes the importance of the movement moving forward, and the necessary need to bring balance and clarity to the subject.

**\*Berardi, A & Morton, BM (2017). Maximizing academic success for foster care students: A trauma-informed approach. *The***

 ***Journal of At-Risk Issues*, 20 (1) 10-16.**

The authors’ propose a trauma-informed approach that can be adapted for children residing in foster care families who also receive special education services in schools. The systematic approach calls for social service agencies, schools and foster-care families to create a communication system and supportive culture for supporting children who have experienced trauma and are in the foster care system. They provide a conceptual framework from which the parties can work together in a creating a safe, welcoming and supportive environment for the children.

**Bloom, S. (2016). Advancing a national cradle-to-grave-cradle public health agenda*. Journal of Trauma and Dissociation*,**

 **17 (4): 383-396. doi: 10.1080.15299732.2016.1164025.**

The author speaks to changes in public health from first, a historical perspective, and secondly, the challenges confronting public health in the present. She argues that stress and trauma underlie a lot of what society manages as health crises. Per her position, cultural shifts and awareness of trauma on health are important to shifting service delivery. Towards that end, she advocates clear public policy, and clear dissemination to address the public needs.

**Bloom, S. (2010). Organizational stress and trauma-informed services. In B.L Levin, M.A. Becker (eds.), *A Public Health***

 ***Perspective of Women’s Mental Health*, DOI 10.1007/978-1-4419-1526-9\_15, Springer Science+Business Media LLC.**

Bloom argues that there are parallel processes that work into organizational structures and systems resultant from the work they do with women who have trauma histories. Sometimes there is a direct correlation, in a positive manner, to the work provided. Sometimes the correlation is related to secondary loss in the tangle between doing what’s right versus what organizations are able. Bloom defines areas of struggle and proposes paradigm shifts organizations should consider to be more responsive.

**Bowen EA & Murshid, NS (2016). Trauma-informed social policy: A conceptual framework for policy analysis and advocacy.**

 ***American Journal of Public Health*, 106 (2)223-229. doi: 10.2015/AJPH.2015.302970.**

The authors make the argument that the principles of trauma-informed care can and should be incorporated into public health policy. They provide examples of using the six core principles of TIC: trustworthiness and transparency, collaboration and peer support, empowerment, choice, safety and cultural sensitivity. They asserted that public health policy obligates systems to pay attention to health delivery and recognize service disparities. They further assert that policies provide a framework for disrupting health disparities and righting the ship. This politicization, in itself, acknowledges key constructs of TIC.

**Chafouleas SM, Johnson AH, Overstreet S & Santos NM (2016). Toward a blueprint for trauma-informed service delivery in**

 **schools. *School Mental Health*, 8: 144-162. doi 10.1007/s12310-015-9166-8**

The authors draw from literature to propose a method for implementing and monitoring a trauma-informed school wide system of services. Emphasis is on the implementation, professional development and evaluation of proposed program. Care is taken to advocate critical oversight and strategic planning in developing a trauma-informed system.

**Dodd, P, Dowling, S & Hollins, S (2005). A review of the emotional, psychiatric and behavioural responses to bereavement in**

 **people with intellectual disabilities. *Journal of Intellectual Disability Research*, 49(7): 537-543.**

The authors completed a comprehensive literature review on the pathological outcomes of bereavement on with intellectual disabilities. They found that bereavement and loss had specific impact on people with ID. These symptoms had treatment relevance. They make recommendations for further research, particularly as it applies to traumatic grief symptoms.

**Elliott, Denise E., Bjelajac, Paula, Fallot, Roger D., Markoff, Laurie S. & Glover- Reed, Beth (2005).**

 **Trauma –informed or trauma-denied: Principles and implementation of trauma-informed services for**

 **women. *Journal of Community Psychology*, 33: 461-477.**

The authors advocate a systematic approach to trauma-informed services for women. They define these principles in practice (service delivery) and philosophy (trauma theory, empowerment, and relational theory). Specifically, they identify 10 principles that define trauma-informed service, discuss the need for this type of service, and give some characteristics of trauma-informed services in eight different human service areas. The areas include outreach and engagement, screening and assessment, resource coordination and advocacy, crisis intervention, mental health and substance abuse services, trauma-specific services, parenting support, and healthcare. The authors reported on their experiences with nine sites involved in the Substance Abuse and Mental Health Service Administration's (SAMHSA) 5-year grant project, “Women, Co-occurring Disorders and Violence Study (WCDVS. This article presents an excellent overview on principles of trauma-informed service.

**Falkenburger, E, Arena, A & Wolin, J. (2018). Trauma-informed community building and engagement. Position Paper of the**

 ***Metropolitan Housing and Communities Policy Center, Urban Institute*, San Francisco, CA**

The authors’ present this guide as a means to discuss how trauma impacts community healing, strategies for TIC engagement in work and in the community and they provide two case studies to demonstrate how services and supports have been achieved using this model guide..

**Fallot, RD & Harris, M (2002). The trauma recovery and empowerment model (TREM): Conceptual and practical issues in a**

 **group intervention for women. *Community Mental Health Journal*, 38(6): 475-485.**

The authors’ describe the TREM model in its application to women survivors of trauma who have co-occurring mental health and or substance use disorders. This group model is designed to accommodate treatment based on the co-occurring nature of need, e.g.: adaptations to increase skill building, creating a safe environment, helping label experiences such that emotion regulation skills can be harnessed, etc.

**Fallot, RD & Harris, M (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. In:**

 **Harris, M and Fallot, R (Eds.) *Using Trauma Theory to Design Service Systems*. New directions for Mental Health Services.**

 **San Francisco: Jossey-Bass.**

The authors provide a template for implementing TIC services. They define terms of TIC, discuss how it fits into service models, and detail why TIC is important to the people served and the whole organization.

**Fave N & Bay-Cheng, LY (2012). Trauma-informed sexuality education: recognizing the rights and resilience of youth. *Sex***

 ***Education: Sexuality, Society and Learning*: 1-12.** [**http://dx.doi.org/10.1080/14681811.2012.745808**](http://dx.doi.org/10.1080/14681811.2012.745808)**.**

The authors may the case that critical service overlap is indicated in systems that treat childhood maltreatment and systems that provide adolescent and youth sex education. They point to the disparate goals and potentially problematic outcomes that may be encountered by youth who have experienced sexual maltreatment. The author’s review the current cultures of each treatment domain. They then make an argument for the introduction of trauma0-informed merging of the fields in a manner that can be beneficial to those youth who had been maltreated.

**Finklestein, N, VanderMark, N, Fallot, R, Brown, V, Cadiz, S & Heckman, J (2004). Enhancing substance abuse recovery**

 **through integrated trauma treatment. *National Trauma Consortium*, Sarasota, FL.**

The authors’ present a position paper on trauma-informed substance abuse treatment. They review key elements of trauma-informed services and provide a brief overview of five program models, each developed by one of the authors of the report, that have elements of a trauma-informed treatment.

**Frydman, JS (2016). Role theory and executive functioning: Constructing cooperative paradigms of drama therapy and**

 **cognitive neuropsychology. *The Arts in Psychotherapy*, 47: 41-47.**

The author examines the parallels between drama therapy and neuropsychology using role theory. An emphasis on the selection and activation of executive function is considered. The author argues that working memory, attention, cognitive control and theory of mind are actively addressed in drama therapy. That is concordant with constructs in neuropsychology and should be examined in context to cooperating of paradigms between both, to the extent that this new understanding benefits those receiving services.

**Glaesser, J, Neuner, F, Lutgehetmann, R, Schmidt, R & Elbert, T (2004). Posttraumatic stress disorder in patients with**

 **traumatic injury. *BMC Psychiatry*, 4:5 1-6.**

The authors’ researched the effect of consciousness on the development of PTSD symptoms in patients who have

sustained a TBI. Their research found that patients suffering TBI who lost consciousness as a result of the traumatic event were less likely to experience PTSD symptoms three and six months following the incident than those who remained conscious following their trauma incident.

**Goldman-Fraser, Jenifer, Griffin, Jessica L., Barto, Beth L, Lo, Charmaine, Wenz-Gross, Melodie,**

 **Spinazzola, Joseph, Bodian, Ruth A., Nisenbaum, Jan N. & Dym Bartlett, Jessica (2014).**

 **Implementation of a workforce initiative to build trauma-informed child welfare practice and**

 **services: Findings from the Massachusetts Child Trauma Project. *Children and Youth Services Review*,**

 **44: 233-242.**

The authors report on the development and implementation of the Massachusetts Child Trauma Project (MCTP). This initiative was launched statewide to enhance the capacity of child welfare workers and child mental health providers to identify, respond, and intervene early and effectively with children traumatized by chronic loss, abuse, neglect, and violence. They note three primary goals of the initiative as, “(1) training child welfare staff and resource parents to recognize and respond to child trauma, (2) disseminating three trauma-focused EBTs in community-based mental health agencies via sequential cohorts of intensive Learning Collaboratives, and (3) implementing child welfare-led Trauma Informed Leadership Teams (TILTs) that bring mental health providers, child welfare workers, and consumers together to sustain efforts to implement, maintain and spread trauma-informed practices”.. Essentially the discussion goes to development and process of implementation of the initiative. It provides insight into the collaborative process and challenges to implementing a trauma-informed project with many moving parts.

**Hanson, A (2013). Recovering from trauma-informed care. *Clinical Psychiatric News*. Retrieved from**

 **http://www.clinicalpsychiaticnews.com/index.**

The author discusses her experiences with psychiatric care in the 1980s when she was getting started. Her experience with false memory syndrome, driven by alleged traumatic life events is reflected on in her concerns about TIC as a movement. At what point do we consider each person has been traumatized? Does that interfere with considering other treatment options and diagnostic observations? What precludes current service delivery from being humane and person centered? These questions are left for consideration and as a cautionary tale to the potential of TIC morphing into the elephant in the room.

**Hanson R & Lang, J (2016). A critical look at trauma-informed care among agencies and systems serving maltreated youth**

 **and their families. *Child Maltreatment*, 21 (2), 95-100. DOI: 10.1177/1077559516635274.**

The authors undertook to examine a literature search on trauma-informed care in child-serving agencies. Criteria were that the articles must contain a definition of TIC, have implemented at least one component strategy of TIC in the research they report, and have been rigorously analyzed for supporting evidence. In all they found six articles, which they report on. A concern they note is that each article defined TIC differently. Also noted is that research analysis varied between studies. They propose more research is indicated and clearly definitions of TIC to inform the research makes sense.

**Johnson, D (2017). Tangible trauma informed care. *Scottish Journal of Residential Child Care*. 16 (1): 1-21.**

The author reviewed the literature on trauma-informed care. Based on three themes of work force development, trauma focused services and organizational delivery he emphasizes incorporating 15 components of TIC that can be incorporated into service delivery. The author defines how those services may look, and provides a case example of implementation in one setting.

**Katz, Sarah & Haldar, Deeya (2016). The pedagogy of trauma-informed lawyering. 22 Clinical Law Review 359 (2016) *Temple***

 ***University Legal Studies Research Paper* No. 2016-29: 359-393.**

The authors posit the importance of incorporating trauma-informed instruction in law schools to prepare students for responsibilities when they become future attorneys. Four primary components of instruction include, “identifying trauma, adjusting the attorney-client relationship, adapting litigation strategy, and preventing vicarious trauma.”

**\*Keesler, John M. (2014). A call for the integration of trauma-informed care among intellectual and**

 **developmental disability organizations. *Journal of Policy and Practice in Developmental Disability*,**

 **11: 34-42.**

The author presents the case that Trauma-Informed service models should be adopted to the treatment of individuals who have intellectual disabilities. He notes that, “Trauma-informed care (TIC), a systems-focused model for service delivery, is a fast-developing interest among the broader field of trauma in the general population. It recognizes the prevalence and impact of trauma, and creates a culture of safety, trustworthiness, choice, collaboration, and empowerment.” The author discussed relevant literature from both the intellectual and developmental disabilities areas and with TIC and trauma literature drawn from the general population. He makes a strong case that trauma-informed systems should be adapted to services for people with I/DD.

**\*Keesler, John M. (2014). Trauma through the lens of service coordinators: exploring their awareness of**

 **adverse life events among adults with intellectual disabilities. *Advances in Mental Health and***

 ***Intellectual Disabilities*, 8: 151-164.**

The author argues that with our growing understanding of trauma in the field of intellectual disabilities (ID) there is a responsibility among service providers to be trauma-informed. In this article he focuses on service coordinators (SCs) who “are involved in the lives of individuals through the assessment of needs and linkage with necessary supports”. To explore SCs’ understanding of individuals’ experiences of adverse life events, trauma, and related services the author employed semi-structured interviews conducted with 15 SCs. Data were analyzed using a grounded theory approach. The author described SCs’ perceived that individuals’ experiences were comprised of three major categories – experiencing adversity, responding to adversity and adapting to adversity, influenced by precipitating and perpetuating conditions. The author does not advocate additional training or note how the underlying understanding SC’s report is applied in their daily work.

**\*Keesler, John M. (2016). Trauma-informed day services for individuals with intellectual/developmental**

 **disabilities: Exploring staff understanding and perception within an innovative programme. *Journal of***

 ***Applied Research in Intellectual Disabilities*, 29: 481-492.**

**ABSTRACT**

Trauma-informed care (TIC) is a systems-focused philosophy of service delivery based upon principles of choice, collaboration, empowerment, safety and trustworthiness that recognizes the pervasive impact of trauma across the human experience. In a grassroots effort, one organization developed an innovative, trauma-informed day program to meet the needs of individuals with intellectual and developmental disabilities (IDD) who were recently deinstitutionalized. The present study is intended to provide an initial conceptualization and preliminary assessment of TIC within IDD services in order to understand its impact among individuals and staff. The study sought to answer the following questions: Has the program’s culture been stable over time? How have individuals’ behaviors changed over time? What have been the experiences of the program’s staff members with TIC? Through a mixed methods design, secondary data analysis and semi structured staff interviews were used to assess the impact of TIC. Findings revealed an initial strong presence of choice, collaboration, empowerment, safety, and trustworthiness within the program’s culture, with non significant changes at follow-up. Significant reductions were noted in overall challenging behavior, aggression, and PRN medication usage; while non significant changes were noted in physical interventions with the exception of “other” interventions (i.e., least restrictive) which significantly increased. Three major categories emerged from the qualitative data (making a difference, recognizing progress and compromising factors), illuminating staff satisfaction with work experiences, individuals’ progress, and factors that challenged fidelity to TIC. The study provides a preliminary conceptualization and evidence for the efficacy of the integration of TIC into IDD services despite methodological limitations and concerns regarding the use of physical interventions. Directions for future research are presented.

**Keesler, John M., Green, Susan A. & Nochajski, Thomas H. (2017). Creating a trauma-informed community through**

 **university-community partnerships: An institute agenda. *Advances in Social Work*, 18: 39-52.**

The author discussed an alliance established between the School of Social Work at Buffalo State University and several community agencies with regard to supporting the implementation of trauma-informed services. He discusses several university-community alliances leading to how The Institute on Trauma and Trauma informed Care (ITTIC) demonstrated the positive outcomes of partnership between university and community such as: having fostered a common language within and between organizations to promote community level awareness and understanding of trauma. The author describes the formation of the Institute and discusses its model and contributions to the local community and abroad. The implications of ITTIC for the School, University and community were discussed.

**\*King, Robert (2010). Commentary: Complex post-traumatic stress disorder: Implications for individuals with autism**

 **spectrum disorders- Part 1. *Journal on Developmental Disabilities/Le journal sur les handicaps du developpement*, 16 (3):**

 **91-100.**

The author presents a construct in which to think about trauma and how individuals with ASD process their

experiences. He further emphasizes modification to CBT-based therapy as one means to treatment.

**\*King, Robert & Desaulnier, CL (2011). Commentary: Complex post-traumatic stress disorder: Implications for individuals**

 **with autism spectrum disorders- Part 2. *Journal on Developmental Disabilities/Le journal sur les handicaps du***

 ***developpement*, 17 (1): 47-59.**

The authors discuss practice based evidence with regards to the treatment of CPTSD in neuro-typical individuals and

highlight mechanisms for modifying practices to meet the distinct characteristics of people with ADS and CPTSD.

**Ko, SL, Ford, JD, Kassam-Adams, N, Berkowitz, SJ, Wilson, C, Wong, M Brymer, MJ & Layne, CM (2008). Creating trauma-**

 **informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology:***

 ***Research and Practice*, 39 (4): 396-404.**

The authors provide child and adolescent responses to trauma and stress. They review the typical responses from agencies with whom the children interface. Finally they make recommendations for creating systematic trauma-informed practices that agencies may adapt to help children navigate the system and receive the care and treatment necessary to them.

**Krause, DE, Green, SA, Koury, SP & Hales, TW (2017). Solution-focused trauma-informed care (SF-TIC): An integration of**

 **models. *Journal of Public Child Welfare*. doi: 10.1080/15548732.2017.1348312.**

The authors propose that using solution-focused practice techniques allows organizations to put into practice techniques that enable consistent adherence to trauma-informed care principles. They define TIC and SF for the reader and provide an outline for how engaging with and implementing services to the people served in an organization.

**Levenson, Jill (2013). Incorporating trauma-informed care into evidence based sex offender treatment.**

 ***Journal of Sexual Aggression*,** [**http://dx.doi.org/10.1080/13552600.2013.8611523**](http://dx.doi.org/10.1080/13552600.2013.8611523)

In this article the author argues that clinicians should consider incorporating principles of trauma-informed care (TIC) into evidence-based sex offender treatment models. As she advanced her argument the author referred to literature that supports her premise from other treatment settings. She noted that early adverse experiences are prevalent in the general population and more so in criminal and sex offender populations. As the author noted, “Early trauma paves the way for maladaptive coping and interpersonal deficits, which can lead to abusive behaviour.” The author recommends that content-oriented sex offender treatment models emphasizing cognitive-behavioral skills should also integrate process-oriented components. Through that added treatment approach the clinician and offender address the ways in which early trauma shaped the adult offenders cognitions and behavior. From a skills perspective the author argues that “relational approaches to therapy can enhance clients’ interpersonal skills and improve general well-being.” If done correctly, these new skills would contribute to mitigating future offending.

**Levenson, Jill, Willis, Gwenda & Prescott, David (2014*). Adverse childhood experiences in the lives of male sex offenders:***

 ***Implications for trauma informed care*. *Sexual Abuse: A Journal of Research and Treatment*,**

[**http://sax.sagepub.com/content/early/2014/05/27/1079063214535819**](http://sax.sagepub.com/content/early/2014/05/27/1079063214535819)**.**

This study explored the prevalence of childhood trauma in a sample of male sexual offenders (*N* = 679) using the Adverse Childhood Experience (ACE) scale. Compared with males in the general population, sex offenders had more than 3 times the odds of child sexual abuse (CSA), nearly twice the odds of physical abuse, 13 times the odds of verbal abuse, and more than 4 times the odds of emotional neglect and coming from a broken home. Less than 16% endorsed zero ACEs and nearly half endorsed four or more. Multiple maltreatments often co-occurred with other types of household dysfunction, suggesting that many sex offenders were raised within a disordered social environment. Higher ACE scores were associated with higher risk scores. By enhancing our understanding of the frequency and correlates of early adverse experiences, we can better devise trauma-informed interventions that respond to the clinical needs of sex offender clients.

**Levenson, Jill, Willis, Gwenda & Prescott, David (2014*). Adverse childhood experiences in the lives of female sex offenders***

 ***Sexual Abuse: A Journal of Research and Treatment*,**

[**http://sax.sagepub.com/content/early/2014/09/09/1079063214544332**](http://sax.sagepub.com/content/early/2014/09/09/1079063214544332)**.**

This study explored the prevalence of early trauma in a sample of U.S. female sexual offenders (*N* = 47) using the Adverse Childhood Experiences (ACE) scale. Compared with females in the general population, sex offenders had more than three times the odds of child sexual abuse, four times the odds of verbal abuse, and more than three times the odds of emotional neglect and having an incarcerated family member. Half of the female sex offenders had been sexually abused as a child. Only 20% endorsed zero adverse childhood experiences (compared with 35% of the general female population) and 41% endorsed four or more (compared with 15% of the general female population). Higher ACE scores were associated with having younger victims. Multiple maltreatments often co-occurred in households with other types of dysfunction, suggesting that many female sex offenders were raised within a disordered social environment by adults with problems of their own who were ill-equipped to protect their daughters from harm. By enhancing our understanding of the frequency and correlates of early adverse experiences, we can better devise trauma-informed interventions that respond to the clinical needs of female sex offender clients.

**ABSTRACT**

**\*McCarthy JB & Barbot B (2016). The need for research on intellectual disabilities and severe psychiatric disorders in children**

 **and adolescents. Journal of Mental Disorders and Treatment, 2(1) 112-114. doi: 10.4172/2471-271X.1000112**

The authors’ reviewed the scant literature on co-occurring intellectual disability and mental disorders in children and adolescents with intellectual disabilities. They argue that even less is known about how childhood maltreatment and traumatic experiences impact symptoms. They argue for more rigorous exploration and research focusing on that question and on appropriate treatment protocols.

**\*McClure, KS, Halpern J, Wolper PA & Donahue JJ (2009). Emotion regulation and intellectual disability. *Journal on***

 ***Developmental Disabilities (Le journal sur les handicaps du developpement*, 15(1): 38-44.**

The authors’ explored the literature on emotion regulation in people with intellectual disabilities. They found few published examples. Next they discuss the components of emotion regulation that have been studied. Finally, they make recommendations for future research direction.

**McInerny M & McKlindon, A. (2013). Unlocking the door to learning: Trauma-informed classrooms and transformational**

 **schools. *Education Law Center*, Philadelphia, PA., 1-24.**

The authors’ advocate the importance of preparing teachers and school policy to respond quickly and sensitively to children who have been traumatized, either from social or natural causes. They recommend that school systems shift their priorities to include attending to the sensitized needs of children with trauma histories, past or in real time.

**\*Northway, R, Melsome, M, Flood, S, Bennett, D, Howarth, J, Thomas, B (2013). *How do people with intellectual disabilities***

 ***view abuse and abusers?* Journal of Intellectual Disabilities, 17: 361-377.**

This study was conducted in partnership between the University of South Wales and Rhondda Cynon Taff People (a self-advocacy organization for people with ID). Adults with intellectual disabilities were involved in study design, determining questions to ask, collecting and analyzing the data. A primary premise of the research was that people with intellectual disabilities are often not asked about their experience and feelings about abuse, mistreatment and trauma. In this study 19 adults with ID were individually interviewed and another 47 adults were interviewed through a series of group meetings. Among responses ascertained, participants identified sexual abuse as the worst form of abuse. Results further suggested that participants subjected to repeated abuse of a certain kind were likely to identify that form of abuse as the most troubling. A noteworthy outcome of the study was the perception among adults with ID that there were inadequate avenues for them to get relief from or help treating their trauma histories.

**\*Peek, L & Stough, LM (2010). Children with disabilities in context to disasters: A social vulnerability perspective. *Child***

 ***Development*, 81(4): 1260-1270.**

The authors’ reviewed the literature on individuals with disabilities, and on children in disaster. They found themes in the literature that spoke to resilience and abilities to cope or navigate through a disaster. Focus on adverse impact of disasters related to socio-economic and access to timely support. Resilience was found to be a factor that facilitated copjng strategies. The authors’ then made recommendations for further research and program development.

**Peres, JFP, Moreira-Almeida, A, Nasello, AG & Koenig, HG (2007). Spirituality and resilience in trauma victims. *Journal of***

 ***Religious Health*, DOI: 10.1007/s10943-006-9103-0, Springer Publishing: 1-8.**

The authors’ state that “religiousness or spirituality are strongly based on a personal quest for understanding questions about life and meaning”. The advocate that narratives build on a foundation of understanding might create resilience and assist people to navigate and process stressors such that trauma can be mitigated. Their review of the literature builds a foundation for the primacy of argument. Finally they recommend direction for inquiry and study.

**Raja, S, Memoona, H, Hoersch, M, Gove-Yin, S & Rajagopalan, C (2015). Trauma informed care in medicine. *Family***

 ***Community Health*, 38 (3): 216-226.**

The authors present a model for health care practitioners to approach patient treatment from a trauma-informed perspective. The introduce the concept of universal precaution related to patient-centered communication, understanding the health effects of trauma and interpersonal collaboration in addressing wellness. Tier two of the model speaks to inter-professional collaboration and assessment or screening.

**Rochelle, S. & Buonanno, L (2018). Charting the attitudes of county child protection staff in a post crisis environment.**

 ***Children and Youth Services Review*, 86 (2018) 166-175. https://doi.org/10.1016/jchildyouth.2018.01.032.**

The authors reported on their study of child protective staff in Erie County, NY three post crisis. The crisis in question was the death of three children in child protective services over a two year period. Post crisis, there had been implementation of new policy and procedures. However, the authors’ reported that a primary reality was compassion fatigue which negatively imp-acted on employees. While caseloads had improved, office space was problematic, staff were not consulted in policy decisions and as a matter of practical experience, each time a crisis occurred, i.e.: problem in the child protective services, fingers were pointed, from multiple perspectives with no regard for the staff trying to carry out the law. This article goes into the inner working of bureaucratic action and its impact on employees.

**\*Schalock, RL, Verdugo, MA, Bonham, GS, Fantova, F & Van Loon, J (2008). Enhancing personal outcomes: Organizational**

 **strategies, guidelines, and examples. Jour*nal of Policy and Practice in Intellectual Disabilities*, 4(5): 276-285.**

The authors’ discuss the necessary components to creating truly quality of life (QOL) programs from a policy, organizational and implementation perspective. Many of the key elements that speak to QOL also inform thinking from a trauma-informed perspective, The authors’ emphasize that any QOL model must be evidenced based and focus on enhancing personal outcomes of the individuals receiving services.

**\*Strand, M, Benzein, E & Saverman, B (2003). Violence in the care of adults with intellectual disabilities. *Journal of Clinical***

 ***Nursing*, 13, 506-514.**

In this study the authors investigated levels of violence that people served and staff serving them were exposed to in the previous year. 122 of 164 staff responded to the questionnaire. They worked across thirteen group facilities and four day service programs. Study participants were guaranteed anonymity for their participation in the study. Results found that 35% of the staff reporting admitted to being implicated in or witness to violence perpetrated onto people they served. 61% of staff stated that they had been victims of or witness to violence directed towards themselves and or coworkers by adults with ID at their job site. Primary forms of violence were physical, and psychological. Secondary were financial abuse and 1 instance of sexual abuse was reported. The study described staff responses to the violence and made recommendations for improving staff and client outcomes in a variety of ways.

**Wahab, S., Burks, P, Chapman, C, Hohman, M, Manthey, T, Slack, K, Stout, D, Urquhart, C, Yahne, C (2010). Guiding as**

 **practice: Motivational interviewing and trauma-informed work with survivors of intimate partner violence. *Partner Abuse*,**

 **1(1): 92-104.**

The authors’ provide a framework from which to consider both ethical implications and practice guidelines for use of motivational interviewing, in a trauma-informed construct for survivors of intimate partner violence. The authors provided case vignettes to expound on their assertions. Furthermore they tease out potentially ethical issues in the application of MI to female survivor of IPV.

**Yatchmenoff, DK, Sundborg, SA & Davis, MA (2017). Implementing trauma-informed care: Recommendations on the process.**

 ***Advances in Social Work*, 18 (1) 167-185. doi: 10.18060/21311.**

The authors’ identified that there is growing recognition of the importance of trauma-informed care in the health and human service fields. However, they noted that most discussion on trauma-informed care goes to principles. However, less is written about process, i.e.: how does one achieve TIC in their organizational environment. They discuss avenues for achieving successful implementation of TIC within the organization, using a process driven approach.

***Trauma-Informed Staff Training***

**Azeem, Muhammad Wagar, Aujila, Akashdeep, Rammerth, Michelle, Binsfield, Gary & Jones, Robert B.**

 **(2011). Effectiveness of six core strategies based on trauma informed care in reducing seclusions and**

 **restraints at a child and adolescent psychiatric hospital. *Journal of Child and Adolescent Psychiatric***

 ***Nursing*, 24: 11-15.**

The authors reported on the National Association of State Mental Health Program Directors “of six core strategies based on trauma informed care in reducing the use of seclusion and restraints with hospitalized youth of the study was to determine the effectiveness. “ This was reported as a trauma-informed approach that included the following principles: leadership towards organizational change, use of data to inform practice, workforce development, use of seclusion/restraint reduction techniques, consumer involvement/roles in inpatient settings, and the use of debriefing techniques to assess and analyze the use or prevention of seclusion and or restraint.  Hospital staff received training in the six core strategies. Medical records were reviewed for youth admitted between July 2004 and March 2007. Data were collected on demographics, including age, gender, ethnicity, number of admissions, type of admissions, length of stay, psychiatric diagnosis, number of seclusions, and restraints.   Over the course of the study four hundred fifty-eight youth (females 276/males 182) were admitted between July 2004 and March 2007. The study showed a downward trend in seclusions/restraints among hospitalized youth after implementation of six core strategies based on trauma informed care.

**\*Barger, E, Wacker, J, Macy, R. & Parish, S. (2009). Sexual assault prevention for women with intellectual disabilities: A**

 **critical review of the evidence. *Journal of Intellectual and Developmental Disabilities*, 47($): 249-262, DOI: 10.1352/1934-9**

 **556-47.4.249.**

The authors summarized the existing research regarding sexual assault on women with intellectual disabilities. Their findings (as of 2009) found only four examples of sexual violence prevention programs for this population. Based on their findings they made recommendations for prevention practices and discussed future research needs.

**Brown, Stephen, Baker, Courtney N. & Wilcox, Patricia. Risking connection trauma training: A pathway**

 **toward trauma-informed care in child congregate care settings. *Traumatic Stress Institute of***

 ***Klingberg Family Centers*. (ABSTRACT FORM ARTICLE)**

Staff trauma training is one important intervention for agencies aiming to implement trauma-informed care (TIC), a term describing an international trend in mental health care whereby treatment approaches and cultures recognize the pervasive impact of trauma and aim to ameliorate, rather than exacerbate, the effects of trauma. The current study examines the impact of the curriculum-based Risking Connection (RC) trauma training on the knowledge, beliefs, and behaviors of 261 staff trainees in 12 trainee groups at five child congregate care agencies. RC is one of several models used nationally and internationally as a pathway toward TIC culture change in human service organizations including residential treatment. For a subset of agencies, measures were collected at four different time points. Results showed an increase in knowledge about the core concepts of the RC training consistently across groups, an increase in beliefs favorable to TIC over time, and an increase in self-reported staff behavior favorable to TIC in the milieu. In addition, these findings suggest that the train-the-trainer (TTT) model of dissemination central to RC is effective at increasing beliefs favorable to TIC. Differences in post-training changes between three agencies are qualitatively investigated and discussed as examples of the importance of organization-level factors in successful implementation of agency-wide interventions like RC. Implications for implementing RC and trauma-informed agency change are discussed.

**\*Frankish, P (2016). Evaluating the impact of providing training for direct care staff in how to provide an emotionally**

 **nurturing environment for people with intellectual disability and complex needs. *Journal of Intellectual Disability-***

 ***Diagnosis and Treatment*, 4, 41-43.**

In this brief report the author discusses the outcome for people with ID and complex needs following a training initiative with direct care staff. Those staff participated in 30 hour core training introducing them to concepts in nurturing, trauma histories and attachment issues. Following the training ten individuals were evaluated on the presence of disruptive behavior. In every instance behavior emission was significantly curtailed, if not extinguished.

**Gurwitch RH, Messer EP, Masse J, Olafson E, Boat BW & Putnam, FW (2015). Child-adult relationship enhancement (CARE):**

 **An evidence-informed program for children with a history of trauma and other behavioral challenges. *Child Abuse and***

 ***Neglect*:** [**http://dx.doi.org/10/1016/j.chiabu.2015.10.016**](http://dx.doi.org/10/1016/j.chiabu.2015.10.016)

The authors’ discuss an adjunctive training program designed to enhance adult-child engagement parallel to the Parent-Child Interaction Therapy. This non therapeutic program teaches adults how to engage relationally to children with trauma histories and how to collaborate with other adults in a trauma-informed manner.

**Hales, TW, Nochajski, TH, Green, SA, Hitzel, HK & Wolke-Ganga, E (2017). An association between implementing trauma-informed care and staff satisfaction. *Advances in Social Work*, 18(1): 300-312.**

This study reviewed the efficacy of a TIC implementation on staff satisfaction. It found that where staff were included in materially in implementation of TIC, where they were recognized for their contributions (especially financially), and where collaboration was truly present, staff reported higher rates of satisfaction. As this was a relatively small study, more research is needed to examine the impact of TIC on staff attitudes.

**Koury, SP & Green, SA (2017). Developing trauma-informed care champions: A six month learning collaborative training**

 **model. *Advances in Social Work*, 18 (1): 145-166.**

The authors’ report on a learning collaborative program designed to prepare agencies to implement effective TIC. 14

participants from addiction treatment centers throughout were identified to participate in six month training. Participants met in person one time a month and were taught specific skills to introduce to their employers. Check-ins occurred regularly and participants were linked via online networking to meet and discuss their progress. Results showed some positive outcome, but not to the degree anticipated.

**Muskett, Coral (2013). Trauma-informed care in inpatient mental health settings: A review of the**

 **literature. *International Journal of Mental Health Nursing*, doi: 10.1111/inm.12012**

This article summarizes the findings from the literature from 2000-2011 in identifying those practices and clinical activities that have been implemented to effect trauma-informed care in inpatient mental health settings. The authors noted that trauma-informed care was an emerging value that is fundamental to effective and contemporary mental health nursing practice. However, the difficulty of trauma-informed care is that it often leaves mental health nurses struggling to translate those values into day-to-day nursing practice. “Many are confused about what individual actions they can take to support these values.” In Australia the clearest articulation of that principle is to reduce, and wherever possible, eliminate the use of seclusion and restraint. The authors summarize the published literature on the reduction of seclusion and restraint in hospital settings.

**Whitley, R, Harris, M, Fallot, RD & Wolfson-Berry, R. (2008). The active ingredients of intentional recovery communities:**

 **Focus group evaluation. *Journal of Mental Health*. 17 (2): 173-182.**

The authors’ discuss the benefits of recovery communities in care and treatment of people with mental health and

trauma histories. These communities are self-managed communities that provide a safe, trusting space for like people to attend. The authors’ discuss the components most evident in successful communities.

***Trauma-Informed Assessment***

**\*Bakken, TL, Kildahl, AK, Gjeroe V, Matre E, Kristiansen T, Ro A, Tveter AL & Hoidal SH. (2014). Identification of PTSD in**

 **adults with intellectual disabilities in five patients in a specialized psychiatric inpatient unit. *Advances in Mental Health***

 ***and Intellectual Disabilities*, 8(2): 91-102. DOI: 10.1106/AMHID-01-2013-0002.**

The authors take a critical examination of five people with moderate to severe ID on a specialized psychiatric hospital unit. They discuss the current conceptions of trauma symptoms and understanding of PTSD in people with ID. The authors’ offer insight into symptoms to look for, and encourage future research into formulation how they might be assessed.. A concern they express is that overshadowing, in general, and preconceived ideas about PTSD in this population can interfere with treatment options that might be of potential benefit.

**\*Ballan, MS, Freyer, MB & Powledge, L (2017). Intimate partner violence among men with disabilities: The role of health**

 **care providers. *American Journal of Men’s Health*, 11 (5): 1436-1443.**

The authors’ discuss the prevalence and nature of domestic violence perpetrated against men with disabilities. They discuss the limited resources available to the men for seeking assistance, and the conditions that exist preventing men from communicating their experiences. They advocate the importance of health care practitioners as the first line of treatment and support to the men experiencing violence.

**\*Ballan, MS & Freyer, M (2017) Trauma-informed social work practice with women with disabilities: Working with survivors**

 **of intimate partner violence. *Advances in Social Work*, 18 (1) 131-144.**

The authors’ discuss the vulnerability of women with disabilities and their increased exposure to abuse and mistreatment. They discuss that while exposure is high, there is very little consequential research discussing the problem or how to address it. They propose a trauma-informed model be used for service these women, The model would be guided by critical disability theory and feminist disability theory. They discuss the hallmarks of their theoretical constructs.

**Barol, Beth L (2001). Learning from a person’s biography: An introduction to the biological timeline process. Positive**

 **Approaches, 3(4) 20-29.**

 In this article Dr. Barol provides a rationale for the efficacy of biographical time lines in support of people being

served. Grounded in the practices of Herb Lovett and Robert Post and William Bento the author argues that the timeline also draws out traumas and experiences that heighten service delivery. She is sensitive to the biography remaining within the small circle of the individual and his or her support team. This does not provide the “how-to” of creating a biographical time line, rather it discusses the “what’s and why’s” of its use ion serving individuals.

***Bates-Maves, Julie K & O’Sullivan, Deirdre (2017). Trauma-informed risk assessment in correctional***

 **settings. *International Journal of Criminology and Sociology*, 6: 93-102.**

The authors argue that trauma-informed service delivery is indicated in a correctional setting. The paper outlines a model which infuses trauma-informed principles into the existing Risk-Needs-Responsivity model of risk assessment commonly used in correctional settings. Using existing literature the authors speak to the connection between certain types of trauma and criminality is established. They argue that despite the evidence presented that many risk assessment procedures do not include screening for trauma, or trauma-specific interventions. Trauma-informed practices and assessment recommendations are also provided, along with recommendations for additional resources.

This article provides a quick summary and resource information for the reader.

**\*Bramston, P & Fogarty, G (1999). The nature of stressors experienced by people with an intellectual disability. *Journal of***

 ***Applied Research in Intellectual Disabilities*, 18(6) 435-456.**

In this study, the authors’ compared people with an intellectual disability and a reference group of university students, using the Lifestress Inventory. Results suggested that people with ID reported an average of 8.57 stressors per 31 as compared to 12.02 stressors reported by the students. However, on the Likert scale of impact they ID group reported that stressors were significantly more challenging to them than did the university students.

**\*Brunzell, Tom, Waters, Lea & Stokes, Helen (23015). Teaching with strengths in trauma-affected**

 **students: A new approach to healing and growth in the classroom. *American Journal of***

 ***Orthopsychiatry*, 8: 3-9.**

The authors argue that classrooms can be positioned as a powerful place of intervention for posttraumatic healing both in the context of special education and in mainstream classrooms that contain trauma affected students. They contend that traditional trauma strategies that include “teaching practices that seek to repair emotional dysregulation and fix broken attachment” are not enough to mend trauma alone. Furthermore they advocate that positive psychology has a role to play in contributing to trauma-informed learning. This article presents scientific and practice-based evidence to support their assertions, including practical education interventions aimed to build positive emotions, character strengths, resilient mindsets, and gratitude, and show how these can be embedded in the daily routines of classroom learning to assist struggling students

**\*Catani, C & Sossalla, IM (2015). Child abuse predicts adult PTSD symptoms among individuals diagnosed with intellectual**

 **disabilities. *Frontiers in Psychology*, 6: 1-16.**

The authors used a linear regression model to assess predictors for adult PTSD symptoms in people with ID. They employed a qualitative interview with 56 adults. Of the measures they studied, the single significant predictor for adult symptoms of PTSD was childhood abuse from within the family. This predictor was true for psychopathology in adulthood, criminal and on-going abuse in adulthood. They offer recommendations for further research.

**Covington, Stephanie S., Burke, Cynthia, Keaton, Sandy & Norcott, Candice (2008). Evaluation of trauma-**

 **informed and gender-responsive intervention for women in drug treatment. *Journal of Psychoactive Drugs*. 5: 387-398.**

In this study the authors report on a recent study that examined the use of two gender-responsive, trauma-informed curricula presented in a residential facility for women. Results of the study found This treatment model is named “Women’s Integrated Treatment” (WIT). Helping Women Recover and Beyond Trauma are both manualized programs founded on research and clinical practice and are grounded in the theories of addiction, trauma, and women’s psychological development. This treatment model is named “Women’s Integrated Treatment” (WIT).Women who successfully completed the programs were assessed at several points in time on several scales, including trauma symptomology, depression, and substance use before and after the programs. The findings indicated less substance use, less depression, and fewer trauma symptoms (p ≤ .05)—including anxiety, sleep disturbances, and dissociation—after participation in the WIT curricula. The authors argue that these women often are not well served by the services found in their communities, which separate substance abuse and mental health programs, despite the fact that research shows that integrated, trauma-informed treatment services will increase the success of their recovery.

**Cowell RA, Cicchetti D, Rogosch FA & Toth SL (2015). Childhood maltreatment and its effect on neurocognitive functions:**

 **Timing and chronicity matter. *Developmental Psychopathology*, 27(2): 521-533. doi:10.1017/S05954579415000139.**

The authors’ assessed how early childhood and repeated childhood trauma impacted children’s inhibition and memory. They found that these children experienced significantly poorer inhibitory control and working memory performance. Furthermore, that the trauma experiences in infants disrupts the, “normative structure and function” of the brain.

**Dackis MN, Rogoosch FA & Cicchetti D (2015). Child Maltreatment, callous-unemotional traits, and defensive responding in**

 **high-risk children: An investigation of emotion-modulated startle response. *Developmental Psychopathology*, 27(4):**

 **1527-1545. doi:10.1017/S095459415000929**

The authors’ wanted to measure the risk factors of callous-unemotional (CU) traits in children. Using a sample of children with and without histories of maltreatment attending a summer day camp, they studies startle responses to positive-neutral and negative visual stimuli. Their findings suggested that children with a history of maltreatment showed an increased trajectory towards CU. Their finding further suggested that physiological factor, alone did not explain this phenomena. Implications for intervention are offered.

**D’Andrea, Wendy, Ford, Julian, Stolbach, Bradley, Spinazzola, Joseph & Van der Kolk, Bessel A. (2012).**

 **Understanding interpersonal trauma in children: Why we need a developmentally appropriate**

 **trauma diagnosis. *American Journal of Orthopsychiatry*, 82: 187-200.**

The authors’ make the argument that childhood exposure to victimization is prevalent and has been shown to contribute to significant immediate and long-term psychological distress and functional impairment. They note that these children often do not meet criteria for posttraumatic stress disorder (PTSD). Next they review existing literature and common themes in the practice of trauma treatment. Finally they advance the concept of creating a more descriptive and accurate diagnosis interpersonal trauma experienced in childhood. Recommendations for future research aimed at enhancing diagnosis and treatment of victimized children are provided.

**\*Eastgate, G, Van Driel, ML, Lennox, N & Scheermeyer, E (2011). Women with intellectual disabilities: A study of sexuality,**

 **sexual abuse and protection skills. *Australian Family Physician*, 40(4): 226-230.**

The authors’ interviewed 9 women with mild intellectual disability to discuss their experiences in negotiating sexual relationships, sexual knowledge and sources of that knowledge, experiences declining unwanted sexual advances, self-protection strategies they’d endorsed, sexual abuse experiences and their sequelae of sexual abuse experiences. Most reported experiences of abuse. The majority reported inadequate or no sexual education had been provided to them. Many felt trapped by virtue that their sexual abuse occurred within family in childhood or by caregivers in adulthood. Recommendations were made for further training and policy.

**Felitti, Vincent, Anda, Robert F., Nordenberg, Dale, Williamson, David F., Spitz, Alison M., Edwards,**

 **Valerie, Koss, Mary P. & Marks, James 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: 245-258.**

The relationship of health risk behavior and disease in adulthood to the breadth of exposure to childhood emotional, physical, or sexual abuse, and household dysfunction during childhood has not previously been described. A questionnaire about adverse childhood experiences was mailed to 13,494 adults who had completed a standardized medical evaluation at a large HMO; 9,508 (70.5%) responded. Seven categories of adverse childhood experiences were studied: psychological, physical, or sexual abuse; violence against mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. The number of categories of these adverse childhood experiences was then compared to measures of adult risk behavior, health status, and disease. The number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The seven categories of adverse childhood experiences were strongly interrelated and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life. We found a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults

**\*Focht-New, G, Clements, PT, Barol, B, Faulkner, MJ & Pekala-Service, K (2008). Persons with developmental disabilities**

 **exposed to interpersonal violence and crime: Strategies and guidance for assessment. *Perspectives in Psychiatric Care:* 44**

 **(1) 3-13.**

The authors advocate for intermediary support personnel in the psychiatric care of individuals with I/DD at the community and hospital level. This position, they call an Advanced Practice psychiatric nurse (APPN), would serve as liaison between prescriber and support team. Emphasis of the role would be two fold. For the support team, it would encourage them to appreciate the impact of trauma on peoples’ lives and educate them about its impact. For the prescribing practitioner the APPN would be a resource to discuss how I/DD presents, consider symptoms and gain a better understanding of those individuals.

**\*Hartley, SL & MacLean, WE (2005). Perceptions of stress and coping among adults with mild mental retardation: Insight into**

 **psychological distress. American Journal on Mental Retardation 110 (4) 285-297.**

The authors’ investigated perceptions of stress in 88 individuals diagnosed with mild ID, using the Lifestress Inventory. They also interviewed each participant to learn from them how they cope and manage their stress. They found that people with mild ID used more active strat5egies to cope with their stress. Avoidant coping was particularly strong, however, in managing negative interpersonal stress. This non adaptive coping strategy is hypothesized to increase vulnerability.

**\*Hartley, SL & MacLean, WE (2008). Coping strategies of adults with mild intellectual disability for stressful social**

 **interactions. *Journal of Mental Health Research In Intellectual Disabilities*, 1(2) 109-127.**

## Abstract

Adults with mild intellectual disability (ID) experience stressful social interactions and often utilize maladaptive coping strategies to manage these interactions. We investigated the specific types of Active and Avoidant coping strategies reported by 114 adults with mild ID to deal with stressful social interactions. Open-ended responses to a sentence stem task were coded into five dimensions of Active and Avoidant coping. Adults with mild ID used Problem-Focused coping most frequently and this strategy was negatively correlated with psychological distress. Emotion-Focused coping was used infrequently but was also negatively related to psychological distress. Coping accounted for a significant portion of variance in psychological distress after controlling for perceptions of stressful social interactions. Findings have important implications for informing the development of interventions to enhance the ability of adults with mild ID to cope with stressful social interactions.

**\*Hartley, SL & MacLean, WE (2009). Stressful social interactions experienced by adults with mild intellectual disability.**

 ***American Journal of Intellectual and Developmental Disabilities*, 114(2): 71-84**

## Abstract

Adults with intellectual disability are vulnerable to stressful social interactions. We determined frequency and severity of various stressful social interactions, identified the social partners in these interactions, and examined the specific interpersonal skill difficulties of 114 adults with mild intellectual disability. Participants’ characteristic risk factors for stressful social interactions were also identified. Minor and unintentional negative actions of others had high frequency but low severity of stress. Serious and intentional negative actions of others had a low frequency but high severity of stress. Stressful social interactions with other people who have intellectual disability occurred frequently and had a high severity. Difficulty controlling aggression predicted stressful social interactions. Findings are beneficial to developers of interventions to decrease stressful social interactions

**\*Hartley, SL & MacLean, WE (2009). Depression in adults with mild intellectual disability: Role of stress, attributions, and**

 **coping. *American Journal of Intellectual and Developmental Disabilities*, 114 (3): 147-160**

## Abstract

The experience of stressful social interactions, negative causal attributions, and the use of maladaptive coping efforts help maintain depression over time in the general population. We investigated whether a similar experience occurs among adults with mild intellectual disability. We compared the frequency and stress impact of such interactions, identified causal attributions for these interactions, and determined the coping strategies of 47 depressed and 47 nondepressed adults with mild intellectual disability matched on subject characteristics. The depressed group reported a higher frequency and stress impact of stressful social interactions, more negative attribution style, and more avoidant and less active coping strategies did than the nondepressed group. Findings have implications for theory building and development of psychotherapies to treat depression.

The experience of stressful social interactions, negative causal attributions, and the use of maladaptive coping efforts help maintain depression over time in the general population. We investigated whether a similar experience occurs among adults with mild intellectual disability. We compared the frequency and stress impact of such interactions, identified causal attributions for these interactions, and determined the coping strategies of 47 depressed and 47 non-depressed adults with mild intellectual disability matched on subject characteristics. The depressed group reported a higher frequency and stress impact of stressful social interactions, more negative attribution style, and more avoidant and less active coping strategies did than the non-depressed group. Findings have implications for theory building and development of psychotherapies to treat depression.

**\*Janssen, CGC, Schuengel, C & Stolk, J (2002). Understanding challenging behaviour in people with severe and profound**

 **intellectual disability: A stress-attachment model. *Journal of Intellectual Disability Research*. 46: 445-453.**

The authors reviewed the literature on stress, coping and attachment in people with intellectual disability. Their research found that individuals with intellectual disability are at increased vulnerability to stress due to poor coping capacity. As a result they are more apt to develop insecure and disorganized attachment. The authors speculate this increases the likelihood of developing behavior problems.

**Kim J & Cicchetti D (2010). Longitudinal pathways linking childhood maltreatment, emotion regulation, peer relations, and**

 **psychopathology. *Journal of Child Psychology and Psychiatry*. 51(6): 706-716. doi:10.1111/j.1469-7610.2009.02202.x.**

In this study of children aged 6-12 from low income families the authors’ sought to assess emotion regulation and internal-external symptomology secondary to early childhood maltreatment. They compared 215 maltreated children with 206 non-maltreated children. They found differences in internalized emotion regulation which contributed to later child rejection and increased external symptoms in maltreated children. Their conclusions suggest that emotion regulation as both risk or protective mechanism has influence on later psychopathology and peer relations.

**\*Lunsky, Y & Branston, P (2006). A preliminary study of perceived stress in adults with intellectual disabilities according to**

 **self-report and informant ratings. *Journal of Intellectual and Developmental Disability*, 31(1), 20-27.**

The authors’ investigated compared self-report versus informant report on the Lifestress Inventory. N=70 compared self-report, informant report by family and by professional staff. Reports suggested that informant report was adequate in capturing individual stress factors. However, in important areas, family report was closer to self- informant than was professional response to the survey. Thus, while the authors’ found that information gleaned by others could be beneficial to assessing stress, family members were more closely aligned to an individual’s perceived

stress.

**Lyons-Ruth, Karlen (2003). Dissociation and the parent-infant dialogue: A longitudinal perspective from attachment research.**

 ***Journal of the American Psychoanalytic Association*, 51: 883-911.**

The author reports on two longitudinal studies that followed children of ‘at-risk’ families from infancy through late adolescence. Data from both studies found that disorganized attachment in infancy was precursor to dissociative symptomology in late adolescence. Children’s vulnerability was related to the affective engagement with parents, particularly as related to emotional unavailability and role reversal. That unavailability in childhood may relate to why dissociative symptoms emerge in later trauma experiences.

**\*Mehtar,M & Mukaddes, NM (2010). Posttraumatic stress disorder in individuals with a diagnosis of autism spectrum**

 **disorder. *Research in Autism Spectrum Disorders*, 5: 539-546, doi:10.1016/j-rasd.2010.06.020**

The authors’ used a semi-structured interview of 69 children and adolescents diagnosed with ASD to assess risk factors and symptoms secondary to traumatic experiences and PTSD. They found deterioration in social and communication skills among those who had experienced traumatic events. Those symptoms included increased stereotypic behavior, aggression, distractibility, sleep disturbance, agitation, hyperactivity, self-injury and loss of self care/adaptive behavior skills. They argue that better assessment and treatment supports are needed. They also speak to the need for increased research on the subject.

**\*Minnis, H, Fleming, G & Cooper S-S (2010). Reactive attachment disorder symptoms in adults with intellectual disabilities.**

 ***Journal of Applied Research in Intellectual Disabilities*, 23: 398-403. doi: 10.1111/j.1468-3148.2009.00532.x**

The authors’ reported on a study they conducted comparing RAD symptoms in adluts with /ID to previous studies on children. They looked at 50 individuals and conducted interviews and testing with them and their caregivers. Results suggested that characteristics and symptoms of RAD were present in adults at rates similar to at-risk children. Results also suggested that the further removed, temporally, from traumatic events, the less pervasive were the symptoms. Just as in typical populations there were individuals who were resistant to treatment or recovery, The authors’ recommended further research.

**Vachon DD, Krueger RF, Rogosch FA & Cicchetti D (2015). Assessment of harmful psychiatric and behavioral effects of**

 **different forms of child maltreatment. *Journal of the American Medical Association Psychiatry*, 72(11): 1135-1142.**

 **doi: 10/1001/jamapsychiatry.2015.1792.**

This longitudinal study looked at the effect of different types of childhood maltreatment on children and youth over a 26 year period. The authors’ found that symptom outcomes from maltreatment of omission or commission were relatively consistent across gender. The findings suggest that, rather than specific focused treatment for different maltreatment types, any established treatment should provide, “comprehensive psychological benefits.”

**Van der Kolk, Bessel A (1998). Trauma and memory. *Psychiatry and Clinical Neurosciences*, 52:**

 **(SI) S52-S64.**

This article reviews the literature on traumatic memories. The author also advocates neuro-imaging as a means to clarify the neurobiological underpinning of trauma. He argues that the study of traumatic memories challenges basic notions about the nature of memory.

**\*Van der Put, CE, Asscher, JJ, Wissink, IB & Stams, GJJM (2013). The relationship between maltreatment victimization and**

 **sexual and violent offending: Differences between adolescent offenders with and without intellectual disability*. Journal of***

 ***Intellectual Disability Research*, doi: 10.1111/jir.12031: 1- 13.**

This research undertook to understand differences in offending behavior and prior abuse experiences in adolescent offenders with or without intellectual disability. They sampled 102 offenders identified as having ID and 526 not so identified. Using personal interview, risk assessment informant and record review they found 1) adolescents with ID were significantly more likely to have experienced sexual and physical abuse than those offenders without ID. The authors’ speculated on the cause and proposed research focus moving forward.

**\*Wigham, Sarah & Emerson, Eric (2015). Trauma and life events in adults with intellectual disability.**

 ***Current Developmental Disorders Reports*, 2: 93-99.**

This paper considers recent developments in knowledge on the psychological effects of exposure to adverse life events and environmental stressors in adults with intellectual disabilities. The author’s reviewed recent and current practices in the treatment of PTSD in people with ID. They noted advances have occurred in the field of trauma in intellectual disability, for example a number of assessment measures have been developed for PTSD, a small number of studies evaluated treatment interventions such as cognitive behavioral therapy (CBT) and eye movement

**\*Wigham, S, Hatton, C & Taylor, JL (2011). The effects of traumatizing life events on people with intellectual disabilities: A**

 **systematic review. *Journal of Mental Health Research*, 4: 19-39.**

This review of the literature studied the effects of adverse life events on people with ID. What they found was that articles used different definitions of what constituted trauma. They also lacked a consistent measurement for looking at trauma in people with ID. They found few articles that causally lined early adverse events and trauma in people with ID. Recommendations included further research, common definitions, and a consistent measurement system for studies on adverse effects and trauma.

**\*Wigham, S, Hatton, C & Taylor, JL (2011). The Lancaster and Northgate trauma scales (LANTS): The development and**

 **psychometric properties of a measure of trauma for people with mild to moderate intellectual disabilities. *Journal of***

 ***Research in Developmental Disabilities*, 32(6): 2651-2659, doi: 10.1016/jridd.2011.06.008**

The authors’ describe the development of a self-report and informant measure of trauma on people with mild to moderate intellectual disabilities. They report on psychometric measures of the screening tool and how it may be used to affect treatment decisions.

***TRAUMA***

**Agrawal HR, Gunderson J, Holmes BM & Lyons-Ruth K (2004). Attachment studies with borderline patients: A review.**

 **Harv Rev Psychiatry, 12(2): 94-104.**

The authors’ reviewed 13 articles on BPD and attachment disorder. Every study found a strong association between insecure attachment and BPD, especially in characteristics of unresolved, preoccupied and fearful. Findings suggest that young adults with BPD long for intimacy at the same time they are preoccupied with rejection and dependence on others. They make recommendations for further research.

**Edalati, H & Krank, MD (2016). Childhood maltreatment and development of substance use disorders: A review and a**

 **model of cognitive pathways. *Trauma Violence Abuse*, 17 (5): 454-467.**

The authors’ discuss how early childhood maltreatment exerts negative impact on cognitive function, i.e.: intellectual; performance, memory, attention and executive function. Furthermore, there appears to a link between CM and the development of substance use disorder. They suggest that more research is needed to understand the pathways between CM, cognition and substance use disorders.

**Flory, JD & Yehuda, R (2018). Is PTSD a systemic disorder? *Psychiatric Times*, 32(4): 1-5. April 30, 2018.**

In this brief report the authors’ examine PTSD severity in context to metabolic and inflammatory markers, chronic

health problems, and behavioral relationship to said presentation. They briefly describe some studies on each and leave the practitioner with questions to consider when treating PTSD.

**\*Gardiner, E, Iarocci, G & Moretti, M (2017). Integrative care for adolescents with dual diagnosis: Considering trauma and**

 **attachment within an innovative model for clinical practice. *Journal of Mental Health Research in Intellectual***

 ***Disabilities*, 10(4): 321-344.**

The authors’ reviewed the literature on intellectual disabilities and trauma and attachment. They argue that this under represented treatment need is in fact important. They also argue that there are some promising treatment applications that may be beneficial to adolescents with ID and mental health disorders.

**Harris, WW, Putnam, FW & Fairbank, JA (2006). Mobilizing trauma resources for children. In” Alicia F Lieberman and**

 **Robert DeMartino (Eds.), *Interventions for Children Exposed to Violence*, Johnson and Johnson Pediatric Institute, LLC,**

 **pp: 311-339.**

The authors discuss the importance creating a collaborative framework between institutions (medicine, courts, police and social service agencies. They discuss the importance of partnership in first response and meeting the needs of children at the moments of key decisions/trauma experiences. Throughout they provide vignettes and examples to support their assertions.

**Harris, WW, Lieberman, AF & Marans, S (2007). In the best interests of society. *Journal of Child Psychology and***

 ***Psychiatry*, 48 (3/4): 392-411.**

The authors’ argue that children exposed to violence at a young age are not only traumatized by those experiences, but also by systemic failures to treat early and blame children later as “trouble-children”, secondary to their manifestation of trauma symptoms. They use this paper to describe the impact and outcomes of exposure to violence in children; examine both opportunities and barriers that interfere with inter-agency collaboration; and “critique current national policies that militate against a more rational and coherent approach to addressing these needs”.

**\*Hurley, A & Silka V (2001). Ask the doctor: The role of stressful life events in psychiatric assessment and treatment with**

 **patients with mental retardation and developmental disabilities. *Mental Health Aspects of Developmental Disabilities*,**

 **4(2): 85-88.**

The authors’ provide an overview of implications of stress on the lives of individuals with IDD. Furthermore, they explore stressors common to people with IDD that are often overlooked or dismissed. Within that context, discussion of stress on people with ID, how to assess it, and how to treat it are provided.

**Masson, M, East-Richard, C & Cellard, C (2015). A meta-analysis on the impact of psychiatric disorders and maltreatment**

 **on cognition. *Clinical Neuropsychology*, 29(5): 573-594. doi: 10.1080/13854046.2015.1061057.**

The authors’ reviewed a narrow literature on the impact to cognition for individuals who had experienced maltreatment and had a psychiatric disorder; had been subject to at least 1 standardized neuropsychological measure, and where there was a control group. They found 12 articles meeting that criteria between 1970 and 2013. The articles, in sum, found that there were significant negative impacts on cognition for those who had psychiatric disorders and had a history of maltreatment. In children, aged 7 to 18 the most affected areas of cognition were episodic memory, executive function and intelligence. In adults the most impacted areas of cognition were verbal memory, visuospatial/problem solving and attention.

**Netto, LR, Pereira, JL, Nogueira, JE, Cavalcanti-Ribeiro, P, Santana, RC, Teles, CA, Koenen, KC, The Trauma and anxiety**

 **disorders study group-UFBA & Quarantini, LC (2016). Impulsivity is relevant for trauma exposure and PTSD symptoms**

 **in a non-clinical population. *Psychiatry Research*, 239 (2016): 204-211.**

The authors’ studied the impact of impulsivity in PTSD outcomes. A primary question before them was whether or not people with impulsive traits are more likely to suffer trauma and PTSD than those who have a lower threshold; and or, do people who experience trauma and are diagnosed with PTSD suffer increased impulsivity secondary to the trauma event. Their findings found that, “…increased impulsive behaviors were highly associated with a greater prevalence of PTSD.” The results of this study also found that impulsivity was a defensive mechanism or protective factor in the face of a traumatic event.

**Perry, BD (2009). Examining child maltreatment through a neurodevelopmental lens: Clinical applications of the**

 **neurosequential model of therapeutics. *Journal of Loss and Trauma*, 14: 240-255. doi: 10.1080/15325020903004350.**

The author presents a theoretical overview of how to use a neurodevelopment approach to identifying treatment options for maltreated and traumatized children and youth. The model identifies treatment applying the neurosequential model of therapeutics, which selects key areas of the brain that have been impacted by adverse developmental experiences. In thus approaching service, treatment is driven by neuro structures.

**Perry, BD (2008). Child maltreatment: A neurodevelopmental perspective on the role of trauma and neglect in**

 **psychopathology. In Theodore Beauchaine and Stephen P Hinshaw (eds.) *Child and Adolescent Psychopathology*. John**

 **Wiley & Sons, Hoboken, NJ: 93-129.**

The author discusses neurodevelopmental systems, and their interplay and role in development. He also describes how traumatic or neglectful events impact these neurodevelopmental systems. Additionally, the timing and exposure of these events and subsequent treatment can and will influence the psychopathological outcomes of affected children and youth.

**Perry, BD, Pollard, RA, Blaicley, TL, Baker, WL & Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation,**

 **and “use-dependent” development of the brain” How states become “traits”. *Infant Mental Health Journal*, 16(4):**

 **271-291.**

The authors’ discuss the neurobiological implications of traumatic events in infants and young children. They present the case for the how neuron driven reactions mark themselves as the primacy of reaction to such events. A curious parallel exists in the often non-supportive reactive of adults to children following a traumatic event. They argue that adults often misread a child’s silence as a sign of disaffection. In fact, this “resilience” is actually a defense mechanism. And because the child is not supported, that defense mechanism is integrated into the neurobiology of the child, making state a trait.

**Putnam, Frank W (2003). Ten year research update review: Child sexual abuse. *Journal of the American Academy of Child***

 ***and Adolescent Psychiatry*, 42(3) 269-278.**

This review of childhood sexual abuse looks at prevalence data, as well as, treatment efficacy over a ten year period. Findings culled from the literature suggested that CBT had short term treatment benefits, but longitudinal efficacy had yet be established. Future research direction is advocated.

**\*Schuengel, C, Kef, S., Damen, S. & Worm, M (2010). ‘People who need people’: Attachment and professional caregiving**.

 ***Journal of Intellectual Disability Research*. 54 (Supplement 1), 38-47. doi: 10.1111/j.1365-2788.2009.01236.x**

The authors’ critically examine the role of attachment theory as it applies to caregivers and individuals with ID receiving services. They discuss engagement from attachment theory, using video tape interactions and providing case examples. The authors’ suggest that attachment is normative and didactic. They also warn that quality review patterns dismissing attachment engagements run the risk of losing out on the positive contribution that sensitivity and affective attunement have on the well-being of persons with ID.

**\*Stough, LM, McAdams-Ducy, E & Kang, D (2017). Addressing the needs of children with disabilities experiencing disaster**

 **or terrorism. *Current Psychiatry Reports*, 19(4): 1-10, DOI: 10.1007/s11920-017-0776-8**

The authors’ review the literature on psychosocial factors impacting children with disabilities exposed to natural disaster or terrorist events. Their study found a significant body of studies on psychosocial impact of trauma on adults with disabilities. They found little research on the exposure of children with disabilities and even less on empirical studies of therapy outcomes for children thus exposed. The authors speculated on concerns such as health, vulnerability and social stigma on access to services. They make some recommendations for care and access to care.

**Van der Kolk, B & Fisler, R. (1995). Dissociation and the fragmentary nature of traumatic memories: Overview and**

 **exploratory study. *Journal of Traumatic Stress*, 8(4): 505-525 found in Google Scholar,** [**http://www.trauma-**](http://www.trauma-)

 **pages.com/vanderk2.htm**

The authors’ reviewed the evidence on recollections of stressful events versus traumatic events. Next they reviewed the evidence that dissociation is central to pathogenic responses giving rise to PTSD. Next they present results of a study they conducted that indicated that traumatic memories are retrieved in the form of dissociated “imprints” of both sensory and affective elements of the traumatic experience.

**Van der Kolk B, Perry C & Herman JL (1991). Childhood origins of self-destructive behavior. *The American Journal of***

 ***Psychiatry*, 148(12): 1665-1671.**

The authors’ reported on their research comparing childhood histories of trauma / disrupted parental care on adolescent and adult engagement in self destructive behavior. Their findings found that childhood trauma often contributed to onset of self-destructive behavior. However, lack of secure attachments maintained or extended that behavior pattern. Furthermore, patients who continued to make repetitive suicidal attempts or chronically self-cut were often found to return to current stressors as a continuum of early childhood trauma, neglect or abandonment.

**Van der kolk, B, Roth, S, Pelcovitz. D, Sunday, S & Spinazzola, J (2005). Disorders of extreme stress: The empirical**

 **foundation of a complex adaptation to trauma. *Journal of Traumatic Stress*, 18(5), 389-399.**

The authors’ argue that children and adults exposed to chronic interpersonal traumatic events display features unique and different from symptomology seen in PTSD. They suggest changes in affect, memory, interpersonal relationships, finding meaning are constituted in consistent, yet different light. They further argue that there is evidence to propose further research which could shed light on their preliminary findings.

**Van der Kolk, Bessel A (2006). Clinical implications of neuroscience research in PTSD. *Annals New York***

 ***Academy of Science*, doi: 10.1196/annals.1364.022.**

The research showing how exposure to extreme stress affects brain function is making important contributions to understanding the nature of traumatic stress. This includes the notion that traumatized individuals are vulnerable to react to sensory information with subcortically initiated responses that are irrelevant, and often harmful, in the present. Reminders of traumatic experiences activate brain regions that support intense emotions, and decrease activation in the central nervous system (CNS) regions involved in (a) the integration of sensory input with motor output, (b) the modulation of physiological arousal, and (c) the capacity to communicate experience in words. Failures of attention and memory in posttraumatic stress disorder (PTSD) interfere with the capacity to engage in the present: traumatized individuals “lose their way in the world.” This article discusses the implications of this research by suggesting that effective treatment needs to involve (1) learning to tolerate feelings and sensations by increasing the capacity for interoception, (2) learning to modulate arousal, and (3) learning that after confrontation with physical

helplessness it is essential to engage in taking effective action.

**Van der Kolk, Bessel (2005). Developmental trauma disorder: Toward a rational diagnosis for children with complex**

 **trauma histories. *Psychiatric Annals* 35(5): 401-409.**

The author describes diagnostic criteria and rational for a developmental trauma disorder. He argues that children who experience repeated and complex trauma in their childhood present with unique symptoms and require different treatment than folks diagnosed with PTSD. He defines the unique conditions specific to developmental trauma and conditions necessary to successfully treat the condition.

**Van der Kolk, B (2016). Commentary on: Teicher & Sampson, 2016).The devastating effects of ignoring maltreatment in**

 **Psychiatry. *Journal of Child Psychology and Psychiatry***

In this brief the author highlights key facets of treatment integrity to our understanding of trauma. How that impact treatment decision making and future direction for research and further investigation.

**Wylie, Mary Sykes (2010). The long shadow of trauma. *Psychotherapy Networker*, March/April 2010: 2027, 50-51 & 54.**

In this essay/article the author provides an overview of trauma treatment, the alleged importance of the DSM, and advocates a closer look at a diagnosis of Complex trauma. She provides an overview of the work of a task force and discusses the positive implications of recognition by the APA.

***Trauma treatment:***

**Allen, B & Johnson, JC (2012). Utilization and implementation of trauma-focused cognitive-behavioral therapy for the**

 **treatment of maltreated children. Child Maltreatment, 17 (1): 80-85. doi: 10.1177/1077559511418220**

The authors’ surveyed 132 clinicians who practiced TF-CBT with children and adolescents who had been mistreated. The main focus of the survey was to assess clinician perceptions of TF-CBT efficacy and to evaluate how much of the prescribed manual each applied to their work. Results suggested that component parts of the TF-CBT were used more consistently than others. An area of concern was that the manual aspects not applied with consistency were cognitive restructuring, and developing a trauma narrative. These are arguably the components that make TF-CBT trauma-informed.

**\*Barol. Beth I & Seubert, A (2010). Stepping stones: EMDR treatment of individuals with intellectual and developmental**

 **disabilities and challenging behavior. *Journal of EMDR Practice and Research*, 4: 156-169.**

The authors report on their adaptation of modified EMDR protocol to study the effectiveness of that treatment for six individuals with ID. They report that in all cases there was improvement in a decline of PTSD symptoms in the individuals assessed. However, the reduction in symptoms varied widely. They argue that more research is indicated using EMDR to treat trauma in people with ID

**\*Brown, Julie, Brown, Milton Z. & Dibiasio, Paige (2013). Treating individuals with intellectual disabilities**

 **and challenging behaviors with adapted dialectical behavior therapy. *Journal of Mental Health***

 ***Research in Intellectual Disabilities*, 6: 280-303.**

This article reports on the implementation and longitudinal outcomes of a modified DBT and skills system designed to decrease challenging behavior. The article outlines core concepts of the training curriculum as well as its pilot implementation. The authors reported that, “These findings suggest that modified DBT holds promise for effectively treating individuals with intellectual and developmental disabilities”.

**Cloitre, Marylene (2015). The “one size fits all” approach to trauma treatment: Should we be satisfied? *European Journal of***

 ***Psychotraumatology*: 6 (1): 27344, DOI: 10.3402/ejpt.vg.27344**

The author provides a brief overview of best practices in the treatment of PTSD and other trauma symptoms. She reviews the dogma associated with theoretical systems. Advocating for a more pragmatic approach, the author further promotes the collaboration between client and practitioner as the critical point of treatment.

**Dass-Brailsford, Pricilla (2007). Models of Trauma Treatment. *A Practical Approach to Trauma: Empowering Interventions*,**

 **pg: 51-70, Sage Publications, Inc. Thousands oak, CA.**

The author discusses models of treatment for trauma. She reviews psychodynamic, cognitive-behavioral and EMDR strategies. Furthermore, she presents and defines both stage-specific model and stage –oriented models of treatments. This synopsis offers a brief overview of some trauma treatment approaches.

**\*Delgado, Kolina J (2011). Trauma focused treatment in individuals with intellectual disabilities: A group treatment**

 **approach. *Wright State University CORE Scholar*, http://corescholar.libraries.wright.edu/psych\_student/9.**

The author first defines intellectual disability and discusses the prevalence of trauma experienced by people with I/DD. She then discusses group based treatment of trauma for individuals with I/DD. She describes the Interactive Behavior Model (Razza & Tomasulo, 2005; Tomasulo and Razza, 2006) and advances its utility for trauma treatment through case vignettes. Her argument is both positive and touches on critical pre-group planning to affect positive change.

**Diehle J, Opmeer BC, Boer F, Mannarino AP & Lindlauer RJL (2014). Trauma-focused cognitive behavioral therapy oe eye**

 **movement desensitization and reprocessing: What works in children with posttraumatic stress symptoms? A randomized**

 **controlled trial. *European Child and Adolescent Psychiatry.* DOI: 10.1007/s00787-014-0572-5**

The authors’ randomly assigned 48 children with PTS symptoms to one of two groups. One received EMDR treatment and the other CBT, both over eight sessions. Both treatments proved effective. By report parents’ identified noted decreases in comorbid depression and hyperactive activity in children who received CBT treatment.

**Dittmann, I & Jensen, TK (2013). Giving a voice to traumatized youth: Experiences with trauma-focused cognitive-behavioral**

 **therapy, *Child Abuse and Neglect*.** [**http://dx.doi.org/10.1016/j.chiabu.2013.11.008**](http://dx.doi.org/10.1016/j.chiabu.2013.11.008)**.**

The authors’ sought to assess the efficacy and success of TF-CBT through the perceptions of youth and adolescents who had received the service. Using a qualitative thematic analysis they asked participants a series of questions that went to their feelings about service, how they were treated, what aspects of treatment were best, what they did not like and whether they would recommend this service to others. While responses from the young people were generally positive, some critical aspects were highlighted for future consideration. For example, some children felt pressured into discussing their traumatic experiences and believed they were not treated empathetically by their therapists. Others felt that parental involvement made them uncomfortable and would have been easier to accept had the therapist informed them of confidentiality and made a contract with them about what they could and would not talk about with parents.

**Efekhari, A, Stines, LR & Zoellner, LA (2006). Do you need to talk about it? Prolonged exposure for the treatment of chronic**

 **PTSD. *Behavior Analysis Today*. 7 (1) 70-83.**

The authors’ argue that prolonged exposure, using cognitive behavioral therapy, is an efficacious method for treating chronic PTSD. They review the literature and address this treatment approach as stand alone or in combination with other treatment strategies, e.g.: medication. They argue that prolonged exposure needs to be exported and made available on a consistent basis. They also suggest that PE has implications for the treatment of other trauma related conditions.

**\*Focht-New, G, Barol, B, Clements, PT & Milliken, TF (2008). Persons with developmental disabilities exposed to**

 **interpersonal violence and crime: Approaches for intervention. *Perspectives in Psychiatric Care*, 44 (2) 89-98**

The authors discuss strategies for interventions applicable to people with DD using advanced practice registered nurse support to navigate service delivery. The importance of trauma and its impasct on people is emphasized in the treatment protocols the authors’ propose.

**Ford, Julian D & Russo, Eileen (2006). Trauma-focused, present-centered, emotional self-regulation approach to integrated**

 **treatment for posttraumatic stress and addiction: Trauma adaptive recovery group education and therapy. *American***

 ***Journal of Psychotherapy,* 60 (4): 335-355**.

The authors discuss the application of trauma adaptive recovery group education and therapy (TARGET) to adults who suffer from co-occurring PTSD symptoms and addiction. TARGET is defined in clear manner. It is advanced as adjunct to other treatment. Using an educational and group dynamic, they discuss overcoming treatment needs at odds with one another as well as provide case examples of TARGET application.

**\*Freeman, James (2015). Reclaiming social skills and relationships. *Reclaiming children and youth*, reclaimingjournal.com, 23,**

 **48- 52.**

Using the experience of a young person with lagging social skills, this article provides an example of relational exchange using Life Space Crisis Intervention, a positive strategy for promoting growth and change.

**\*Gilderthorp, RC (2014). Is EMDR an effective treatment for people diagnosed with intellectual disability and post-traumatic**

 **stress disorder? *Journal of Intellectual Disabilities*, doi: 10.1177/17446295I4560638.**

This study is a critical review of the published literature that have set out to evaluate the use of eye movement desensitization and reprocessing (EMDR) for people diagnosed with both intellectual disability (ID) and post-traumatic stress disorder (PTSD). The author reviewed five studies. Key positive points from the review included, “the high clinical salience of the studies and their high external validity. Several common methodological criticisms are highlighted, however, including difficulty in the definition of the terms ID and PTSD, lack of control in design and a lack of consideration of ethical implications”. The author concluded that there was cause for cautious optimism about the utility of EMDR with this population. The clinical and research implications of this review are discussed

**Grossman, Frances K, Spinazzola, Joseph; Zucker, Marla & Hopper, Elizabeth (2017). Treating adult**

 **survivors of childhood emotional abuse and neglect: A new framework. *American Journal of***

 ***Orthopsychiatry*, 87: 86-93.**

In this brief introduction to Core Beliefs Psychotherapy (CBP), a structured therapeutic intervention that incorporates elements of cognitive-behavioral, psychodynamic, and humanistic therapy, the authors’ described how the model integrates current trauma intervention with classic approaches to psychotherapy. They advance, “four intertwined components within both the client and therapist: relationship (working within a relational frame), regulation (increasing self-regulatory capacity), parts (working with dissociative parts), and narrative (identity development, integration, and meaning-making of traumatic and other life experiences through narrative work as both therapist and client come to construct a shared understanding of the client’s story”. Its relevance to adults with I/DD is not explored.

**Hayes, SC, Luoma, JB, Bond, FW, Masuda, A & Lillis, J (2006). Acceptance and commitment therapy: Model, processes and**

 **outcomes. *Psychology Faculty Publications*. Paper 101.** [**http://scholarworks.gsu.edu/psych\_facpub/101**](http://scholarworks.gsu.edu/psych_facpub/101)**.**

The present article presents and reviews the model of psychopathology and treatment underlying Acceptance and Commitment Therapy (ACT). According to the authors’, ACT is linked to (Relational Frame Theory) which is also described. Per the authors’, “The evidence from correlational, component, process of change, and outcome comparisons relevant to the model are broadly supportive, but there are not enough well-controlled studies to conclude that ACT is generally more effective than other active treatments across the range of problems examined, but so far the data seem promising”.

**Heir, Teresa (2015). The use of ABA and CBT in combat veterans with PTSD and TBI. *Unpublished manuscript,* Kaplan**

 **University. 1-20.**

**ABSTRACT**

Researchers are finding that numbers are on the rise for veterans coming home from overseas with post traumatic stress disorder (PTSD) and traumatic brain injury (TBI). The purpose of this research is to test whether applied behavior analysis (ABA) and Cognitive behavior therapy (CBT) will benefit the treatment of veterans with communication disorders that have been diagnosed with PTSD/TBI by using ABA and CBT therapy and tests including

the LaTrobe Communication Questionnaire (LCQ) and the Awareness of Social Inference Test (TASIT).

**\*Hollins, S & Sinason, V (2000). Psychotherapy, learning disabilities and trauma: New perspectives. *British Journal of***

 ***Psychiatry*, 176: 32-36.**

The authors’ discuss the current state of psychotherapy and cognitive-behavioral therapy use for people with intellectual disabilities. They review current advances in education and propose theoretical and clinical underpinnings that lend themselves to encourage psychotherapy in treatment. The authors’ also advance that therapists extend their repertoire to at least consider therapy for treatment.

**Jentoft-Kinniburgh K, Blaustein, M, Spinazzola, J & van der Kolk, B. (2005). Attachment, self-regulation, and competency.**

 ***Psychiatric Annals*, 35(5): 424-430.**

The authors describe the attachment-self-regulation and competency model (ARC). This model is expressly designed for children who have a significant history of traumatization to develop competencies in self-reflection, information processing, self-regulation, positive affect enhancement and relationships. They describe components of the ARC model and provide examples of its application.

**Kaiser, Erika M, Gillette, Craig S. & Spinazzola, Joseph (2010). Trauma Treatment: A controlled pilot-**

 **outcome study of sensory integration (SI) in the treatment of complex adaptation to traumatic stress.**

 ***Journal of Aggression, Maltreatment & Trauma*, 19: 699-720.**

This study tested whether sensory integration (SI) treatment combined with psychotherapy would improve symptom outcome over psychotherapy alone in the treatment of complex posttraumatic stress, as measured by the Disorders of Extreme Stress Not Otherwise Specified (DESNOS). Results indicated significant differential improvement for the group treated with Sensory Learning Program SLP.

**Kar, Nilamadhab (2011). Cognitive behavioral therapy for the treatment of post-traumatic stress disorder: A review.**

 ***Neuropsychiatric Disease and Treatment*, 7 (1) 167-181.**

The author reviews the literature on the efficacy of CBT treatment in PTSD. He argues that it has been demonstrated to be successful across a range of settings and cultures in the treatment of PTSD. He further found that it was effective in group settings, as well as during individual counseling sessions. The author advocates research into its adaptation in treating post disaster trauma, and other types of traumatic events.

**Kubany, ES, Hill, EE, Owens, JA, Iannce-Spencer, C, McCaig, MA, Tremayne, KJ & Williams, PL (2004). *Cognitive-trauma***

 ***therapy for battered women with PTSD (CTT-BW)*. Journal of Counseling and Clinical Psychology, 72: 3-18.**

The authors studied the efficacy of Cognitive trauma therapy on a randomly assigned group of one hundred twenty five women with PTSD symptoms. Results found that PTSD symptoms were reduced in 87% of participants who completed the study, Furthermore the authors report sharp declines in depressive symptoms and feelings of guilt in most participants. These results were maintained at 3 and 6 months. The authors reported that white and ethnically diverse women benefitted equally from the treatment.

**Larkin, H & Records, J. (2006).Adverse childhood experiences: Overview, response strategies and integral theory perspective.**

 ***Journal of Integral Theory and Practice*, 2 (3): 1-34.**

The authors discuss the use of integral theory quadrants as a means to highlight trauma and establish goals of treatment. That model discusses placement of identified trauma care needs into quadrants of internal and external self and internal and external community /cultural values. The authors’ introduce the model for consideration in trauma treatment.

**Larkin, H & Records, J (2011). Restorative integral support (RIS) for post-trauma wellness. *aceresponse.org/img/uploads/file/RestorativeIntegralSupportCPTW.pdf 1-18.***

The authors’ elaborate on restorative integral support in this article. They provide evidence based examples across a

variety of post-trauma conditions, including natural disaster, homelessness, and substance abuse. Emphasis is on treatment efficacy and application of the principles behind RIS

**\*Lew M, Matta C, Tripp-Tebo, C & Watts, D (2006). Dialectical Behavior Therapy (DBT) for individuals with intellectual**

 **disabilities: A program description. *Mental Health Aspects of Developmental Disabilities*, 9(1): 1-13.**

The authors’ describe a modified DBT program they introduced in Massachusetts. Their focus is on the overgirding program concept, how DBT was modified for the people receiving treatment and preliminary data from the programs’ outset. The Bridge of Central Massachusetts received consultative support by the first two authors’ in modifying and implementing the DBT curriculum.

**\*Mevissen, L & de Jongh, A. (2010). PTSD and its treatment in people with intellectual disabilities: A review of the literature.**

 ***Clinical Psychology Review*, 30: 308-316.**

The purpose of this article was to present a comprehensive account of the literature on the prevalence, assessment, and treatment of PTSD in people with ID. Nine articles concern the treatment of PTSD in people with ID. Interventions reported involved making environmental change, the use of medication and psychological treatments (i.e., cognitive behavioral therapy, EMDR and psycho-dynamic based treatments). A ccording to the authors’ case reports suggested positive treatment effects for various treatment methods. They recommended that development of diagnostic instruments for the assessment of PTSD symptomatology in this population is needed and could facilitate further research on its prevalence and treatment.

**\*Mevissen, L, Lievgoed, R & de Jongh, A (2011). EMDR treatment in individuals with mild ID and PTSD: 4 cases*. Psychiatric***

 ***Quarterly*, 82: 43-57.**

The authors’ aim investigated the applicability of an evidence-based treatment for PTSD (i.e., EMDR) in four people with mild ID, who also were diagnosed with PTSD resulted. They reported that, “in all cases PTSD symptoms decreased and the gains were maintained at 3 months to 2.5 year follow-up. In addition, depressive symptoms and physical complaints subsided, and social and adaptive skills improved. ” They concluded that improvements observed in the individuals suggests there is probable applicability of EMDR in people with mild ID.

**\*Mevissen, Liesbeth, Lievegoed, R, Seubert, A, de Jongh, A. (2011). Do persons with intellectual disability**

 **and limited verbal capacities respond to trauma treatment? *Journal of Intellectual & Developmental***

 ***Disability*, 36: 274-279.**

The authors’ report that there is not one case report of successful trauma treatment with the use of an evidence-based treatment method in people with substantially limited verbal capacities. They assessed the applicability of eye movement desensitization and reprocessing (EMDR) in two clients with moderate ID, serious behavioural problems, and histories of negative life events. They applied an, “ 8-phase protocol of EMDR, a first-line treatment for psychological trauma” . It is reported that (PTSD)-like symptoms decreased in a total of only 6 and 5 sessions, respectively. Gains were maintained at 32 and 10 months' follow-up.

**\*Mevissen, L, Lievegoed, R, Seubert, A, & de Jongh, A (2012). Treatment of PTSD in people with severe intellectual**

 **disabilities: A case series. *Developmental Neurorehabilitation*, 15: 223-232.**

#### The treatment of four single cases with Eye Movement Desensitization and Reprocessing (EMDR) was evaluated. Participants included adults and children with histories of PTSD. They report that in all cases PTSD symptoms decreased and that, in all but one case, the gains were maintained at 15.5 months to 2.5 years following treatment. They concluded that, “ EMDR seems to be an applicable treatment method for clients with severe ID. Reduction and maintenance of PTSD symptoms in individuals with severe ID appears to be both desirable and obtainable.

**\*Mevissen, L, Barnhoorn, E, Didden, R, Korzilius, HJ & de Jongh, A (2014). Clinical assessment of PTSD in children with mild to**

 **borderline intellectual disabilities: A pilot study. *Developmental Neurorehabilitation*, 17: 16-23.**

The purposes of this study were to determine if an adapted version of a post-traumatic stress disorder (PTSD)-clinical interview was possible for people with ID and to identify to what extent manifestation of PTSD symptoms in a sample of children with mild to borderline ID corresponded with existing PTSD algorithms. Fifteen children were interviewed. The authors found that “potentially traumatic events (A1 criterion), and PTSD symptoms for children with mild to borderline ID were similar to those observed in children without ID.”

**\*Mevissen, L, Didden R, Korzilius, H, de Jongh, A (2016). Assessing posttraumatic stress disorder in children with mild to**

 **borderline intellectual disabilities. *European Journal of Psychotraumatology*, 7: 29786.**

Children with mild to borderline intellectual disabilities (MBID; IQ 50–85) have an elevated risk for both being exposed to potentially traumatic events and developing a posttraumatic stress disorder (PTSD), however PTSD often remains undiscovered due to a lack of diagnostic instruments. This study looked to validate the adapted PTSD section of the Anxiety Disorders Interview Schedule for Children (ADIS-C) for the assessment of PTSD in children with MBID according to DSM-IV-TR and DSM-5 criteria. Eighty children (aged 6–18 years) with MBID who were referred to an outpatient psychiatric service and their primary caregivers were interviewed using the adapted ADIS-C. Results support the reliability and validity of the adapted ADIS-C PTSD section for assessing PTSD in children with MBID. According to the authors’ the use of this clinical interview helps to improve detection of PTSD and subsequent access to trauma-focused interventions for this at risk target group.

**\*Mevissen L, Didden R & de Jongh A (2016). Assessment and treatment of PTSD in people with intellectual disabilities. In**

 **Martin, Preedy & Patel (eds.), *Comprehensive Guide to Post-Traumatic Stress Disorder*, Springer, Switzerland.**

The authors’ provide a brief overview of assessment measures for PTSD and of the efficacy of EMDR and TF-CBT treatment for people intellectual disability. Their review includes an examination of the literature and comparison of several assessment mechanisms developed or adapted for people with ID.

**\*Mevissen, L, Didden, R, Korzilius, H & de Jongh, A. (2017). Eye movement desensitization and reprocessing therapy for**

 **posttraumatice stress disorder in a child and an adolescent with mild to borderline intellectual disability: A multiple**

 **baseline across subjects study. *Journal of Applied Research in Intellectual Disabilities*, doi: 1D.1111/jar.12335**.

This study explored the effectiveness of eye movement desensitization and reprocessing (EMDR) therapy for post-traumatic stress disorder (PTSD) in persons with mild to borderline intellectual disability (MBID) using a multiple baseline across subjects design. According to the research, both participants, number of PTSD symptoms decreased in response to treatment and both no longer met PTSD criteria at post-treatment. This result was maintained at 6-week follow-up.

**\*Prather, Walter (2007). Trauma and psychotherapy: Implications from a behavior analysis perspective. *International Journal***

 ***of Behavioral Consultation and Therapy*, 3: 555-570**

This article considers attachment theory and more traditional family therapy from a behavior analytic perspective.

The author proposes a research model founded on attachment theory and attachment family therapy. In considering emotional and behavioral symptoms of children placed in foster care this artical addresses a behavioral approach to treatment.

**\*Prather, W & Golden, J.A (2009). A behavioral perspective of childhood trauma and attachment issues: Toward alternative**

 **treatment approaches for children with a history of abuse. *International Journal of Behavioral and Consultation Therapy*,**

 **5: 56-74.**

The authors expound on a theory of treating attachment dysregulation using a CBT and applied behavior approach. They argue that the, “role of emotion in behavioral causation and the teaching and learning of new behaviors are central to the treatment process”. They conclude that previous learning guides parent-child interaction and that behavioral interventions can improve attachment.

**Pressley, Jana & Smith, Rachel (2017). No ordinary life: Complex narratives of trauma and resilience in**

 **under-resourced communities. *Journal of Aggression, Maltreatment & Trauma,* 26: 137-154**

This investigation examines the occurrence and impact of chronic adversity for young adults who grew up amidst poverty and community violence. Using grounded theory analysis the researchers explored how participants perceive and make meaning of their experiences. Interview data revealed consistent narratives of childhood neglect and psychological maltreatment, chronic loss, intergenerational trauma exposure, and the resulting survival-based adaptation. The research identified “3 primary themes across the participant narratives: lack of need fulfillment; paradoxical experience of self, others, and the world; and persistent sense of purpose and meaning. The article concludes that there is need for an increased focus in trauma-informed treatment of adults in under resourced communities is discussed.

**\*Razza, NJ & Tomasulo DJ (2005). Group dynamics in the treatment of people with intellectual disabilities: Optimizing**

 **therapeutic gain. *Mental Health Aspects of Developmental Disabilities*, 8 (1): 22-28**.

The authors’ discuss the exigency of therapeutic preparedness when doing group psychotherapy. That preparation, they argue, allows for therapeutic opportunities that might otherwise be missed in individual counseling, for example how personality traits are exposed in group, how the dynamics of the group feed off on each participant. This can be a useful tool in engaging individuals through the group activities, particularly as pertains to anxiety, depression and trauma. The authors’ provide case examples and a review of the literature to support their argument.

**\*Razza, Nancy J, Tomasulo, Daniel J & Sobsey Dick (2011). *Group psychotherapy for trauma-related disorders in people with***

 ***intellectual disabilities*. Advances in Mental Health and Intellectual Disabilities, 5: 40-45.**

The authors discuss prevalence of abuse among people with ID, the relationship of trauma and psychological distress associated with the abuse, and discuss a framework using group psychotherapy to treat trauma in adults with ID. They argue that understanding abuse prevalence and its impact on people with ID justifies the need for increasing treatment options. Next they offer one such option from a theoretical perspective

**Rollnick, S & Allison, J (2004). Motivational interviewing. In: N. Heather & T. Stockwell (eds). *The Essential Handbook of***

***Treatment and Prevention of Alcohol Problems*. John Wiley & Sons, LTD, The Atrium, Southern Gate, Chichester, West Sussex, England..**

 This chapter provides an overview of motivational interviewing, how it is used and best practices of implementation.

.

**Schauer, M & Elbert, T (2010). Dissociation following traumatic stress. *Zeitschrift fÜr Psychologie/Journal of Psychology*,**

 **218 (2): 109-127. doi: 10.1027/0044-3409/a000018.**

The authors’ propose that there is a coherent sequence to fear response, a cascade that includes “Freeze-Flight-Fight-Fright-Flag-Faint”. People who experience dissociative responses to trauma often follow the whole cascade sequence and may be more at risk for dissociation than those who respond in the moment and use only aspects of fear response. The authors’ propose that differentiating trauma responses in individuals holds important treatment implications.

**Seidler, GH & Wagner, FE (2006). Comparing the efficacy of EMDR and trauma-focused cognitive behavioral therapy in the**

 **treatment of PTSD: A meta-analytic study. *Psychological Medicine*, Cambridge University Press, doi:**

 **10.1017/S0033291706007963.**

The author’s review the efficacy of CBT and EMDR in the treatment of PTSD. They conclude that both treatments are

effective and they were unable to say one was better than another in outcome rates.

**Silverman WK, Ortiz CD, Viswesvaran C, Burns BJ, Kolko DL, Putnam FW & Amaya-Jackson L (2008). Evidence-based**

 **psychosocial treatments for children and adolescents exposed to traumatic events. *Journal of Clinical Child and Adolescent***

 ***Psychology*, 37(1): 156-183**.

This article reviewed 21 studies on the efficacy of treatment for children exposed to trauma. Based on their review the authors’ rated the efficacy of treatment and made recommendations for establishing practice guidelines and future research focus

**\*Tamas, D, Glu mbic, N & Golubovic, S (2016). Correlation between aggressive behaviour and stress in people with**

 **intellectual disability in relations to the type of housing. Journal of Special Education and Rehabilitation, 17 (3-4), 46-61.**

The authors discuss their research into the correlation between housing and aggression in individuals with ID. Their results suggest that people residing in large congregate care facilities are more likely to emit aggression than those residing in smaller community settings or at home. Interestingly, individuals residing at home had the second highest emission of aggression. One factor that the authors’ discuss is that increased exposure to victimization, blame and trauma played a role in helping to explain their findings.

**\*Tomasulo, DJ (2014). Positive group psychotherapy modified for adults with intellectual disabilities*. Journal of Intellectual***

 ***Disabilities*, 1-14, doi: 10.1177.744629514552153.jid.sagepub.com.**

This article focuses on a review of evidence for interactive behavioral therapy, a widely used model of group psychotherapy for adults with co-occurring ID and mental health difficulties. A sample of a modified positive intervention, the virtual gratitude visit, is explained and suggestions for future research are given.

**Van der Kolk, Bessel A, Hodgdon, Hilary, Gapen, Mark, Musicaro, Regina, Suvak, Michael K, Hamlin, Ed &**

 **Spinazzola, Joseph (2016). A randomized controlled study of neurofeedback for chronic PTSD. *PLoS***

 ***ONE*, 11(12) DOI: 10.1371/journal.pone.0166752.**

Brain/Computer Interaction (BCI) devices are designed to alter neural signals and, thereby, mental activity. This study used a randomized design to assess EEG neurofeedback training (NF), in patients with chronic PTSD. Per the authors, “Compared with the control group NF produced significant PTSD symptom improvement in individuals with chronic PTSD, as well as in affect regulation capacities. NF deserves further investigation for its potential to ameliorate PTSD and to improve affect regulation, and to clarify its mechanisms of action.”

**Van der Kolk, Bessel A, Spinazzola, Joseph, Blaustein, Margaret E, Hopper, James W, Hopper, Elizabeth K, Korn, Deborah L &**

 **Simson, William B (2007). A randomized clinical trial of eye movement desensitization and reprocessing (EMDR),**

 **fluoxetine, and pill placebo in the treatment of posttraumatic stress disorder: Treatment effects and long term**

 **maintenance. *Journal of Clinical Psychiatry*, 68:0**

The relative short-term efficacy and long-term benefits of pharmacologic versus psychotherapeutic interventions have not been studied for posttraumatic stress disorder (PTSD). This study compared the efficacy of a selective serotonin reuptake inhibitor (SSRI), fluoxetine, with a psychotherapeutic treatment, eye movement desensitization and reprocessing (EMDR), and pill placebo Results were psychotherapy intervention was more successful than pharmacotherapy in achieving sustained reductions in PTSD and depression symptoms, but “this benefit accrued primarily for adult onset trauma survivors.” According to the authors, their study supported the efficacy of brief EMDR treatment to produce substantial and sustained reduction of PTSD and depression in most victims of adult-onset trauma. Furthermore, there was positive role for SSRIs as a reliable first-line intervention to achieve moderate symptom relief for adult victims of childhood-onset trauma.

**Wahab, S, Trimble, J, Mejia, A, Mitchell, SR & Thomas, MJ (2014). Motivational interviewing at the intersections of**

 **depression and intimate partner violence among African American women. Jo*urnal of Evidence-Based Social Work*, 11(3):**

 **291-303.**

The study focused on the a treatment protocol using case-management and motivational interviewing, applied in a culturally relevant context, to reduce depression severity in African American women who were survivors of intimate partner violence. The findings suggest that well trained case managers, using motivational interviewing techniques could assist women manage their depression and assert greater control in their lives.

**\*Whitehouse, RM, Tudway, JA, Look, R & Kroese, BS (2005). Adapting individual psychotherapy for adults with intellectual**

 **disabilities: A comparative review of the cognitive-behavioural and psychodynamic literature. *Journal of Applied Research***

 ***in Intellectual Disabilities*, 19: 55-65.** The authors’ reviewed the literature for examples of treatment using psychotherapy in adults with intellectual

disabilities. They analyzed the literature for examples of what adaptions were used in treatment and what hadn’t worked. Based on their review the authors’ present adaptive methodology that might be used in a therapeutic session and discuss strengths and weaknesses in the cognitive-behavioral and psychodynamic models of treatment.

**Zoellner, LA, Feeny, NC, Bittinger, JN, Bedard-Gilligan, MA, Slagle, DM, Post, LM & Chen, JA (2011). Teaching trauma-focused**

 **exposure therapy for PTSD: Critical clinical lessons for novice exposure therapists. *Psychological Trauma*, 3(3): 300-308.**

The authors’ provide a working guidepost to teaching ET to novice therapists. They discuss components of training that will assist new therapists to navigate implementation. Illustrated throughout the article are case examples that highlight key points of awareness, such as managing covert avoidance, handling client distress during treatment sessions and so forth

**Qualitative assessments of Trauma-informed Organizational Implementation**

**Damian, AJ, Gallo, J, Leaf, P & Mendelson, T (2017). Organizational and provider level factors in implementation of trauma-**

 **informed care after a city-wide training: An explanatory mixed methods assessment. *BMC Health Services Research*, 17:**

 **750. John’s Hopkins Bloomberg School of Public Health, BioMed Central, Baltimore MD**

The authors implemented their research using two validated questionnaires (Safety Attitudes Questionnaire and Professional Quality of Life, and semi structured interviews. Focus was on staff perceptions of trauma-informed implementation following a SAMHSA based training. Results suggest that staff were sensitive to proactive changes implemented wi9thin the agencies they worked for, e.g.: more tolerant/less punitive policies toward clinets, and were more sensitive to their own needs and challenges. Implications for further research and trauma-informed designs were then articulated.

**Hopper, EK, Bassuk, EL & Olivet, J (2010). Shelter from the storm: Trauma-informed care in homeless services settings. *The***

 ***Open Health Services and Policy Journal*, 3: 80-100.**

This review of the literature explored the efficacy of trauma-informed practices in homeless services. They reviewed both quantitative and qualitative research articles to glean evidence for those services. The authors’ then advance themes from the literature review for further elaboration. Finally, they make recommendations for further research.

**Musik, M, Bonham, C, Rosenblum, K, Broderick, A & Kirk, R (2013). Perspectives on trauma-informed care from mothers with**

 **a history of maltreatment: A qualitative study. *Journal of Child Abuse and Neglect*, 37(12):**

 **doi:10.1016/jchiabu.2013.07.014.**

The author’s set out to learn about heath care preferences of trauma-exposed women in their early post-partum care. They used qualitative interviews to glean perspectives on care, ease of access, comfort, treatment and environmental factors. One observation made by the authors’ was that the women in their study navigate between ambivalence and hope. Their ambivalence often delays seeking help in a timely manner. One positive outcome the authors’ promote for future research is that these mothers’ children offered a pathway to service for them, not least of which was to provide a different life outcome to the children than they experienced. Based on that, trauma-informed services can go a long way towards welcoming and supporting the women to continue services.

**Raja S, Hasnain M, Vadakumchery t, Hamad J, Shah R & Hoersch M (2017). Identifying elements of patient-centered care in**

 **underserved populations: A qualitative study of patient perspectives. *PLoS ONE* 10 (5): e0126708, doi:**

 **10.1371/journal.pone.0126708, 1-16.**

The authors sought to understand patient attitudes about health care participation among patients who were underserved and underinsured. Using semi-structured interviews the following themes emerged: greater need for empathy and rapport with their providers; behaviors of providers that would foster positive clinical experiences, e.g.: body language, timely and concrete explanation of procedures, atmosphere of clinic; creating an environment welcoming of children, cost prohibitions to seeking care, and an over girding sense of dehumanization and feeling judged by their status which kept them away.

**Wilson, JM, Fauci, JE & Goodman, L (2015). Bringing trauma-informed practice to domestic violence programs: A qualitative**

 **analysis of current approaches. *American Journal of Orthopsychiatry*, 85(6), 586-599.**

The authors’ conducted a qualitative content analysis in which they reviewed publications on policy, treatment or trauma-informed programming for men and women receiving domestic violence support or services. They reviewed the literature for themes that emerged from a theoretical perspective. These themes become a cornerstone for understanding best practices and evidence-based services. What emerged to the authors’ is that a fundamental shift in services had taken place in domestic violence programming.

***Media***

**Holman, EA, Garfin, DR & Silver, RC (2014). Media’s role in broadcasting acute stress following the Boston Marathon**

 **bombings. *PNAS*, 111 (1) 93-98**

The authors compared the impact of media versus direct exposure to stress responses in individuals. In an internet survey of approximately 4000 individuals (846 Boston, 941 New York and 2888 throughout the rest of the US) the authors found that prolonged attention to post-event coverage increased the likelihood for acute stress. Particularly of note was exposure to trauma events of violent acts: e.g.: Boston Marathon Bombing, Sandy Hook shootings, Twin Towers attack. Coverage of the effects of Hurricane Sandy did not produce the same level of stress in individuals reporting to the survey. The authors did prospectively account for pre-bombing mental health status.

**Pfefferbaum, B, Newman, E, Nelson, SD, Nitema, P, Pfefferbaum, RL & Rahman, A (2014). Disaster media coverage and**

 **psychological outcomes: Descriptive findings in the extant research. *Current Psychiatry Reports*, 16 (9): 464-475.**

The authors reviewed the literature on media coverage, consumption and psychological outcomes. They report good evidence correlating viewing media disaster coverage and increases in PTSD, PTS, depression anxiety, substance use and stress symptoms.

**Schechter, DS, Gross, A, Willheim, E, McCaw, J, Turner, JB, Myers, MM, Zeanah, CH & Gleason, MM (2009). Is maternal PTSD**

 **associated with greater exposure of very young children to violent media? *Journal of Traumatic Stress*, 22(6): 658-662.**

The authors examined the viewing habits of mothers with PTSD in their young children’s viewing habits and behaviors. The results suggest that mothers who have violence based PTSD alone were not statistically more likely to expose their children to higher rates of television violence. However, if co-occurring dissociative symptoms were observed, effects found greater violence exposure, increased hyperarousal and acting out on behalf of those children. A small sample size (N=67) limits the voracity of results.

***Positive Psychology***

**Bonanno, George (2008). Loss, trauma and human resilience: Have we underestimated the human**

 **capacity to thrive after extremely aversive events? *Psychological Trauma, Theory, Research and Policy*, 8: 101-113.**

The author notes that most people are exposed to loss or potentially traumatic events at some point in their lives, and yet, “they continue to have positive emotional experiences and show only minor and transient disruptions in their ability to function”. He asserts that much of our trauma knowledge and treatment is designed in context to people who seek treatment, and not in context to the many that do not. He argues that resilience represents “a distinct trajectory from the process of recovery” and that it is underappreciated. However, he does not advance how to help people get to resilience so much as that some people have it.

**\*Conder JA, Mirfin-Veitch BF & Gates S (2015). Risk and resilience factors in the mental health and well-being of women with**

 **intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, 28: 572-583. doi: 10.1111/jar.12153**

The authors’ used a qualitative research design to assess resilience skills in 25 women with ID in New Zealand. Women who had experienced early childhood trauma were most at risk for failing to adapt resiliency to their daily lives. Crucial to successful adoption of resilient skills was to be in a supportive network. Significant mental health symptoms in adulthood added to the risk of breakdown of supports.

**Connor, Kathryn M., Davidson, Jonathon R. & Lee, Li-Chang (2003). Spirituality, resilience, and anger in**

 **survivors of violent trauma: A community survey. *Journal of Traumatic Stress*, 16: 487-494.**

**ABSTRACT**

This study evaluates the relationship between spirituality, resilience, anger and health status, and posttraumatic symptom severity in trauma survivors. A community sample (N = 1,200) completed an online survey that included measures of resilience, spirituality (general beliefs and reincarnation), anger, forgiveness, and hatred. In survivors of violent trauma (n = 648), these measures were evaluated with respect to their relationship to physical and mental health, trauma-related distress, and posttraumatic symptom severity. Using multivariate regression models, general spiritual beliefs and anger emerged in association with each outcome, whereas resilience was associated with health status and posttraumatic symptom severity only. Forgiveness, hatred, and beliefs in reincarnation were not associated with outcome. The importance of these findings to treating trauma survivors is discussed.

**Donaldson, SI, Dollwet, M & Rao, MA (2015). Happiness, excellence, and optimal human functioning revisited: Examining the**

 **peer-reviewed literature linked to positive psychology. *The Journal of Positive Psychology*, 10(3): 185-195. doi:**

 **10.1080/17439760.2014.943801**

The authors’ reviewed applications of positive psychology from over 1300 peer-reviewed articles between 1999 and 2013. Of those over 750 reported on empirical research. They found the results promising, as the rigorous nature of the research was well founded. the authors’ concluded that continued need for research is indicated to grow positive psychology.

**Duckworth, Angela Lee, Steen, Tracy A. & Seligman, Martin E.P. (2005). Positive psychology in clinical**

 **practice. *Annual Review of Clinical Psychology*, 1: 629-651.**

**ABSTRACT**

Positive psychology is the scientific study of positive experiences and positive individual traits, and the institutions that facilitate their development. A field concerned with well-being and optimal functioning, positive psychology aims to broaden the focus of clinical psychology beyond suffering and its direct alleviation. Our proposed conceptual framework parses happiness into three domains: pleasure, engagement, and meaning. For each of these constructs, there are now valid and practical assessment tools appropriate for the clinical setting. Additionally, mounting evidence demonstrates the efficacy and effectiveness of positive interventions aimed at cultivating pleasure, engagement, and meaning. We contend that positive interventions are justifiable in their own right. Positive interventions may also usefully supplement direct attempts to prevent and treat psychopathology and, indeed, may covertly be a central component of good psychotherapy as it is done now.

**Duckworth, Angela Lee, Quinn, Patrick D & Seligman, Martin EP (2009). Positive predictors of teacher**

 **effectiveness. *The Journal of Positive Psychology*, 4: 540-547.**

**ABSTRACT**

Some teachers are dramatically more effective than others, but traditional indicators of competence (e.g., certification) explain minimal variance in performance. The rigors of teaching suggest that positive traits that buffer against adversity might contribute to teacher effectiveness. In this prospective longitudinal study, novice teachers (*N* = 390) placed in under-resourced public schools completed measures of optimistic explanatory style, grit, and life satisfaction prior to the school year. At the conclusion of the school year, teacher effectiveness was measured in terms of the academic gains of students. All three positive traits individually predicted teacher performance. When entered simultaneously, however, only grit and life satisfaction remained significant predictors. These findings suggest that positive traits should be considered in the selection and training of teachers.

Keywords: [learned helplessness](http://www.tandfonline.com/keyword/Learned%2BHelplessness), [explanatory style](http://www.tandfonline.com/keyword/Explanatory%2BStyle), [grit](http://www.tandfonline.com/keyword/Grit), [life satisfaction](http://www.tandfonline.com/keyword/Life%2BSatisfaction), [teacher performance](http://www.tandfonline.com/keyword/Teacher%2BPerformance).

**\*Dykens, EM (2006). Toward a positive psychology of mental retardation. *American Journal of Orthopsychiatry*,**

 **76(2): 185-193.**

Dykens reviews the historical trends qualitative trends in in service to people with intellectual disabilities, including constructs like quality of life, dual diagnosis, personality motivation and inclusion. She argues that these concepts don’t go fatr enough in addressing positive psychology concepts of happiness or well-being (internal states). She discusses some of the complex nature of research and advocate a new research focus on these significant factors.

**Frederickson, Barbara L (2001). The role of positive emotions in positive psychology: The broaden-and-**

 **build theory of positive emotions. American Psychology, 56: 218-226.**

 **ABSTRACT**

In this article, the author describes a new theoretical perspective on positive emotions and situates this new perspective within the emerging field of positive psychology. The broaden-and-build theory posits that experiences of positive emotions broaden people's momentary thought-action repertoires, which in turn serves to build their enduring personal resources, ranging from physical and intellectual resources to social and psychological resources. Preliminary empirical evidence supporting the broaden-and-build theory is reviewed, and open empirical questions that remain to be tested are identified. The theory and findings suggest that the capacity to experience positive emotions may be a fundamental human strength central to the study of human flourishing.

**\*Gilmore, L & Cuskelly, M (2014). Vulnerability to loneliness in people with intellectual disability: An explanatory model.**

 ***Journal of Policy and Practice in Intellectual Disabilities*, 11 (3): 192-199. doi: 10.1111/jppi.12089**

The authors’ propose a model for understanding loneliness in people with intellectual disability. That model looks at the interplay of social attitudes, skill deficits and reduced/limited social opportunities as a mechanism for viewing vulnerability to loneliness. They argue that this model can be used to further research on the intricacies of the interplay and as a means to better define what loneliness means to people with ID/DD.

**\*Niemac, RM, Shogren, KA & Wehmeyer, ML (2017). Character strengths and intellectual and developmental disability: A**

 **strengths-based approach from positive psychology. *Education and Training in Autism and Developmental Disabilities*,**

 **52(1): 13-25.**

The authors’ review the literature on character strengths, and interventions that have been used to promote strengths of character in the positive psychology field. Furthermore, they point out that there is a dearth of study as character strengths relate to people with intellectual disability. They make the argument and showcase how research on this topic would be helpful to people with ID/DD.

**\*Noone, SJ & Hastings, RP (2009). Building psychological resilience in support staff caring for people with intellectual**

 **disabilities: Pilot evaluation of an acceptance-based intervention. *Journal of Intellectual Disabilities*, 13(1): 45-53. doi:**

 **10.1177/1744629509103519.**

The authors’ report on a pilot study in which they introduced a two day training intervention incorporating acceptance and commitment therapy for staff (Promotion of acceptance in carers and teachers: PACT). Results, post training showed promise for the diminution of psychological distress on staff who completed the training. they conclude more research is indicated, including comparing PACT with a CBT model of managing stress through cognitive reprocessing.

**\*Schalock, RL, Verdugo, MA, Gomez, LE & Reinders, HS (2016). Moving us toward a theory of individual quality of life.**

 ***American Journal on Intellectual and Developmental Disabilities*, 121(1): 1-12. doi: 10.1352/1944-7558-121.1.1**

The authors’ argue that quality-of-life has long impacted research and service delivery to people with ID/DD. Conceptually it includes values related to empowerment, self-determination, equality of opportunity and inclusion and also delves into a personal definition of quality. However, from thence, various definitions have made it hard to assess relevance and scope in the literature. The authors’ propose a systemic means to achieve a useful theory of quality-of-life.

**\*Shogren KA, Wehmeyer, ML, Buchanan, CL & Lopez, SJ (2006). The application of positive psychology and self-**

 **determination to research in intellectual disability: A content analysis of 30 years of literature. *Research and Practice for***

 ***Persons with Severe Disabilities*, 31(4) 338-345.**

The authors’ reviewed peer reviewed articles on intellectual disability across a thirty year period, breaking that time frame into three 10 year cycles. They searched out articles that spoke to applications of positive psychological nature. In that context, they divided articles into focuses of attributes of strength, deficits, mixed and neutral. What they found is that over each ten year period there was an inverse relationship between strengths, which increased percentage wise, each decade and deficit and mixed perspectives which decreased consecutively each decade. Neutral articles remained about the same, though there was a decrease in the third decade. They argue that, while the trend is positive, there is still much to be done to think about positive psychology as it relates to people with ID/DD, and applications that can improve peoples’ lives.

**\*Shogren, KA, Lopex, SJ, Wehmeyer, ML, Little, TD & Pressgrove, CL (2006). The role of positive psychology constructs in**

 **predicting life satisfaction in adolescents with and without cognitive disabilities: An explanatory study. *The Journal of***

 ***Positive Psychology*, 1 (1): 37-52.**

This study undertook to explore the interrelationship between positive psychology constructs as related to students with and without disabilities in Kansas school districts. Within each school district, administrators, teachers, ancillary personnel and aides were asked to complete the Adolescent Self-determination scale with adolescent students. They also asked students to complete the Children’s Hope Scale, Life Orientation Test-Revised, The Norwicki-Strickland Internal-External Scales and the Satisfaction with Life Scale. Results found that there were significant differences between disabled and non-disabled participants. Still there were significant results that spoke to optimism and the opportunity to introduce Positive Psychology research and application into the schools for children and adolescents with ID/DD.

**\*Wehmeyer, ML & Shogren, KA (2014). Disability and positive psychology. In J. Termoto Pedrotti and L.M. Edwards (eds.),**

 ***Perspectives on the Intersection of Multiculturalism and Positive Psychology,* Cross-Cultural Advancements in Positive**

 **Psychology 7: 175-188, DOI: 10.1007/978-94-017-8654-6\_12, Springer Science + Media.**

In this chapter the authors’ argue that the changing nature of disability from a pathological to a functional view opens the door to greater investigation of a positive psychological framework. To date, a review of the Journal of Positive Psychology have identified on 4% of articles pertained to people with disabilities. They argue that more research is indicated on the application of positive psychology in this arena.

**Winblad, NE, Changaris, M & Stein, PK (2018). Effect of somatic experiencing resiliency-based trauma treatment training on**

 **quality of life and psychological health as potential markers of resilience in treating professionals. *Frontiers in***

 ***Neuroscience*, 12, article 70, 1-10. doi: 10.3389/fnins.2018.0070**

The authors’ report on research testing the efficacy of the Somatic Experience Training and Resilience (SETR) program. Over a three year period, they implemented the SER program to 18 students training to work as trauma therapists. Using established measures, they found that the SETR program significantly lessened the mental and physical symptoms of vicarious trauma and that participants were happier and more self-regulated, such that they could recognize early warning signs and correct for them. While promising, they conclude more research is indicated.

***Mindfulness: staff training***

**Brooker, Joanne, Julian, John, Webber, Lynne, Chan, Jeffrey, Shawyer, Frances & Meadows, Graham**

 **(2012). Evaluation of an occupational mindfulness program for staff employed in the disability sector**

 **in Australia. *Mindfulness*, DOI: 10.1007/s12671-012-0112-7**

The authors’ examined the impact of a group-based training program, known as ‘Occupational Mindfulness’ (OM), on employee coping and wellbeing within a disability service in Australia. The study involved a longitudinal observational design. The program was positively evaluated by participants and found to be associated with significant increases in positive affect and the mindfulness of observing. However, extrinsic job satisfaction decreased significantly from baseline while negative affect, perceived stress, anxiety and negative emotional symptoms increased significantly. The authors then explore the seemingly paradoxical results of the study and make recommendations for further research.

**Byron, Gerald, Ziedonis, Douglas M., McGrath, Caroline, Frazier, Jean A., de Torrijos, Fernando &**

 **Fulwiler, Carl (2015). Implementation of mindfulness training for mental health staff: Organizational**

 **context and stakeholder perspectives*. Mindfulness* 6: 861-877.**

The authors’ note that occupational stress and burnout adversely impacts mental health care staff well-being and patient outcomes. They add that few studies have examined Mindfulness stress reduction training in mental health settings. In this article they examined, “stakeholders’ perceptions of organizational factors affecting implementation of an adapted version of Mindfulness-Based Stress Reduction (MBSR) for staff on adolescent mental health units” using a series of focus group discussions. Their results found that common barriers were limited staff time to attend training sessions and insufficient training coverage for some staff. Those staff who had completed training reported improved focus when interacting with adolescents and improved social cohesion on the units. The authors concluded that a mindfulness-based program for reducing occupational stress can be successfully implemented on adolescent mental health units. They also suggested that attention be paid to the importance of environmental factors in shaping attitudes, diffusion of innovation, and acculturation of wellness program implementations.

**Dane, Eric & Brummel, Bradley J. (2013). Examining workplace mindfulness and its relations to job**

 **performance and turnover intention. *Human Relations*, 67: 105-128.**

The authors examined workplace mindfulness, defined as, “the degree to which individuals are mindful in their work setting”. They hypothesized that, in a dynamic work environment, mindfulness is positively related to job performance and negatively related to turnover. They found support for a positive relationship between workplace mindfulness and job performance that holds. We also found support for a negative relationship between workplace mindfulness and turnover, though to a lesser degree. Finally, the authors’ consider the theoretical and practical implications of these findings and highlight a number of avenues for conducting research on mindfulness in the workplace.

**Lamothe, Martin, Rondeau, Emelie, Malboeuf-Hurtubise, Catherine & Duval, Michel (2016). Outcomes**

 **of MBSR or MBSR-based interventions in health care providers: A systematic review with a focus on**

 **empathy and emotional competencies. Complimentary Therapies in Medicine, 24: 19-28.**

The authors’ performed a systematic review on interventional studies evaluating the effect of MBSR in healthcare professionals. A primary focus was to focus on empathy and emotional competence. Thirty nine studies were identified. Fourteen measured empathy or some form of emotional competence in healthcare providers. The review showed that MBSR training is associated with improvements in burnout, stress, anxiety and depression. The review also noted improvements in empathy are also suggested but no clear evidence is currently available on emotional competencies. Highlights of the study found that the effect of MBSR on professionals' mental health “of emotional competencies have been identified as being of major importance for high quality care, they are still scarcely studied.” They concluded that studying these outcomes is important, as it may help explain how mindfulness contributes to professionals' mental health and thus help develop targeted interventions

**Mackensie, Corey S, Poulin, Patricia A & Seidman-Carlson, Rhonda (2006). A brief mindfulness-based**

 **stress reduction intervention for nurses and nurse aides. *Applied Nursing Research*, 19: 105-109.**

In this study an evaluation of a brief 4-week mindfulness intervention for nurses and nurse aides. They found that “In comparison with 14 wait-list control participants, 16 participants in the mindfulness intervention experienced significant improvements in burnout symptoms, relaxation, and life satisfaction.” They concluded that mindfulness training is a promising method for helping those in the nursing profession manage stress, even when provided in a brief format.

**\*Miorrag, N, Lense, MD & Dykens, EM (2012). A pilot study of a mindfulness intervention for individuals with Williams**

 **syndrome: Physiological outcomes. *Mindfulness*, 3 (4) doi: 10.1007/s12671-012-0178-2.**

The authors’ studied the impact of a mindfulness-based stress reduction intervention on the cortisol levels and self-rated anxiety of 24 adults who had William’s syndrome. Findings were that cortisol levels decreased following treatment sessions. Anxiety-rating also was predicative of cortisol levels. However, the study was limited by the scale and nature of the mindfulness sessions (short session/short period of time). Future study is indicated to see if results can be replicated.

**Poulin, Patricia A., Mackenzie, Corey S., Soloway, Geoffrey & Karayolas, Eric (2008). Mindfulness**

 **training as an evidenced-based approach to reducing stress and promoting well-being among human**

 **service professionals. *International Journal of Health Promotion & Education*, 46: 35-43.**

In this follow up study to (Mackenzie, et al, 2006) two mindfulness-based interventions are described. Study 1 explored whether a brief mindfulness intervention was superior to a traditional relaxation intervention for nursing staff. In study 2, teacher trainees who participated in a Mindfulness- Based Wellness Education (MBWE) program as part of their academic training experienced significantly greater increases than controls in mindfulness, satisfaction with life, and teaching self-efficacy. They found that mindfulness-based interventions are proving to be an effective way to support these pivotal members of our society. At the same time they point to weaknesses in the study and advocate further study.

**\*Singh, N.N.; Lancioni, G.E., Winton, A.S.W , Singh, A.N., Curtic, W.J., Wahler, R.G., Sabaawi, M, Singh, J.**

 **J.& McAleavey, K. (2006). Mindful staff increase learning and reduce aggression in adults with**

 **developmental disabilities. *Research in Developmental Disabilities*, 27: 545-558.**

The authors’ used a multiple baseline design across group homes to assess the impact on aggressive behaviors and the number of learning objectives mastered by individuals in their care. Staff training included behavioral training only and a combination of behavioral and mindfulness training. Compared to baseline, the number of staff interventions for aggression showed some reduction following behavioral training, but decreased substantially only following mindfulness training. They also noted an increase in the number of learning objectives mastered by the individuals following behavioral training, but greater and more consistent increases were obtained only after mindfulness training. Their results suggest that the addition of mindfulness training considerably enhanced the ability of the group home staff to effectively manage the aggressive behavior and learning of the individuals.

**\*Singh, N.N., Lancioni, G.E., Winton, A.S.W., Singh, A.N., Adkins, A.D., & Singh, J. (2009). Mindful staff can**

 **reduce the use of physical restraints when providing care to individuals with intellectual disabilities.**

 ***Journal of Applied Research in Intellectual Disabilities,* 22: 194-202.**

In this article the authors’ report on “how training staff members in mindfulness affected their use of physical restraints for aggressive and destructive behaviors of individuals with intellectual disabilities.” Staff across four group homes participated in a 12-week mindfulness-training program. They noted that as mindfulness training progressed, the use of restraints decreased, with almost no use being recorded by the end of the study. A secondary benefit noted by the authors’ was that as needed medications administered also decreased and staff and peer injuries were close to zero levels during the latter stages of mindfulness practice. They concluded that staff training in mindfulness is potentially beneficial to both staff and the individuals with intellectual disabilities.,

**\*Singh, N.N., Lancioni, G.E., Karazsia, B.T. & Myers, R.E. (2016). Caregiver training in mindfulness-based**

 **positive behavior supports (MBPBS): Effects on caregivers and adults with intellectual and**

 **developmental disabilities. *Frontiers in Psychology*, *(7)*:98. doi:10.3389/fpsyg.2016.00098.**

In this study the authors’ report on a 7-day intensive Mindfulness-Based Positive Behavior Support (MBPBS) training to caregivers from community group homes and assessed the outcomes in terms of caregiver variables, individuals’ behaviors, and an administrative outcome. They reported that compared to pre-MBPBS training, the MBPBS training resulted in the caregivers using significantly less physical restraints, and staff stress and staff turnover were considerably reduced. The frequency of injury to caregivers and peers caused by the individuals was significantly reduced. A benefit-cost analysis showed substantial financial savings due to staff participation in the MBPBS program. This study provides further proof-of-concept for the effectiveness of MBPBS training for caregivers, and strengthens the call for training staff in mindfulness meditation.

**\*Singh, N.N., Lancioni, G.E., Karazsia, B.T., Chan, J. & Winton, A.S.W. (2016). Effectiveness of caregiver**

 **training in mindfulness-based positive behavior support (MBPBS) vs. training-as-usual (TAU): A**

 **randomized controlled study. *Frontiers in Psychology* *, (7) 1549*. doi: 10.3389/fpsyg.2016.1549**

**ABSTRACT**

The focus of the present study was to evaluate in a randomized controlled trial (RCT) the comparative effectiveness of Mindfulness-Based Positive Behavior Support (MBPBS) and Training-as-Usual (TAU) for caregivers in a congregate care facility for individuals with severe and profound IDD. The comparative effects of the two training conditions were assessed in terms of caregiver variables care recipient variable (number of aggressive events), and agency variables Results showed that MBPBS was significantly more effective than TAU in enabling the caregivers to manage their perceived psychological stress, and to reduce the use of physical restraints and stat medications for aggressive behavior of the individuals in their care. In addition, there were significant reductions in aggressive events by the individuals in their care, 1:1 staffing of individuals with aggressive behavior, and staff turnover. Furthermore, the MBPBS training was significantly more cost-effective than the TAU training. If replicated in future RCT studies, MBPBS may provide an effective means of enhancing socially acceptable bidirectional engagement of caregivers and care recipients within a person-centered context.

***Mindfulness in practice:***

**Bogels, S, Hoogstad, B, van Dun, L, de Shutter, S & Restifo, K (2008). Mindfulness training for adolescents with**

 **externalizing disorders and their parents. *Behavioral and Cognitive Psychotherapy*, 36: 193-209.**

 **doi: 10.1017/S1352465808004190**

The authors’ report on a mindfulness-based treatment program designed to address attention and impulsivity problems in adolescents with a variety of disorders. The treatment was designed for children and their parents. Child participation was N=16. Parental was N=14. A mindfulness-based cognitive behavior treatment was provided to participants over 8 sessions. They were assessed immediately following the sessions and eight weeks later. Results were positive for improvement in impulsivity, being attuned, responding to social problems and happiness. These were maintained at eight weeks. However, quality of life was not improved, by report. Results were promising, more research was indicated.

**\*Chapman, Melanie J, Hare, Dougal J., Caton, Sue, Donalds, Dene, McInnis, Erica, & Mitchell, Duncan**

 **(2013). The use of mindfulness with people with intellectual disabilities: A systematic review and**

 **narrative analysis. *Mindfulness,*  4: 179-189.**

This article presented a systematic review of the evidence on the effectiveness of mindfulness for people with intellectual disabilities. Between 1980 and 2012 the authors’ identified eleven relevant studies evaluating mindfulness training and practice. They reported that there were, “improvements in aggression and sexual arousal for people with intellectual disabilities after mindfulness training”. The review noted that staff training in mindfulness led to benefits for people with intellectual disabilities, decreased use of physical restraint for aggressive behavior and increased job satisfaction and that training parents led to improved parental satisfaction and well-being and improved parent–child interactions. The findings have to be interpreted with caution due to methodological weaknesses identified in the studies and the dearth of available studies for review.

**Davis, Daphne M. & Hayes, Jeffrey A. (2011). What are the benefits of mindfulness? A practice review of**

 **psychotherapy-related research. *Psychotherapy*, 48: 198-208.**

**ABSTRACT**

This paper provides psychotherapists with a synthesis of the empirically supported advantages of mindfulness. Definitions of mindfulness and evidence-based interpersonal, affective, and intrapersonal benefits of mindfulness are presented. Research on therapists who meditate and client outcomes of therapists who meditate are reviewed. Implications for practice, research, and training are discussed.

**\*Harper, Sarah K., Webb, Thomas L. & Rayner, Kelly (2013). The effectiveness of mindfulness-based**

 **interventions for supporting people with intellectual disabilities: A narrative review. *Behavior***

 ***Modification*, 37: 431-453.**

The authors’ evaluated 18 studies on mindfulness based interventions for people with I/DD and assessed the research fidelity of their designs and outcome. They noted that strengths included replicable methodological approaches, use of multiple baseline designs, strong construct and criterion validity, and consideration of the mechanisms by which mindfulness influences behavior change. Weaknesses were there was a lack of randomized controlled trials, inclusion of qualitative data without structured analysis, limited use of statistical analyses, and problems with sampling leading to difficulties generalizing findings. They also noted a paucity of research on "Dialectical Behavior Therapy" and "Acceptance and Commitment Therapy" and the role of mindfulness within these approaches.

**Hinton, DE, Pich, V Hofmann, SG & Otto, MW. (2013). Acceptance and mindfulness techniques as applied to refugee and**

 **ethnic minority populations with PTSD: Examples from “culturally adapted CBT”. Cognitive and Behavioral Practice, 20(1)**

 **33-46.**

The authors’ introduce a treatment approach for PTSD treatment in ethnic minority Hispanic and Southeast Asian refugee populations. This Nodal network Model applies a culturally adapted CBT treatment approach. They provide an overview of the program and case examples to illustrate the program efficacy. Arguing that the CA-CBT model increases psychological flexibility, they note positive changes in self-regulation, decreased somatic distress, and decreased focus on threats.

**Lyddy, Christopher, Good, Darren J, Glomb, Theresa M., Bono, Joyce E. & Brown, Kirk W. (2015).**

 **Contemplating mindfulness at work: An integrative review. *School of Business Faculty Publications*, 6.**

[**http://digitalcommons.providence.edu/business\_fac/6**](http://digitalcommons.providence.edu/business_fac/6)**.**

**ABSTRACT**

Mindfulness research activity is surging within organizational science. Emerging evidence across multiple fields suggests that mindfulness is fundamentally connected to many aspects of workplace functioning, but this knowledge base has not been systematically integrated to date. This review coalesces the burgeoning body of mindfulness scholarship into a framework to guide mainstream management research investigating a broad range of constructs. The framework identifies how mindfulness influences attention, with downstream effects on functional domains of cognition, emotion, behavior, and physiology. Ultimately, these domains impact key workplace outcomes, including performance, relationships, and well-being. Consideration of the evidence on mindfulness at work stimulates important questions and challenges key assumptions within management science, generating an agenda for future research.

**Irving, Julie Anne, Dobkin, Patricia L. & Park, Jeeseon (2009). Cultivating mindfulness in health care**

 **professionals: A review of empirical studies of mindfulness-based stress reduction (MBSR).**

 ***Complimentary Therapies in Clinical Practice*, 15: 61-66.**

The authors’ reviewed studies that examined the potential benefits of mindfulness-based stress reduction (MBSR) programs aimed at enhancing well-being and coping with stress in health care professionals. Empirical evidence indicated that participation in MBSR yields positive outcomes for clinicians in the domains of physical and mental health. The article does note that because of varying conceptual and methodological limitations of the existing studies future research was indicated

**\*Hastings, Richard P. (2013). Mindfulness and acceptance in developmental disabilities: Introduction to**

 **the special issue. *Mindfulness*, 4:85-88.**

**ABSTRACT**

Mindfulness and acceptance training programs and interventions have rapidly gained widespread international interest, but their use in the field of developmental disabilities has been much slower. However, the field appears to have overcome the inertia associated with new approaches and is on the tipping point of having a major impact. A major reluctance to adopt these new “therapies” may be attributable to the plethora of fads espoused by some professionals in developmental disabilities. Furthermore, there was some question whether individuals with developmental disabilities would have the cognitive capacity to understand and practice some of the foundational concepts associated with mindfulness-based procedures. As attested by the current research, there is now optimism that mindfulness and acceptance procedures may prove to be valuable in assisting parents and paid carers to enhance the quality of life of individuals with developmental disabilities

**\*Speck, AA, van Ham, NC & Nyklicek, I (2013). Mindfulness-based therapy in adults with an autism spectrum disorder: A**

 **randomized controlled trial. *Research in Developmental Disabilities,* 34: 246-253. doi: 10.1016/j.ridd.2012.08.009.**

The authors’ introduced a modified 9-week mindfulness based therapy program to adults with ASD. The goal was to study whether or not it could be an effective treatment for symptoms of depression and anxiety. In the study the control group was put on a waiting list while the treatment group received the MBT-AS. Results were statistically significant for positive change. The authors’ noted that this was a first time study and more was needed to understand the impact of MBT on folks with ASD.

**Van Dam, Nicholas T, Brown, Anna, Mole, Jake H., Britton, Willoughby B & Brewer, Judson, A. (2015).**

 **Development and validation of the behavioral tendencies questionnaire. *PLoS ONE*, 10: e0140867,**

 **doi: 10: 137/journal.pone.0140867.**

At a fundamental level, taxonomy of behavior and behavioral tendencies can be described in terms of approach, avoid, or equivocate (i.e., neither approach nor avoid). While there are numerous theories of personality, temperament, and character, few seem to take advantage of parsimonious taxonomy. The present study sought to implement this taxonomy by creating a questionnaire based on a categorization of behavioral temperaments/tendencies using the Behavior Tendencies Questionnaire (BTQ). According to the researchers, the cross-validated measure exhibited good construct-consistent relationships with related measures that seemed to corroborate the ideas present in the original Buddhist source documents. They argue that the BTQ is a psychometrically valid questionnaire that is historically consistent, based in behavioral tendencies, and promises practical and clinical utility particularly in settings that teach and study meditation practices such as Mindfulness Based Stress Reduction (MBSR)

***YOGA-Trauma***

**Caplan, M, Portillo, A & Seely, L (2013) Yoga psychotherapy: The integration of western psychological theory and ancient**

 **yogic wisdom. *The Journal of Transpersonal Psychology*, 45 (2): 139-158**

The authors’ produce a historical literature review that looks to trauma, mediation, mindfulness, and yoga practices through the lens of healing. It compares that with movements within Western philosophy of psychology. Bringing that narrative forward, the authors’ then describe methods for integrating these disciplines in a unified way to treat trauma and somatic symptoms.

**Clark, CJ, Lewis-Dmello, A, Anders, D, Parsons, A, Nguyen-Feng, V, Henn, L & Emerson, D (2014). Trauma-sensitive yoga as an**

 **adjunct mental health treatment in group therapy for survivors of domestic violence: A feasibility study. *Complimentary***

 ***Therapies in Clinical Practice* , 20: 152-158. doi: 10.1016/j.ctcp.2014.04.003.**

This study undertook to assess the viability of using yoga as an adjunctive treatment to group therapy for trauma victims. A small sample size (N=17) was broken into a control group (N=9) and experimental group. Through the course of the study there was a 25% dropout rate. The experimental group was offered a 12 session yoga treatment, once a week at the conclusion of their therapy session. Results, per self - report, were that participants felt yoga improved their affect, lessened anxiety and depressive symptoms and help with coping skills related to PTSD.

**Crews, DA, Stolz-Newton, M & Grant, NS (2016). The use of yoga to build self-compassion as a healing method for survivors**

 **of sexual violence. *Journal of Religion and Spirituality in Social Work: Social Thought*, 35(3) 139-156. doi:**

 **10.1080/15426432.2015.1067583.**

In this qualitative study, the authors’ explore the use of yoga to help female survivors of sexual violence build capacity for self-compassion. That was further defined as self-judgement to self-kindness, isolation to common humanity and over-identification to mindfulness. Eight woman and girls were selected in a ‘convenience’ sample. All reported participation in yoga had beneficial effects, though results were nuanced on an individual basis.

**Emerson, D, Sharma, R, Chaudhry, S & Turner, J (2009) Trauma sensitive yoga: Principles, practice, and research.**

 ***International Journal of Yoga Therapy*, 19: 123-128.**

This paper reflects on the efforts to provide yoga as adjunctive to trauma treatment. It reviews best practices and discusses the principles behind yoga therapy. Furthermore, it discusses the use of language, trainer preparation and modifications assessment for adapting yoga on an individualized basis.

**\*Gwynette, MF, Warren, NJ, Warthen, J, Rose, CP & Snook, CA (2015). Yoga as an intervention for patients with autism spectrum disorder: A review of the evidence and future direction. *Autism Open Access*, 5(3). Doi: 104172/2165-7890.1000155**

The authors’ reviewed studies that applied yoga as a treatment for co-morbid conditions in people with ASD. They found only four studies, two of which did not specifically meet the criteria they were looking to. All four studies reported positive outcomes and the authors’ argue that given the paucity of evidence based treatments for people with autism, more research is indicated.

**Kobylinska,D, Lewczuk, K, Marchlewska, M & Pietraszek, A (2018). For body and mind: Practicing yoga and emotion**

 **regulation. *Social Psychology Bulletin*, 13 (1) doi: 10.5964/spb.v13i1.25502.**

This study undertook to evaluate whether participants who practiced yoga over a long period of time (1 year or greater) were able to practice emotion regulation skills more consistently than those who participated in yoga less than a year. 90 female participants were assessed. Finding suggested that long term yoga was beneficial to emotion regulation and conscientiousness.

**Macy, RJ, Jones, E, Graham, LM & Roach, L (2015). Yoga for trauma and related mental health problems: A meta-review with**

 **clinical and service recommendations. *Trauma, Violence and Abuse*, 1-23. doi: 10.1177/15248380156220834.**

The authors’ completed a meta-review, examining 13 reviews that included 185 distinct examinations of yoga as beneficial to helping individuals cope with trauma, anxiety and depression. They found that the general consensus of the research was positive. However, several cautions were noted. Many of the articles were not rigorous. Also, different studies used various definitions, examined different variables, and applied different yoga techniques. Finally, emergent in the articles was an underlying body of how and under what circumstances yoga could be used. As the authors’ note, this begins the journey towards an evidence base.

**Price M, Spinazzola J, Musicaro R, Turner J, Suvak M, Emerson D & van der Kolk B (2017). Effectiveness of an extended yoga**

 **treatment for women with chronic posttraumatic stress disorder. *The Journal of Alternative and Complimentary Medicine*,**

 **23 (4): 300-309. doi: 10.1089/acm.2015.0266.**

The authors’ studied an extended (20 week) trauma-sensitive yoga treatment in a non-randomized study for women with chronic, treatment resistant PTSD. Preliminary results found that PTSD and dissociative symptoms were reduced from a more traditional program of shorter duration. They assert that further research is indicated on a promising intervention for a subset of adults with chronic, treatment-resistant PTSD.

**Rhodes, Alison, M (2015). Claiming peaceful embodiment through yoga in the aftermath of trauma.**

 ***Complementary Therapies in Clinical Practice*, 21: 247-256.**

The purpose of this study was to describe the experiences of practicing yoga and its role within processes of healing for adult women with complex trauma histories. Data were analyzed from interviews with 39 women. Results showed that “the core meaning of participants' experience of healing through yoga is claiming peaceful embodiment”. Peaceful embodiment is an ongoing process occurring on a continuum whereby women experienced improved connections with and sense of ownership and control over their bodies, emotions and thoughts. Per the researchers, participants reported a greater sense of well-being, calmness, and wholeness in their bodies and minds.

**Rhodes A, Spinazzola J & van der Kolk B (2016). Yoga for adult women with chronic PTSD: A long term follow up study. *The***

 ***Journal of Alternative and Complementary Medicine*, 22(3): 189-196. doi: 10.1089/acm.2014.0407.**

This study looked at a randomized, controlled participant pool 1 ½ years following their participation in a 10 week yoga based treatment for women with chronic, treatment-resistant PTSD. Results found that there was no difference in long term outcome between yoga and more traditional treatment group. However, it did find that women who continued to practice yoga with regularity did well. The authors’ note that, “yoga appears to be a useful treatment modality”.

**Van der Kolk, B, Stone, L, West, J, Rhodes, A, Emerson, D, Suvak, M & Spinazzola, J (2014). Yoga as an adjunctive treatment**

 **for posttraumatic stress disorder: A randomized controlled trial. *Journal of Clinical Psychiatry*, 75(6) 559-565.**

The authors’ describe a clinical trial researching the impact of yoga as a supportive treatment to ongoing PTSD treatment in 31 participants. Their research found that yoga significantly reduced PTSD symptoms in the participants who were provided that treatment, as opposed to the 29 participants receiving traditional PTSD treatment, alone.

***Animal-Assisted interventions Trauma***

**Naste, TM, Price, M, Karol, J, Martin, L, Murphy, K, Miguel, J & Spinazzola, J (2017). Equine facilitated therapy for complex**

 **trauma (EFT-CT). *Journal of Child and Adolescent Trauma*. doi: 10.1007/s40653-017-0187-3**

This article reports on Equine Facilitated Therapy adapted for youth who have experienced Complex Trauma. (EFT-CT).Using case examples the authors’ describe the framework and methodology for its application in treatment. They discuss its application in context to adjunctive and direct treatment and make recommendations for future research direction.

**O’Haire, ME, Guerin, NA & Kirkham, AC (2015). Animal-assisted intervention for trauma: A systematic literature review.**

 ***Frontiers in Psychology*, 6: 1121. doi: 10.3389/fpsyg.2015.01121.**

The authors’ review 10 studies on the use of Animal-Assisted Intervention (AAI) as applied to adults with a diagnosis of PTSD. The research was conducted on two primary groups, returning war veterans and adults who suffered maltreatment and abuse as children. The author’s found that much of the research lacked “rigor”. However, while outcomes were variable, data indicated that AAI helped to diminish symptoms of depression, anxiety and PTSD. They argue for more precise research.

**O’Haire, ME, Guerin, NA, Kirkham, AC & Daigle, CL (2015). Animal-assisted intervention for trauma: Including Post-traumatic**

 **stress disorder. *Habri Central Briefs,*** [**www.habricentral.org/kb/management-oversight/editorialboard**](http://www.habricentral.org/kb/management-oversight/editorialboard)**.**

In this article the authors’ articulate the scope and variety of activities and interventions associated with Animal-Assisted Interventions. They also discuss the problematic nature these definitions on getting to more precise or empirical understanding of internevention on PTSD symptoms. At the same time, they acknowledge the generally positive reports on the AAI. The authors’ make recommendations for thinking about, and applying research for creating an evidence base on AAI and trauma.

**Stewart, LA, Bruneau, L & Elliott, A (2015). The role of animal-assisted interventions in addressing trauma-informed care.**

 ***VISTAS Online*, Article 46, counseling.org/knowledge-center/vistas.**

This article presents a framework for applying Animal-Assisted Intervention (AAI) in the therapeutic milieu. First the authors’ provide a review of the literature. They then present examples of application and use in therapy sessions and

in crisis settings. Finally they offer resources for further exploration.

***Art therapy – Trauma***

**Gaskill, RL & Perry, BD (2014). The neurobiological power of play: Using the neurosequential model of therapeutics to**

 **guide play in the healing process. In: Cathy A. Malchiodi and David A. Crenshaw (eds.) *Creative Arts and Play Therapy***

 ***for Attachment Problems*: 178-194. Guildford Press, New York.**

This chapter discusses the application of play as a treatment and healing mechanism for children who have experienced trauma. It focuses the practitioner to a neurosequential model that accommodates trauma from the bottom-up, recognizing that language may be too abstract for children to process traumatic experiences. The authors provide a large literature underpinning and example play vignettes.

**Rowe C, Watson-Ormond R, English L, Rubesin H, Marshall A, Linton K, Amolegbe A, Agnew-Brune C & Eng E (2016).**

 **Evaluating art therapy to heal the effects of trauma among refugee youth: The Burma art therapy program evaluation.**

 ***Health Promotion Practice*. doi: 10.1177/1524839915626413.**

The authors’ evaluated the implementation of art therapy on refugee adolescents from Burma who had experienced trauma and were symptomatic. Using four validated clinical assessment tools they assessed symptoms pre and post intervention. While results found that treatment had improved symptoms, the findings were negligible. However, qualitative analysis of interviews found a more substantial positive outcome. The authors’ suggest further research is necessary and that the development of art-based clinical assessment tools is indicated

**Schouten KA, de Niet GJ, Knipscheer JW, Kleber RJ & Hutschemaekers GJM (2014). The effectiveness of art therapy in the**

 **treatment of traumatized adults: A systematic review of art therapy and trauma. *Trauma, Violence, & Abuse.***

 **DOI: 10.1177/152483801455032**

The authors’ undertook to systematically evaluate the research on art therapy to treat trauma. The reviewed six published research papers using art therapy in the treatment of trauma. Three of the papers found significant treatment efficacy. A fourth was significant for decreases in depression symptomology. The authors’ argue that, while promising, there is greater need for further research into art therapy as a treatment of trauma to improve the evidence base.

**Talwar, Savneet (2007). Accessing traumatic memory through art making: An art therapy trauma protocol (ATTP). *The Arts in***

 ***Psychotherapy*, 34 (2007) 22-35.**

The author provides a rationale, literature evidence and protocol for the use of art therapy practices in trauma treatment. Founded on the concepts of memory and emotion in trauma and theories of art making and brain function, the author demonstrates its application.

**Ugurlu, N, Akca, L & Acarturk, C (2016). An art therapy intervention for symptoms of post-traumatic stress, depression and**

 **anxiety among Syrian refugee children. *Vulnerable Children and Youth Studies*, 11 (2): 89-102. doi:**

 **10.1080/17450128.2016.1181288.**

In this study, 63 Syrian refugee children, aged 7 to 12 residing in Turkey, provided a five day art therapy program, following Skills for Psychological Recovery protocols. The program consisted of three components: a visual arts, dance and music therapy. All three were introduced, each day to the participants. Pre-post testing was used to assess its effectiveness. In three of four measures: PTSD, Depression and Trait anxiety significant results at the .001 level were noted. Only in state anxiety was there no significance.

**van Westrhensen, N & Fritz, E (2014). Creative arts therapy as treatment for child trauma: An overview. *The Arts in***

 ***Psychotherapy*. doi: 10.1016/j.aip.2014.10.004.**

This study undertook a review of reported studies on art therapy as treatment for trauma. It was interested in examining the efficacy of the research. It looked at 38 articles over a ten year period. The authors’ review concluded that most of the studies lacked academic or research rigor, and thus made it difficult to accept art therapy as a valid treatment. However, they also noted that there was enough there, there to look at systematic research on the use of art therapies for treatment.

***Compassion fatigue/ Vicarious trauma:***

**Cocker, Fiona & Joss, Neirda (2016). Compassion fatigue among health care, emergency and community**

 **service workers: A systematic review. *International Journal of Environmental Research and Public***

 ***Health,* 13: 618 DOI: 10.3390/ijerph13060618.**

According to the authors’, professionals regularly exposed to the traumatic experiences of the people they service, such as healthcare, emergency and community service workers, are particularly susceptible to developing compassion fatigue (CF). This can impact standards of patient care, relationships with colleagues, or lead to more serious mental health conditions such as posttraumatic stress disorder (PTSD), anxiety or depression. They conducted a systematic review of the literature on the effectiveness of interventions to reduce CF in healthcare, emergency and community service workers. They concluded that the effectiveness of CF interventions in at-risk health and social care professions is relatively recent in the literature. As such, more research is indicated to determine how best to protect vulnerable workers at work to prevent CF.

**Killian, Kyle D (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians**

 **working with trauma survivors. *Traumatology*, 14(2): 32-44.**

This study undertook to understand the effects of secondary trauma on clinicians providing services to people who have experienced trauma. 20 therapists were subjects of a semi-structured interview and another 104 responded to a questionnaire. Results suggest that therapists self-awareness of stress was quite high. Resources for managing their experiences of traumatic stress were less well established. Implications for organizational policy and support systems are offered.

**Newcomb, M, Burton, Judith, Edwards, N & Hazelwood, Z (2015). How Jung’s concept of the wounded healer can guide**

 **learning and teaching in social work and human services. *Advances in Social Work & Welfare Education*, 17(2): 55-69**

The author’s discuss Jung’s concept of Wounded healer and its practical implication for education of professionals in human services and social work. First defining the term, they discuss wounded healer from the lens of adverse childhood experiences, helper and idealist. Then the authors discuss implications of insights these students have to contribute to the learning environment. Finally they review how focused training can help students gain personal insight and avoid re-traumatization.

**\*Salovilta, T, Italinna, M & Leinonen, E (2003). Explaining the parental stress of fathers and mothers caring for a child with**

 **intellectual disability: A double ABCX model. *Journal of Intellectual Disability Research*, 47(4/5): 300-312.**

The authors’ deployed a questionnaire of 116 mothers and 120 fathers of children with intellectual disabilities. The questionnaire was designed to identify stressors that negatively impacted parenting. Using an ABCX design they discovered several variables implicit in parental stress, though factors of stress differed by gender. Implications for intervention and support are proposed.

**Slocum-Gori, Suzanne, Hemsworth, David, Chan, Winniw WY, Carson, Anna & Kazanjian, Arminee**

 **(2011). Understanding compassion satisfaction, compassion fatigue and burnout: A survey of the hospice palliative care**

 **workforce. *Palliative Medicine*, 27: 172-178.**

The authors employed self-reported measures of Compassion Satisfaction, Compassion Fatigue and Burnout, using validated scales. Their results indicated that there is a significant negative correlation between Compassion Satisfaction and Burnout and between Compassion Satisfaction and Compassion Fatigue and a significant positive correlation between Burnout and Compassion Fatigue. These results indicate that health care systems could increase the prevalence of Compassion Satisfaction through both policy and institutional level programs to support HPC professionals in their jurisdictions.

**Trippany, RL, White-Kress, VE & Wilcoxon, SA (2004). Preventing vicarious trauma: What counselors should know when**

 **working with trauma survivors. *Journal of Counseling & Development*, 82 (winter): 32-37.**

The author’s reviewed the literature on vicarious trauma (VT). They discuss VT’s core symptoms and distinguish VT from burnout or counter transference. Furthermore, they propose training, work place supports and personal wellness activities that can be applied to prevent VT.

**Urdang, E (2010). Awareness of self-A critical tool. *Social Work Education*, 29(5): 523-538.**

The authors discusses the importance of self-awareness to treatment fidelity and as means to personal well-being and avoidance of burnout and boundary violations She provides a template of activities and strategies that can be used by the professional to enhance their experiences. She also argues for the integration of these activities into professional training curricula.

**POWER POINT PRESENTATIONS**

***Trauma Informed Care***

**\*Clark, Kelly (2016). *Trauma informed care for people with ID/DD*.**

This Prezi overview discusses trauma informed care from a holistic perspective. In addition to defining terms of trauma-informed care, the presentation includes focus on wellness, positive psychology and PBS. Additionally, practical worksheets are offered for working with adults with I/DD. These include gratitude journaling and mindfulness exercises.

**\*Clark, Kelly (2018). *Trauma informed care: How can we help build resilience?***

These materials provide practical guides for working with people with people with IDD on self-care planning and gratitude journaling. At the same time, activities for staff are offered that focus on core TIC principles and how engagement supports resilience in the people served.

**THRIVE (2010). *Guide to Trauma-Informed Organizational Development*.**

This power point introduces an organizational overview of TIC implementation elaborating on the Fallot-Harris model of TIC service (2001).

**Gillece, Joan. *Understanding the effects of trauma on the lives of those we serve: Developing trauma***

 ***informed systems of care*. National Association of State Mental Health Program Directors, National**

 **Center for Trauma Informed Care.**

This PPT overview describes the human impact of trauma. It further details how to create trauma informed systems that help placate aspects of trauma on the individuals. This provides an excellent overview of some breadth for understanding trauma mechanisms as they affect individuals with and without I/DD.

**\*Harvey, Karyn. *Trauma-informed care for individuals with intellectual and developmental differences*. (4 versions)**

This PPT provides a trauma definition, including using statistics of abuse as relates to people with I/DD. It further defines the neuro-biological response to trauma. Finally the author advances some positive psychology applications to trauma support and care. In some PPT’s Harvey elaborates in greater detail on the impact of trauma on the body and or on treatment options.

**\*Hinton, Jill. *Trauma-and stressor-related disorders and trauma informed care in IDD*. The Center for**

 **START Services.**

This PPT provides a broad overview of Trauma and stress related disorders. It then distinguishes what is and what is not trauma informed intervention. Focus is on adults with I/DD. Finally, it provides examples of treatment options that may reduce stress in adults with I/DD. These examples are not elaborated upon, so much as bulleted points of reference.

**\*Nunez-Vazquez, Angela. (2017) *Supporting survivors of trauma to thrive: Trauma-informed care.***

 **Commonwealth of Massachusetts, DDS Learning and Development.**

 This PPT discusses trauma and trauma-informed care from the lens of individuals with I/DD. It defines the complexity

of trauma, and its impact on lives. The PPT also instructs service providers on concepts of trauma-informed care, and how to actualize those concepts in practice. This PPT is not about ‘treatment’ as much as conceptually helping caregivers be more vigilant and supportive of those who have experienced trauma.

**\*Prescott, David (July 2014). *Trauma informed care with individuals with intellectual and developmental***

 ***disorders*. Annual ServiceNet Conference, Whitney Avenue Conference Center, Holyoke, MA**

In this PPT the author provides an overview of trauma and its impact on adults with I/DD. He then considers trauma from a Risk Needs Responsivity perspective and a Good-Lives perspective. These two treatment paradigms are used in the treatment of offenders. He discusses advanced skills that can help mediate trauma and the need to be trauma informed in approaching treatment and service delivery.

**\*Struth, John (2017). *Trauma-informed care: service organizations & treatment implications.***

**Commonwealth of Massachusetts, DDS- Berkshire Area.**

This brief PPT discusses trauma-informed care from an organizational perspective. That is, how one focuses on domain areas to serve as trauma-informed components to service. It provides a brief overview of concepts introduced by Keesler (2014) and Fallon & Harris, (2009).

**Wilcox, PD (2017). *We do not work alone: Implementing and sustaining trauma-informed systems*. Klingberg Family Center,**

 **New Britain, CT.**

Provides another perspective of trauma-informed care at a systems level, incorporating Fallot-Harris constructs.

***Trauma Informed Treatment***

**Anderson, Jim & Zeff, Laura (2016). *Behavior support through a trauma-informed lens*.**

 The authors describe a school-wide PBS model that incorporates trauma-informed supports into the body of service

and intervention fopr children and youth.

**\*Bridger, Joanna & Hall, Tom (2018). *Sexual-assault & intellectual or developmental disability: Adaptations of treatment*.**

 **Riverside Trauma Center**

This power point provides an introduction to trauma resulting from sexual victimization and treatment options for people with IDD. The presenters are part of a state wide group, with DDS and DDPC to develop access to systematic treatment options to people with IDD who have been sexually victimized.

**\*Brown, Julie. *Skills system: Trauma-informed treatment for individuals with ID.*** [**www.theskillssystem.com**](http://www.theskillssystem.com)

This PPT provides an overview of Brown’s Skill system and implications of trauma Informed treatment for adults with I/DD. Emphasis here is on relationship regulation.

**\*Crates, Spicer, Burton & Pullen. *Trauma informed support for people with disability*.**

The authors’ PPT discusses trauma-informed treatment supports for adults with I/DD. They provide a decision-tree for thinking of intervention strategies. Additionally they provide concrete examples of when different strategies make sense in treatment decisions. Excellent PPT if thinking about trauma-informed strategies to treat people.

**\*Harvey, Karyn. *Positive identity development and trauma recovery*. Pid.thenadd.org**

In this PPT the author advance the concept of Positive Identity Development (PID) and how it can be used to treat PDSD in adults with IO/DD. She gives examples of PID in bullet form throughout the PPT.

**\*Hinton Jill & Laforce, Anne*. Assessment tools to promote effective services and treatment of people with***

 ***IDD and behavioral health issues*. The Center for START Services.**

 This PPT discusses the use of the a variety of tools for assessing behavior states/traits. It covers observable behavior,

crisis situations, medication effects and personal biography as a means to comprehensively evaluate people with I/DD. This leads to a brief discussion of possible interventions generated from the assessment tools.

**\*Horton, Colleen & Ko, Susan. (July 2016). *The road to recovery: Supporting children with IDD who have***

 ***experienced trauma: A training toolkit.* Hogg Foundation of Mental Health and The National Child**

 **Traumatic Stress Network.**

 This PPT provides an overview of a training toolkit established to help children with I/DD and their families to cope

with trauma. This overview includes assessment, intervention and support highlights of the toolkit. It explores and

defines trauma and the unique features of trauma as it manifests in children with I/DD.

**Hummer, VL, Haynes, R & Rickus, IK (date unknown). *Trauma-informed behavior support: A training & coaching model for***

 ***caregivers*. University of Southern Florida.**

 Provides an overview of a trauma-informed applied behavior analysis model the authors had fashioned and piloted.

The pilot program targeted children and youth residing in a residential setting.

**Mannarino, AP, Cohen, JA (2016). *Trauma-Focused Cognitive-Behavioral Therapy*. Center for Traumatic Stress, Allegheny**

 **General Hospital, Pittsburgh, PA, The National Child Traumatic Stress Network.**

 The authors’ provide an overview of TF-CBT and how it works.

**\*Page, Terry J (2016). Integrating trauma informed care into an ABA model. New Jersey Association of Community Providers,**

 **Annual State Wide Conference. November 18, 2016.**

Provides an overview of a trauma-informed conceptualization of applied behavior analysis . It reviews possible misconceptions, problematic aspects of ABA and structures for incorporating ABA into treatment procedures.

**Prescott, David S. (May 2018). *Trauma-informed care with people who have sexually abused*. UMASS Shrewsbury Campus**

This power point presentation discusses the impact of adve3rse childhood experiences and trauma on the lives of people who offend. It then discusses treatment options that relate, theoretically to the risk-needs-responsivity framework of treatment. Taking into account early experiences, and offering treatment from TIC lens should result in better, more efficient outcomes.

**\*Schwartz, Michelle (2016). *A look ahead-Supporting people we serve through trauma-informed principles*. SAFE Disability**

 **Services, Austin, TX.**

The focus of this PPT is to describe the stress related and trauma responses of people with I/DD. The author discusses these effects in context to co-occurring challenges and how that may both impact or overshadow observed symptoms. The author argues that treatment of the underlying mental illness/trauma is paramount to getting well. Though this PPT enunciated these constructs, it does not go in depth into treatment strategies, per se.

**\*Tomasulo, Daniel J. *Treating trauma: Changes in diagnosis and treatment: The DM-ID and interactive-behavioral therapy*.**

 **www.The Healing Crowd.com**

The author defines trauma from an I/DD perspective. (He is the primary author of the trauma section in the DM-ID). Furthermore he discusses interactional-behavioral theory and presents evidence of its successful use in treating trauma in people with I/DD.

**Van der Kolk, B (2016) . Trauma impacts and treatment.**

 Handout for day-long seminar on trauma, treatment innovations, research and neuro-bio aspects of trauma.

***Trauma-miscellaneous***

**DeSousa, Lynne & Uphaus, Hailey . *Integrating trauma-informed approaches with PBS within an MTSS***

 ***framework*. Colorado PBIS Statewide Network.**

This PPT provides an overview of TIC with PBiS in Colorado. The authors’ briefly discuss trauma, TIC and PBiS. Next they talk about how Tic and PBiS can be integrated into a school wide approach to education. This provides a nice introduction into considering how PBS and TIC can be integrated in service with adults with I/DD.

**Guidry, Laurie L. (June 2018). *Understanding trauma in high risk-high need IDD clientele: Are we missing something?* UMASS**

 **Shrewsbury campus.**

In this PPT, Laurie presents the case that we cannot understand high risk-high need without first understanding the biopsychosocial history of an individual. The impact of trauma at a young age, on top of already compromised neurobiological systems can play a significant role in a person’s physical and mental health and well-being. She discusses how that might take shape, and how to complete a comprehensive assessment to measure need. She then turns to the Risk-Needs-Responsivity framework for thinking about ways to incorporate TI treatment into service delivery.

**LeBoeuf, Heidi Sue (2015). *The silent epidemic: Preventing child sexual abuse*. Pathways for Change,**

 **Worcester, MA.**

This PPT discusses childhood sexual abuse. It provides a means for looking at behavioral signs in perpetrators and in children of sexual abuse. It also provides a context in which to consider how these signs manifest into symptoms and what one can do to intervene if these patterns are noted.

**\*Marcal, Steve. *Adverse childhood experiences and developmental disabilities*. Center for Disability**

 **Services, Albany, NY.**

In this PPT the author describes the influence of ACEs on adults with I/DD. He provides a statistical overview on abuse and mistreatment. Next he defines ACEs. Finally the author suggests symptoms to be aware of and considerations for long term impact of ACEs on folks.

**\*Mohring, K, Shauger, M, Mitchell, M, Shuler, K, Umholtz, E, Potts, K & Stratton, E. (2012). *Adapted dialectical behavior***

 ***therapy*. Conference presentation, Ann Arbor, Michigan.**

 This presentation outlines a justification and overview of an adapted DBT program for individuals with intellectual

disabilities.

**Morrissey, Audrey & Valilla, Nikki (2017). *Teen prostitution vs. commercially sexually exploited child*. My**

 **Life My Choice, A Program of the Justice Resource Institute.**

This PPT discusses sexual exploitation of children. It provides an overview of risk factors, patterns of behavior, coercion and the traumatic reaction that ensues, including the apparent paradoxical impact of resistance to service and mistrust of those trying to intervene. A sobering overview of this national problem.

**Nahme-Huang, Larke (February 2015). *SAMHSA’s comprehensive public health approach to addressing***

 ***trauma*. NASADAD Webinar: NTN ROSC, WSN ROSC, WSN Trauma Workgroup.**

This PPT provides a thorough overview of SAMHSA’s approach and strategies for creating public health approaches to trauma. It advocates a public-private partnership and using common language, hence common understanding of trauma and its impact on people.

**National Council for Community Behavioral Healthcare (2011). Is your organization trauma-informed? Trauma-informed**

 **care: changing cultures, improving practice, transforming lives.**

This PPT covers a gamut of constructs on trauma, trauma-informed care, organizational commintment, principles of care etc. Gleaned from a workshop, several presenters, across various organizations discuss trauma-informed topics and relate them back to their work. A nice overview!

**Paley, Lara. *Trauma and the brain*. Mental and emotional health program: The Center for Systems**

 **Change.**

This PPT provides a brief description of the effect of trauma on individuals. It discusses the body and brain’s reaction to trauma and how they impact trauma treatment. This is a nice overview of the mechanics of trauma on people who have experienced trauma.

**Reynolds, Barbara. *Crisis and emergency risk communication*. Center for Public Health Preparedness, University at Albany,**

 **Albany, NY.**

This PPT briefly outlines approaches to communicating crisis information to a larger population as well as engaging the victims of a crisis in approach and support, and empathy. Focus is in keeping the crisis contained and people feeling supported in real time. Myths and erroneous communicative strategies are identified.

**Center of Health Care Strategies, Inc. Implementing trauma-informed care into organizational culture and practice.**

This PPT describes the importance of creating an organizational culture supporting of implementing trauma-informed services to constituents. It then provides sample models of two large hospital efforts to transform care and service by adopting a TIC approach to practice.

***Positive Psychology***

**Arnold, John (March 2014) *The practices of forgiveness and gratitude in successfully navigating systemic***

 ***change*. SCEAPA Conference.**

The author discusses the constructs of forgiveness and gratitude from a positive psychology perspective. Next the author discusses the implications of these from both an organizational as well as individual perspective. Finally, the author offers some practice skills that can be used to acquire, practice and maintain forgiveness and gratitude.

**Hale, William. *The power of gratitude*. Glenbeigh Hospital.**

This PPT considers gratitude from a religious, spititual and pragmatic cbasis. Defining the term in context to Western and Eastern philosophies, religion and positive psychology the author next turns to giving meaning to gratitude in everday day life. There are some practical recommendations, but this is a largely theoretical look at gratitude and its impact on people.

**Sanford, Lynn (2017). Children who act out their pain: Sexual behavior problems in children. Handout for Traumatic Stress**

 **Certificate Program, Trauma Center of Justice Resource Institute.**

This PPT provides an overview of outcomes secondary to sexual abuse exposure in children. It provides context for children’s behavior and briefly identifies treatment options from a typological context.

**Sharp, Timothy. *Building resilience: Using positive psychology to get through tough times*. The Happiness**

 **Institute.**

This PPT discusses resilience. It describes how resilience sustains people through challenging situations. Next it provides some basic strategies that can be applied to helping people acquire resilience and use the skills they’ve learned.

**Tomasulo, Dan (2010). *Dare to be happy: Positive psychology in practice*.** **tomasulo@att.net****. (two versions)**

The author provides a brief overview of trends and practice in positive psychology. He also provides vignettes of strategies that can be used with regard to simple meditation, positive supervision, and engagement.

***BOOKS (not for distribution)***

Duckworth, Angela (2016). *Grit: The power of passion and perseverance*. Scribner, New York.

Follette, Victoria M, Briere, John, Rozelle, Deborah, Hopper, James W & Rome, David I, Eds. (2015)

 *Mindfulness-Oriented Interventions for trauma: Integrating contemplative practices*. Guilford Press,

 New York.

\*Harvey, Karyn (2012) *Trauma-informed behavioral interventions: What works and what doesn’t.*

 American Association on Intellectual Disabilities, New York.

Herman, Judith (1997). *Trauma and recovery*. Basic Books, New York.

Kabat-Zinn, Jon 1994). *Wherever you go there you are: Mindfulness meditation in everyday life*.

 Hachette Books, New York.

Levine, Peter A (2010. *In an unspoken voice: How the body releases trauma and restores goodness*.

 North Atlantic Books, Berkeley, California.

Levine, Peter A. (2015). *Trauma and memory: Brain and body in a search for the living past*. North

 Atlantic Books, Berkeley, California.

McKay, Matthew, Wood, Jeffery C., Brantley, Jeffery (2007). *The dialectical behavior therapy skills*

 *workbook: Practical DBT exercises for learning mindfulness, interpersonal effectiveness, emotion*

 *regulation & distress tolerance*. New Harbinger Publications, Inc., Oakland, California.

Shapiro, Francine & Silk, Margot (2016) *EMDR: The breakthrough therapy for overcoming anxiety, stress,*

 *and trauma*. Basic Books, New York

Stahl, Bob, Meleo-Meyer, Florence & Koerbel, Lynn (2014). *A mindfulness-based stress reduction*

 *workbook for anxiety*. New Harbinger Publications, Inc., Oakland, California.

Van der Kolk, Bessel (2014). *The body keeps the score: Brain, mind and body in the healing of trauma*.

 Penguin Books, New York.

**TRAUMA RELATED MISCELLANEOUS:**

**Questionnaire/Scale materials with support information:**

1. *Adverse Childhood Experience (ACE) Questionnaire*--- Felitti, et al
2. *Attributional Style Questionnaire (ASQ)*--- Petersen, C, et al
3. *Mindful Attention Awareness Scale (MAAS) trait version*--- Brown, KW, et al
4. *The Oxford Happiness Questionnaire*--- Hills &Argyle
5. *PLC-5 with LEC-5 and Criterion A* (Post-traumatic Stress Disorder Checklist)--- Weathers, et al
6. *PCL-C* (Post-traumatic Stress Disorder Checklist) Civilian version --- Weathers, et al
7. *Recent Stressors Questionnaire*--- Lauren Charlot
8. *The Satisfaction with Life Scale* ---Ed Dernier
9. *Short Grit Scale*---Duckworth & Quinn
10. *Traumatic* Antecedent Questionnaire
11. *Multidimensional Trauma Recover and Resiliency Interview (MTRR1: Short form)---* Harvey, et al
12. *The Maslach Burnout Inventory Manual* --- Maslach, Christina, et al
13. *Impact of Event Scale Revised for People with Intellectual Disabilities (IES*-ID)
14. *Trauma Informed Individualized Safety Plan* --- have to find attribution work sheet

**Treating Trauma Materials:**

1. \*Braastad, Jim *Using Motivational Interviewing techniques in SMART Recovery*
2. Copeland, Mary Ellen (1995-2005). What is a WRAP?: Wellness recovery action plan. The University of Kansas, School

 of Social Work, Lawrence, KS.

1. \*Harvey, Karyn. (2014) *Trauma-informed behavioral interventions with individuals with intellectual disabilities*.
2. American Association of Intellectual and Developmental Disabilities.
3. \*Harvey, Karyn work sheets:
	1. My Goodbye Book
	2. My Book About Myself
	3. My Book About Solving My Problem
	4. Happiness Assessment
	5. Behavior Planning Template
	6. Psychological needs Survey
4. Kabat-Zinn, Jon, (Original author). Revised and edited: Santorelli, Saki F., Meleo-Meyer, Florence

 & Koerbel, Lynn (2017) *Mindfulness-Based Stress Reductions (MBSR) Authorized Curriculum*

 *Guide*. Center for Mindfulness, UMASS Medical School.

1. \*Marcal, Stephen and Trifoso, Shawn (2017) *Trauma-Informed Toolkit for Providers in the Field of Intellectual and*

 *Developmental Disabilities*. Center for Disability Services.

1. Fralich, Terry (2017). *2-Day: Mindfulness Course: Mindfulness and Psychotherapy*. PESI handouts.
2. *A practical guide for creating trauma-informed disability, domestic violence and sexual assault organizations*. (2011).
3. *Wisconsin’s Violence Against Women with Disabilities and Deaf Women Project*. Disability Rights Wisconsin,

 Wisconsin Coalition Against Domestic Violence, and Wisconsin Coalition Against Sexual Assault.

1. Vicarious Trauma Toolkit. Office of Victims of Crime, Dept. of Justice and Northeastern University.
2. *Transforming psychological trauma: A knowledge and skills framework for the Scottish Workforce*. NHS Education

 for Scotland, Scottish Government, gov.scot.

1. CARDEA Connection Project (2016). *A guide to trauma-informed sex education*. CARDEA Training, Organizational

 Development and Research.

1. Perry, BD, MD, PhD (2002). Helping traumatized children: A brief overview for caregivers. *The ChildTrauma*

 *Academy*, Caregiver Education Series

***Trauma-Informed Self-*Assessment *guides/worksheets***

Fallot, Roger D & Harris, Maxine (2011). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning

 protocol. Community Connections, Washington DC.

Guide to completing the agency sel-assessment. Adapted from Fallot and Harris.

Is your work trauma-informed? A self-assessment tool. Klinic Community Health Center at <http://www.klinic.mb.ca>

**Trauma-Informed Definitions-Policy & Practice-Implementation:**

Huckshorn, Kevin Ann (2006). *Six core strategies for reducing seclusion and restraint use*. National

 Association of State Mental Health Program Directors ( a policy guide).

National Child Traumatic Stress Network. *What is complex trauma? A resource guide for youth and*

 *those who care about them*. SAMHSA, US Dept. of Health and Human Services. (resource guide)

\*Saunders, Kylie (2008). *Attachment and trauma in people with intellectual disabilities*. Positive Solutions

 Practice, Office of the Senior Practitioner, Australia. (informational)

Wellbank, Kathy. *Incorporating the sanctuary model at interim house*. (brief)

*Trauma-Informed Initiatives.* Frontline Initiative of NADSP (newsletter)

Menschner, C & Maul, A. *Key ingredients for successful trauma-informed care implementation*. Center

 for Health Care Strategies.

*SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach.* July 2014.

*SAMHSA’s Trauma-Informed Care in Behavioral Health Services – TIP 57*. 2014

\*Baladerian, Nora J, Coleman, Thomas F & Stream, Jim (2013). *Abuse of people with disabilities: Victims and their families speak*

 *out*. A report on the 2012 National Survey on Abuse of People with Disabilities, Spectrum Institute.

American Institutes for Research, WestEd & Justice Resource Institute (2013). *Practice guidelines for the delivery of trauma-*

 *informed and GLBTQ culturally-competent care*.

\*Edwards, Anna (2014). *Motivational Interviewing: Practice guide for practitioners who support people with disability*. Family &

 Community Services, NSW Government.

\*Dykstra, Eric J & Charlton, Margaret (2003, revised 2017). *Dialectical behavior therapy skills training: Adapted for special*

 *populations*. Developmental Enhancement, PLC & Aurora Mental Health Center.

Mindful Awareness Stabilization Training. *Mindfulness and the window of tolerance*. St. Michael’s Hospital.

SAMSHA Spotlight: A series on building resilient and trauma-informed communities. (with sample community projects).

**\*TEXAS Department of Aging and Disability Services: Mental Health Wellness for Individuals with Intellectual and Developmental Disabilities (MHW-IDD) Training Course *---Free on line:***

*Handouts from completed series*

1. Co-occurring Disorders: Intellectual and Developmental Disabilities and Mental Illness (with Andrea Caoili, Systematic, Therapeutic, Assessment, Resources and Treatment (START)
2. Trauma Informed Care Module (with Karyn Harvey).
3. Functional Behavioral Assessment and Positive Behavior Supports Module (with Karen Weisler, START)
4. Genetics Module (Lauren Charlot, advisory board of START)
5. Medical Module (Lauren Charlot, advisory board of START)
6. Putting it All Together (Joan Beasley, START)

***Trauma –Informed / Trauma Treatment Resources***

<http://www.traumacenter.org/> - have a library of articles

<http://childtrauma.org/> -have a library of articles

<https://www.nasmhpd.org/>

<https://www.samhsa.gov/nctic>

<http://www.nctsnet.org/>

<https://www.samhsa.gov/recovery>

<https://tfcbt.musc.edu/>

<https://www.crisisprevention.com/>

<https://aaidd.org>

<https://thenadd.org>

<http://ddslearning.com/the-body-keeps-score/> Bessel A. van der Kolk

***Local resources:***

<https://www.csoinc.org/> -links to other resources from heating asst./to applications for services

<http://www.briencenter.org/-> links to services offered by the Brien Center, including AA/NA etc

<http://berkshirecoalition.org/local-resources/> - suicide prevention

<http://www.westernmassrlc.org/helpful-links-to-other-websites> - links to other resources

<https://www.psychologytoday.com/us/groups/ma/pittsfield> - all sorts of local and regional support group listings

<http://namibc.org/-> Local NAMI

<https://disabilityinfo.org/records/nami-berkshire-county/>

<http://www.esbci.org/programs_and_services/alzheimer_resources.html-> Alzheimer resources and support group listings

<http://berkshirechildren.org/events/> -parenting and child resources in Berkshires

<http://massfamilyties.org/pdf/Western%20Support%20Groups%202017.pdf> –listing of several support groups and schedule

[http://www.berkshireeagle.com/stories/support-groups,504474](http://www.berkshireeagle.com/stories/support-groups%2C504474) –listing of several support groups

<http://www.postpartum.net/locations/massachusetts/> -new mothers support group/resource information

<http://berkshirecoalition.org/local-suicide-loss-resources/> suicide prevention and family support

<http://berkshirestonewall.org/resources/> listing of support groups

<http://www.affirmativecounseling.net/liveoutloudyouthgroup.html-> LGBTQ youth

<https://rainbowseniors.org/> LGBTQ

<https://www.sec.state.ma.us/acp/acpresources/western-region.htm> Lots of information locally

<http://berkshirechildren.org/event/live-loud-youth-project-lgbtq-group/> LGBTQ youth/young adult

<https://www.psychologytoday.com/us/therapists/ma/berkshire-county> - resource guide to registered therapists, psychologists, counselors

<https://www.psychologytoday.com/us/therapists/child-or-adolescent/ma/berkshire-county> - children’s therapists, psychologists, counselors

<https://www.psychologytoday.com/us/therapists/trauma-and-ptsd/ma/berkshire-county> - trauma specialty

<https://www.yellowpages.com/pittsfield-ma/psychologists-> Pittsfield

<http://berkshirepsychiatrists.com/> - local psychiatry- behavioral health and private practice

<https://kripalu.org/>

<https://www.psychologytoday.com/us/groups/mindfulness-based-mbct/ma/berkshire-county>

<https://www.psychologytoday.com/us/therapists/mindfulness-based-mbct/ma/berkshire-county>

<http://mindfulberkshires.com/contact.html>

[http://www.berkshireeagle.com/stories/support-groups,525523](http://www.berkshireeagle.com/stories/support-groups%2C525523) – Nov 2017 Berkshire Eagle

<https://learning-in-action.williams.edu/files/self_support.pdf> -

[**https://www.bcarc.org/programs/dsfg/**](https://www.bcarc.org/programs/dsfg/) **- Down syndrome family group**

<https://hcib.org/bereavement-services/> - Hospice

<http://ucpberkshire.org/programs/caregiver-support-group/> - UCP

<http://berkshirecoalition.org/local-suicide-loss-resources/>

<http://www.berkshirenonprofits.com/agency_list.php>

<https://childrensemotionalhealth.org/> - Western Ma Training Consortium

<https://www.berkshirenursingfamilies.org/weekly-groups/>

<http://berkshireic.com/community-resources/>

***STATE EOHHS Agencies***

Department of Developmental Services <https://www.mass.gov/orgs/department-of-developmental-services>

Berkshire Service Group

Department of Children & Families <https://www.mass.gov/orgs/massachusetts-department-of-children-families>

Elder Services https:// [www.esbci.org/](http://www.esbci.org/)

MASS Commission for the Blind <https://www.mass.gov/orgs/massachusetts-commission-for-the-blind>

MASS Commission for Deaf & Hard of Hearing [www.mass.gov/eohhs/gov/departments/mcdhh/](http://www.mass.gov/eohhs/gov/departments/mcdhh/)

MASS Rehab Commission <https://www.mass.gov/orgs/massachusetts-rehabilitation-commission>

Mental Health Association, Inc <https://www.mhainc.org/>

***ID/DD Service Agencies in Berkshires***

AD LIB, Inc <https://www.adlibcil.org/>

Viability/ Project AIM <https://viability.org/>

Pathlight <https://pathlightgroup.org/>

Autism Connections <https://pathlightgroup.org/programs-and-services/autism-connections/>

Baroco Corporation <https://www.baroco.com/>

Berkshire County ARC <https://bcarc.org/>

BFAIR <https://bfair.org>

Berkshire Meadows <https://jri.org/>

Community Strategies <https://crj.org>

Cadmus Lifesharing Association <http://www.cadmuslife.org/>

Alliance for Special Needs

Leander House <https://leanderhouse.org>

Goodwill Industries of Berkshire Co <https://www.goodwill-berkshires.com/>

Guidewire Inc <https://guidewireinc.org/>

ServiceNet <https://www.servicenet.org/>

Nonotuck Resource Associates <https://www.nonotuck.com/>

Riverbrook School <https://riverbrook.org/>

United Cerebral Palsy <https://ucpberkshire.org/>

Stanton Home <https://stantonhome.org/>

Oakdale Foundation <https://oakdalefoundation.org/>