Optimizing Resilience Through a Trauma-Informed Approach *for* Adolescent Sexual Health

Joann Schladale, MS, LMFT
Brittany Howell-Abbate, LPCC

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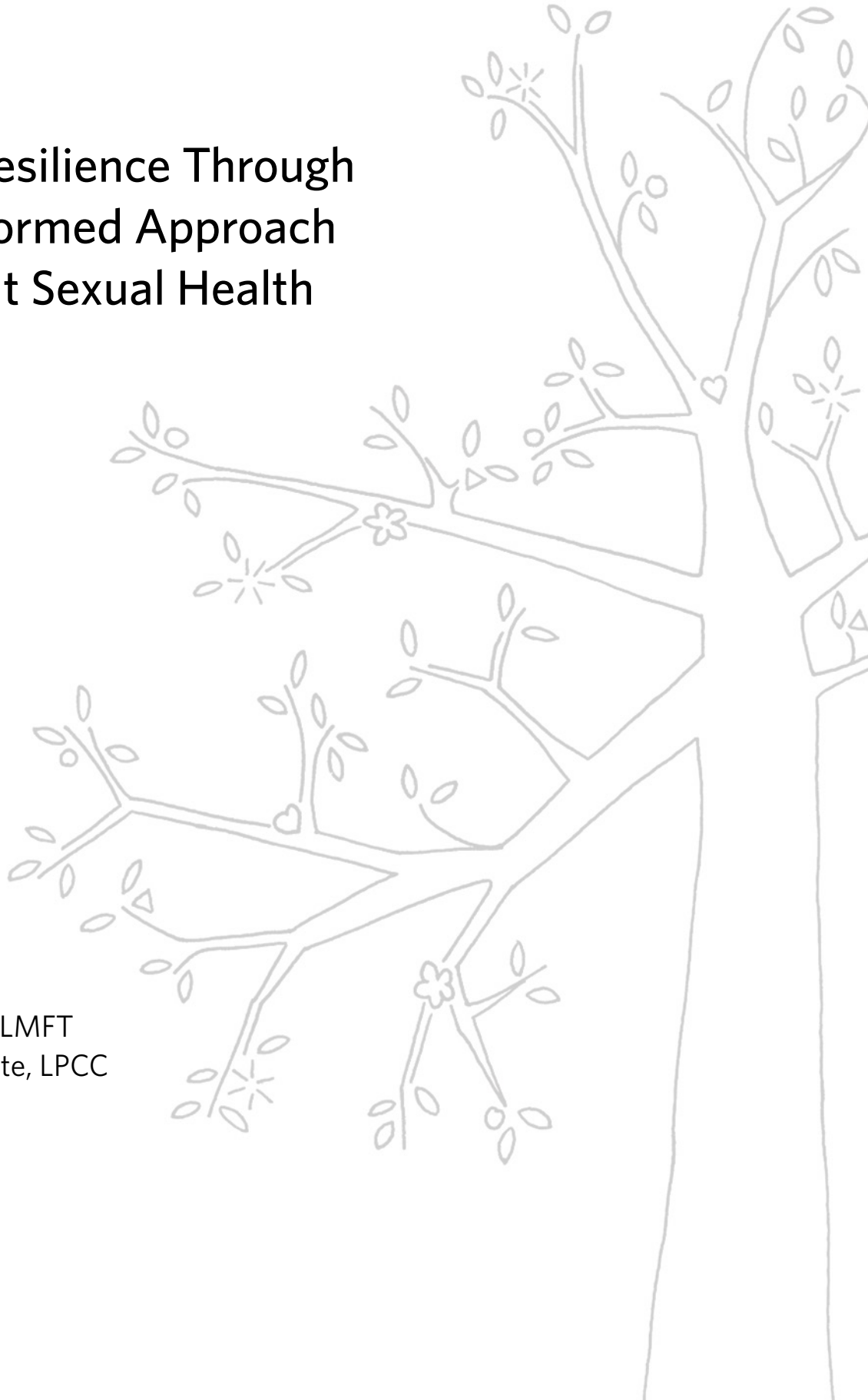

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Such action advances all of our work.

Practice Self-Regulation™
A Trauma-Informed Approach for Health and Well Being

Design by Wendy Clark Design, Freeport, ME wendyclarkdesign.com
Tree Illustration by Maureen Boucher, Brooklyn, NY.

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Introduction

The United States has many evidence-informed sexual health curricula that successfully educate young people, delay sexual activity, reduce the frequency of sexual intercourse, and prevent sexually transmitted infections and disease. Even with such excellent information some young people remain sexually vulnerable in a variety ways. In order to enhance sexual health and well being for everyone it is essential that young people receive accurate sexual health information and additional resources that promote healthy sexual decision-making.

Sex education doesn't ensure abstinence, pregnancy prevention, or protection from infection, disease, and harm. Many young people who have received accurate sex education continue to place themselves at risk of harm and pregnancy. Life experiences greatly influence choices about sexual health and well being. Trauma greatly impacts decisions young people make about sexual expression. Youth in foster care are 71% more likely to experience unplanned pregnancy than are other teens (Love, McIntosh, Rosst, & Tertzakian, 2005). Many youth who have experienced trauma are not involved in child welfare and do not receive trauma-informed services that could greatly enhance resilience and sexual decision making.

Sexual responses to trauma can be managed and turned into coping skills that promote healthy sexual decision making for all youth, not just those involved in social services. In addition to youth involved in child welfare and juvenile justice, young people with intellectual disabilities, those growing up in poverty, some adopted children, non-English speaking young people, undocumented immigrants, lesbian, gay, bi-sexual, transgender and questioning youth, and pregnant and parenting teens require unique consideration in prevention efforts.

Trauma is a deeply distressing or disturbing experience that has a lasting effect on a person's life.

Supporting these teens involves a range of challenges for service providers, parents and guardians. Tasks include engaging young people in ways that motivate them to heal unresolved pain and maintain healthy relationships. These efforts require knowledge about trauma and a clearly defined, structured approach to promote sexual health and well being. Doing so involves integrating research on child development, medically accurate sexual health information, trauma, resilience, competency development, and self-regulation. All of which are addressed throughout this document.

It is also important to involve parents or guardians in this effort. Core approaches to all evidence-based practices for child physical and sexual abuse recommend prioritizing work with caregivers (Saunders, Berliner & Hanson, 2004). A resilience-based trauma-informed approach for sexual health and well being can provide tools for service providers, parents and youth that promote both individual and community safety. Support can be provided in a variety of ways that include training professionals to provide private and/or group discussions, and/or therapy referrals when indicated for youth and their parents or guardians.

The purpose of this document is to provide information that promotes resilience and sexual health through medically accurate, neuroscience-based, trauma-informed services for all young people.

Information is organized in the following ways:

1. Promoting sexual health through optimal development and medically accurate sex education
2. Addressing individual uniqueness
3. Understanding resilience-based, trauma-informed service delivery
4. Practicing effective strategies for implementation

Healthy sexual decision making is a thoughtful and planned approach to behaving sexually that promotes the health and well being of anyone involved. It is behavior that reflects the World Health Organization's definition of sexual health.

This information is vital to understanding how life experiences influence sexual decision making. It promotes life long sexual health and well being to diminish obstacles young people may face as they mature and develop sexually.

Before considering a trauma-informed approach for adolescent sexual health it is important to establish a generally agreed upon foundation for all sexual health to use as a baseline for service delivery.

A resilience-based, trauma-informed, inclusive, and intersectional approach for adolescent sexual health promotion involves ensuring equitable, respectful, and engaging participation in which everyone is treated with thoughtful consideration of all life experiences that influence and potentially challenge health and well-being.

Sexual Health

- **Sexual health** is "a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity.
- Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.
- For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." (World Health Organization, who.int/health-topics/sexual-health)

This explanation of sexual health describes an experience of health and well being based on human rights for everyone. Sexual development, like all other elements of human development, involves physical, cognitive, emotional, social and moral maturation processes. It is complex and potentially confusing not only for children but parents and service providers who may not have accurate information to share.

Ultimately, sexual health is a foundation for experiencing and celebrating sexuality. Yes, celebrating sexuality! When children and youth learn about sexuality as a component of positive youth development, embarrassment and shame are diminished as they learn to understand and appreciate their bodies without negative connotations. Everyone can learn to celebrate sexuality through education and support that embraces pro-social cultural values, personal safety, and boundaries.

Healthy Development

How children are brought up greatly impacts the rest of their lives. Research reveals very important information about what promotes life-long health and well being. The National Research Council and Institute of Medicine (2001) identifies elements of optimum child development. They are:

- Physical and psychological safety
- Appropriate structure
- Supportive relationships
- Opportunities to belong
- Positive social norms
- Support for efficacy and mattering
- Opportunities for skill building
- Integration of family, school and community efforts

Physical and Psychological Safety

Safety and stability are the foundation for both secure attachment, and for managing adversity. In order to thrive, young children must have a stable and secure base from which to explore life. When this occurs, children learn to take calculated risks, and to know they can rely on their caregivers, to provide

comfort, care, and wise council as needed.

Secure attachment comes from the experience of both physical and psychological safety. When physical safety is threatened, psychological safety is too. Yet people can be physically safe while feeling unsafe emotionally.

Physical safety is the condition of being protected from harm. **Psychological safety** is an emotional experience of feeling safe and protected from harm.

Physical safety is easier to identify than emotional safety. Assessing a youth's physical proximity to danger indicates their level of physical safety. After children witness violence, they can be in a physically safe environment while feeling psychologically unsafe. This is why children removed from violent situations often exhibit symptoms influenced by violence long after it has stopped (Groves, 2004; Kagan, 2004; Stein & Kendall, 2004).

When children grow up feeling safe, secure and respected they thrive. When bad things happen and adults respond with care and compassion and adequate services (if necessary) children continue to thrive.

Appropriate Structure

Appropriate structure for children can be a challenge to provide when parents are overworked, underpaid, and required to do more with less in order to provide adequately for their families. Providing elements of optimum child development requires creativity on the parts of parents and community organizations in order to best meet the needs of all children.

Some children have too little structure in their lives. This can result in boredom, lack of energy, restlessness and insecurity. Statistics indicating the amount of television American children watch in comparison to children in other countries indicates a frightening lack of structure. Too much structure, or too little structure causes problems in the lives of children. Finding a balance sometimes flies in the face of cultural expectations.

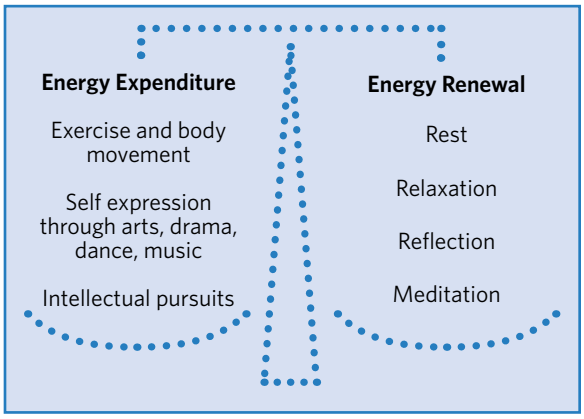
Appropriate structure is ideal organization of a child's daily life. It involves predictable daily activities and timetables allowing for periods of activity and rest that promote physical and emotional growth.

Conversely, many children are over structured in their daily activities. Parents may feel pressure to maintain a fast paced lifestyle for all family members. Youth may be so over scheduled with extra-curricular activities that they have little time for rest, reflection, and/or solitude throughout the day (all of which are known to contribute to health and well being). When adults are over scheduled, they can often do something about it. Children can't, and may be shuttled from activity to activity with little consideration for what best meets their needs.

Reggie, 14, is in the 8th grade and is diagnosed with attention problems and autism. Even though Reggie takes medication and is receiving home-based therapy, their symptoms are not decreasing. Reggie's mom continually gives Reggie consequences when their inability to focus causes them to get behind in schoolwork and misbehave. Reggie's mom is unwilling to help with homework or provide more supervision. She stated that she does not want Reggie to become dependent on medication. She believes Reggie has to learn how to behave now without extra support so they can control their emotions and ability ot focus as an adult.

Problems can also occur when parents have unrealistic expectations for structure that do not meet a child's unique needs. For example, punishing a child with attention problems, when they do not sit still and follow rules and have no medication or behavioral plan sets everyone up for failure. All structure should be developmentally appropriate and include predictable routine.

> "There's more to balance than not falling over."
>
> — Chinese Proverb



All human beings need both activity and rest. What does this mean? Appropriate structure is different for children based on their personality and needs. It includes quiet time, rest, and solitude in addition to learning, social activities, and body movement. Uri Bronfenbrenner, a world famous specialist in child development was known to have said that play is children's work. Both structured and unstructured play help children learn, explore, create, fantasize, develop competencies, and build self-esteem and autonomy.

Kids should get a good night's sleep of at least eight hours, eat nutritious food, exercise regularly, have quiet time, and time for learning in a variety of ways through schoolwork and play. Make sure everyone has lots of time for a balance of activity and rest. Adults need this too.

It's important that everyone has lots of time for a balance of activity and rest. When everyone gets these needs met everyone feels better and gets along better.

Supportive Relationships

Research from the Centers for Disease Control and Prevention (Thornton, Craft, Dahlberg, Lynch, & Baer, 2002) shows that supportive relationships promote optimum development and prevent harm. Supportive relationships promote secure attachment and restore safety and security when attachments have been

harmed or broken. All adults share responsibility for providing supportive relationships in every child's life. These may involve parents, siblings, extended family, neighbors, coaches, clergy, school personnel, community mentors, and peers.

Supportive relationships are simply connections with others that promote optimum growth, health and well-being.

Research indicates that optimal child development includes at least three consistent people in a child's life to provide long-term unconditional support. Paid professionals do not fulfill this role as children age out of youth services if, and when they transition into adult services.

Opportunities to Belong

Opportunities to belong provide a sense of positive connection necessary for children to become responsible and productive community members. Connectedness, or belonging, promotes resilience.

Opportunities to belong are activities that make it possible for a child to develop a sense of connection and fitting in with a positive group or community.

The first connection children have is to their family. Becoming a family member is their first opportunity to develop attachment, self-esteem, and emotional and physical safety.

Adults must be sensitive to the needs of children and encourage opportunities for participation in cooperative activities. Such activities promote self-esteem and well being. When children are shy, socially awkward, or suffer from disorders of attachment, they are more likely to feel left out or isolated, especially in settings outside their own homes. Such activities can be as simple as regularly scheduled story time, eating meals together, and participating in community activities that extend a child's social network and promote acceptance of differences.

When children are bullies, or being bullied they too are at risk of not fitting in. All youth who perceive themselves as different from others may feel vulnerable when trying to establish a sense of belonging. Some, such as children with disabilities and young people identifying as lesbian, gay, bi-sexual, or transgendered are even more at risk of being rejected, harassed or the victims of hate crimes.

Resilience is the ability to bounce back after something bad happens.

Everyone needs human connection and a sense of belonging or

fitting in. Adults should make children feel welcome and valued wherever and whoever they are. Adults should also encourage all children to be more inclusive and supportive of one another.

Positive Social Norms

Positive social norms are how society expects people to act and get along. Such behavior promotes respect and law-abiding behavior.

Positive social norms are what make societies work. While many adults talk about pro-social beliefs, their behavior may not always reflect such values. Differences between personal values and ways people act can give children unintended mixed messages.

Adults cause confusion by claiming to promote respect while modeling subtle anti-social behavior such as revenge, racism, sexism, or general disregard for others, or the environment. When parents smoke, or abuse substances and complain when their teenagers do the same, young people feel unjustly accused and may view the adults as hypocrites.

positive social norms hold adults responsible for good behavior so we are good role models. This is no small task! It's hard to be good all the time, especially when we're going through tough times or just having a bad day.

Support for Efficacy and Mattering

Human beings need to know they are good at something and that others notice these skills. This concept promotes good decision-making, competence, and confidence. When children are encouraged and supported in using their own resources to solve life challenges they learn to be responsible, work with others, and take good care of themselves.

Efficacy is an ability to make things happen. **Mattering** is the understanding that something is important. **Support for efficacy and mattering** is a youth's understanding that they are important and can impact change.

Such support helps self-esteem blossom. An example of mattering is giving children age-appropriate responsibilities such as picking up after themselves, feeding a family pet, or other household chores. Focusing on natural consequences rather than punishment when kids mess up can go a long way in showing children efficacy and mattering.

Letting children know they matter, and have value, even when they make mistakes or cause harm is extremely important. It allows them to know they can get support when they mess up and obtain guidance to prevent the problem from happening again.

Sometimes adults don't want to do this, particularly if they are hurt or angry about the youth's behavior. Modeling patience and tolerance can go a long way in promoting optimum development.

Opportunities for Skill Building

Human beings continually develop skills throughout life. An easy example is learning mathematics. Mastery of addition, subtraction, multiplication and division is a foundation for successfully learning more advanced subjects such as algebra, geometry, and calculus.

It is important for children to develop skills based on physical and emotional maturity. Trying to teach an average five-year-old calculus usually far exceeds a youngster's ability to master such advanced math. Conversely, holding children back and inhibiting development of very simple, yet important skills like setting an alarm clock and getting up for school on time, can cause problems with development.

Skill building is competency development.

In addition to developmentally inappropriate tasks, children who are asked to simply do too much or too little can also become overwhelmed and unable to move forward with normal developmental tasks. Overload occurs when children are expected to perform too many tasks or those that are too advanced for their ability. Under load occurs when they are required to do too little. Either way causes problems with development.

Children thrive when they learn new developmentally congruent skills. Give them lots of opportunities to do so, support their hard work through mentoring and monitoring their progress, and provide corrective feedback when necessary.

Integration of Family, School and Community Efforts

This element of optimum child development highlights the importance of collaboration between everyone involved in a child's life. Interaction among these systems promotes consistent and clear expectations for success. They are important in teaching children how all parts of life are interrelated. Providing consistent messages about expectations for behavior can reduce mixed

Integration of family, school and community efforts is effective coordination of activities among all parts of a child's life in order to optimize health and well being.

messages that cause confusion and prevent optimum development.

These elements of optimum child development provide a baseline for understanding and addressing the needs of all children.

All elements of optimum development take into consideration each child's unique cultural experiences. Culture plays a tremendous role in development. Sexual health is influenced by where a child grows up, their race, ethnicity, religion, socio-economic status, and family make-up. All of these categories create a complex web of influence on every child's personal growth.

Peer relationships are particularly important for adolescents and can greatly influence development. Young people often rely heavily on the relationships they make with those they feel most connected to. Such relationships often begin in school and community activities. Friendships are vital to sexual health when they are a source of information and opinion that influence decision making. Modeling and encouraging teens to develop respectful and supportive friendships can enhance a sense of belonging across all areas of their lives.

Maurice, a father of two young children, lives in an urban neighborhood with families having a range of income levels. He met a lot of children and families who his children interact with at school and in the local park. Many parents traveled some distance out of the neighborhood to access summer enrichment programs for their children. Parents with fewer resources were less able to obtain summer programs for their children. Maurice contacted people at a local university with facilities that were unused most of the summer. With minimal effort, he convinced the university to provide space for the positive development of local youth that could have long-term impact on the community. Maurice worked with the university to organize a summer program for recreation, academic, and arts enrichment. What an unsung hero Maurice is for those youth and families!

Children's lives should easily flow between their family, school and community life. If there are struggles in any, or all areas, act fast to get them back in sync. This may involve parents addressing concerns at school or in the community, or professionals addressing concerns in any setting.

Developmental Categories

While it is important to know the eight areas of optimum child development and what adults can do to enhance a child's growth, it is also important to understand that biologically child development is a very complex process. Children develop physiologically, cognitively, emotionally, socially, and morally. Such development does not necessarily occur in a step-wise fashion, varies greatly among all children, and does not necessarily occur in all categories for a variety of reasons.

These developmental categories greatly influence a young person's sexual decision making. Onset of puberty plays a big role in physiological development and physical maturation. Hormonal changes (a part of physiological development) can also impact both cognition and emotional development.

Physiology is all the ways body parts function. **Cognition** refers to brain processing that has to do with thinking, reasoning, and remembering. **Emotion** is brain processing that has to do with feelings. **Social skills** involve interactions with others. **Moral development** is a person's ability to make good decisions based on a desire to do the right thing.

Cognitive development involves childhood changes from concrete thinking to abstract reasoning. When a child experiences optimum development their brain maturation enables them to understand things of a more complex nature than when they were little. This is why children learn word problems that help them use numbers in a more meaningful way such as paying for their lunch in the school cafeteria, or later on figuring out a menstrual cycle. When young people learn human biology and understand their reproduction systems, it is critical that they then learn how their biological system plays such an important part in relationships, especially sexual relationships.

Like cognition, emotional development is critical to sexual decision making. As children learn to think more complexly they also learn how complicated emotions can be. A commitment to sexual health can be really hard to develop and maintain when hormones and life experiences are causing a great deal of confusion for a young person. When adolescents learn to think clearly and pay attention to the range of emotions that influence sexual decisions they can learn to control their behavior in a way that promotes health and prevents harm to self and/or others.

Social development is critical for building interpersonal skills that influence a youth's interactions and

sense of belonging and fitting in. When young people are surrounded by supportive adults and other teens who treat each other with respect and warm regard social skills develop and can be practiced consistently. Youngsters then develop an ability to withstand peer pressure that is vital for sexual decision making and self-protection. They can also learn to celebrate their sexuality in a way that is congruent with their values and beliefs and reinforces optimum sexual decision making.

Finally, moral development plays a huge part in sexual decision making! Making the right decision for the right reasons can be quite challenging especially when the human brain sometimes does not develop moral reasoning until a young person is in their early 20's. People make sexual decisions for a variety of reasons it is darn near impossible to figure out every element of motivation occurring as a young person decides to express their sexuality.

Sex Education

Sex education is a controversial topic in the United States but it doesn't have to be. Most western industrial countries promote sexual health for children through comprehensive sex education for everyone. Some people fear that sex education will result in early onset of sexual intercourse.* The Sexuality Information and Education Council of the United States (SIECUS) reports that, "strong evidence suggests that comprehensive approaches to sex education help young people both to withstand the pressures to have sex too soon and to have healthy, responsible and mutually protective relationships when they do become sexually active" (SIECUS, 2010, Page 1). According to the Guttmacher Institute, sex education, and more specifically contraceptive use, are known to effectively delay onset of sexual intercourse, prevent unplanned teen pregnancy and sexually transmitted infections and diseases (Boonstra, 2010). As a matter of fact, viewing a lot of sexual content on television is more likely than sex education to increase initiation of sexual activity (Chandra, Martino, Collin, Elliott, Berry, Kanouse, & Miu, 2008).

The United States has many organizations dedicated to promoting accurate sexual health information for everyone. Since much of it is web-based for easy access and free of charge, a list of resources is provided at the end of this document.

Sex education is a primary foundation for sexual health and well being and is addressed at length later in the document. As mentioned in the introduction, there are many evidence-informed sex education curricula that have been shown to be effective throughout many rigorous research studies. Most sex educa-

* yet that myth was proven to be false years ago

tion curricula were created for school classes, some are geared towards small groups for after school or church settings, and a few focus on individual meetings with behavioral health professionals.

Successful efforts to promote adolescent sexual health begin with optimum child development that includes accurate sexual health information. Unfortunately, not all children receive adequate care and concern to promote health and prevent harm. Those children require special consideration in a variety of ways that are highlighted in the next section.

Unique Populations

When youngsters have not experienced adequate development it is critical to provide them with research-based support that can reduce vulnerabilities caused by a range of challenges in life. According to research on teen pregnancy prevention unique populations include young people in foster care, youth involved in juvenile justice especially those who are incarcerated, homeless, and marginalized children (Brendis, 2011). Even when a sex positive approach is consistently provided all child serving organizations have a responsibility to address prevention of any sexual harm, unplanned and unwanted pregnancy, or disease.

After defining prevention, this section identifies unique elements of sexuality and prevention efforts relating to each one. This is important for identifying challenges in sexual development youth may face when they have unique needs and may have experienced trauma.

Prevention

Types of Prevention

Primary, or Universal: Public service efforts to keep harm from happening.

Secondary, or Selective: Efforts aimed towards vulnerable populations before harm occurs.

Tertiary, or Indicated: Interventions to stop harm from happening again, once it has occurred.

While promotion of sexual health and well being is at the core of optimum development, prevention is the key to managing trauma and recovery. At the primary, or universal level of prevention, public service efforts to keep harm from happening can include developmentally congruent sex education in all schools and also something as simple as smartphone applications such as Birdees Sex Ed App for Parents (Birdeesapp.com), which provides parents with accurate and practical information about childhood sexual development. Secondary, or selective prevention efforts geared towards vulnerable youth before harm occurs can involve a trauma-informed approach for sexual health that targets financially impoverished young people, youth in foster care, or those involved in juvenile justice (Schladale, 2010b). Tertiary, or indicated prevention efforts to reduce repeat pregnancies, eliminate infections or disease, or stop sexual harm from happening again, require a conscious effort to provide youth with accurate sexual health information that promotes affect regulation and pro-social decision making. It is unrealistic to think that vulnerable youth can successfully make good decisions without a solid foundation of sexual health education, information, and support.

Everyone's Not the Same

While sex education practitioners seldom have specialized training in providing a trauma-informed approach, a little information can often go a long way. All adults involved with teens can achieve compe-

tence in addressing the impact of trauma and develop confidence that comes through practice, support and good supervision.

Effectively providing a trauma-informed approach for adolescent sexual health is unique for each young person. What works for one individual may not work for another. Providing individualized services requires attention to the unique strengths and needs of each young person. Prevention efforts follow each area of uniqueness and the section on Effective Strategies addresses in-depth solutions.

Many young people who are vulnerable to early onset of sexual intercourse, unprotected sex, and/or sexual harm have experienced poverty, a disadvantaged family background, child abuse, sexual harm, exposure to substance abuse, interpersonal violence, academic struggles, and a lack of adequate health care. The most vulnerable youth are in foster care, incarcerated, homeless, or marginalized. A range of unique issues are described in order to help service providers gain greater understanding about challenges these youth face in their sexual decision making.

Culture

So many cultural issues impact sexual decision making it can be challenging to make sense of them all. Skin color plays a huge part. African American and Latino youth are disproportionately involved in poverty, child welfare, teen pregnancy, and the juvenile justice system. Ethnicity, nationality, tribal membership, or religious background, as well as political and religious beliefs, can also influence adolescent sexual health and well being.

Geography is an important component of cultural influence on sexuality. Availability and access to services varies depending on where a child lives. Typically cities offer more services than rural areas. Geography also reflects socio-economic status, or class. Wealthy people more often live in safer communities where vulnerabilities may be less visible. However, children in wealthier communities who have less parental supervision or structure in their lives may still engage in risk taking behaviors that promote harm to self and others. People with less money, who are more likely to be African American, Hispanic, and/or immigrants, are more likely to live in areas with higher incidence of teen pregnancies that may appear to be accepted as part of the community's culture.

Family values influence adolescent sexual health in a variety of ways. Personal values and beliefs about sex education, sexual violence and abuse, along with religious values and beliefs about sexual orientation, sexual intercourse, procreation, and abortion all greatly impact a young person's sexual deci-

sion making. When families demean children and/or promote violence to manage conflict, such as intimate partner violence, young people are likely to develop values and beliefs that promote harm. Such experiences also influence poor self-esteem and diminish a youth's capacity for self-protection both physically and emotionally.

Prevention Strategies

- **Primary prevention** is successfully accomplished when children are taught both sex education and respect for all living things. Parents, caregivers and all service providers can provide accurate information, promote acceptance, and model ways to embrace diversity. All child-serving settings can provide consistent messages about acceptance and tolerance. When adults provide both accurate sex education and enthusiastic messages about diversity and enrichment through cultural understanding everyone's life is improved.

- **Secondary prevention** strategies involve sex education and zero tolerance for any type of demeaning or discriminatory behavior. When adults witness such practices it is imperative that they respond immediately and effectively. Simply telling youth when behavior is offensive and that it will not be tolerated may be enough to stop it. All child serving settings are required to train staff to provide a culturally sensitive protective response whenever discrimination rears its ugly head. Adults who have a role in guiding children should closely consider the words and attitudes they use to communicate so they are promoting only respectful and kind messages. A list of suggested trauma-informed answers to a variety of questions about sexuality is provided in the appendix.

- **Tertiary prevention** requires competent intervention. Licensed mental health professionals are required to obtain continuing education on cultural competence. Therapeutic interventions should address sexual decision making in the context of a young person's life and day-to-day experiences. Supporting youth involves creating a safe and stable setting in which they can address experiences of discrimination in order to explore potential solutions for managing it without resorting to harm. Helping youth learn to embrace sexual health and well being enables them to decide how they want to promote meaningful cultural experiences as they create a vision for their future.

Violence and Aggression

Violence and aggression include a broad range of behavior. Types of violence involve, but are not limited to: bullying, harassment, cyberaggression, hazing, verbal abuse, emotional abuse, physical assault, sexual assault, destruction of property, arson, murder, self-harm and suicide. Additionally, violence includes anything that meets a criminal code in state and federal statutes. Individuals, groups or formal gangs

commit violence. Sometimes it is impulsive and sometimes it is planned, or premeditated.

Violence and aggression have a lot to do with adolescent sexual health and sexual decision making. Experiencing violence prevents optimum development and has the power to negatively impact and sometimes destroy self worth, competency development and confidence in a variety of ways.

In her book, Children Who See Too Much, Groves (2002) states exposure to violence, "includes being the direct victim of violence. It also includes seeing or hearing violence, or even knowing of its aftermath" (Groves, 2002, p. 19). Groves reports the following effects of witnessing violence on young children:

- Impulsive behavior
- Apathy and desensitization
- Less ability to sequence events in time, or to accurately establish a time frame
- Increased fragmentation of memories
- Anxious anticipation of violence happening again
- High levels of anxiety
- Pervasive pessimism
- Distorted self-appraisal
- Sense of foreshortened future
- Hyper arousal and chronic over activation of stress response
- Increase in aggressive and impulsive behavior
- Loss of newly acquired developmental skill
- Misattribution of events
- Use of disruption to avoid quiet
- Increased delinquency, antisocial behavior, substance abuse, mental illness
- Post Traumatic Stress Disorder
- Psychologically robs children of both parents
- Sense that there is no refuge
- Emotional numbness

Violence is the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation. World Health Organization (WHO)

Aggression is hostile behavior or attitude toward another implying a readiness to attack or confront. It is the action of attacking without provocation, especially in beginning a quarrel. It is forceful and sometimes overly assertive pursuit of one's aims or interests.

"Exposure to violence changes the landscape of childhood forever."

— Betsy McAlister Groves

These effects can greatly influence sexual development and sexual decision making. Apathy may cause a youth to not care about themself and not bother to use adequate protection. Increases in aggressive

Risk Factors for Youth Violence
(cdc.gov, 2024. injury center/violence prevention/youth violence/risk and protective factors)

- Diminished economic opportunities
- High levels of family disruption
- History of violent victimization and early aggressive behavior
- Individual, parent, or caregiver substance use
- Low parental involvement, attachment, education, and income
- Deficits in attention, learning, information processing, and social interaction
- Association with delinquent peers, gang involvement, or social rejection
- Academic and school struggles

and/or impulsive behavior can influence coercion and force or spontaneous decision making that might result in harm to self or others. Even when violence is not sexual in nature it influences physiological processes throughout the human biological system. This will be addressed in greater detail in the following section on trauma.

Research shows there are certain sexual values and beliefs that can influence sexual violence. They are:

- Showing hostility towards women
- Supporting myths about rape, such as victims ask for it, or enjoy it
- Hanging around others who agree with such myths
- Believing there is a lot of conflict between women and men
- Not caring about others, and their feelings
- Heavy drinking
- Casual attitudes about sex
- Having a lot of casual sexual relationships
- Experiencing violence and abuse as children (Abbey, 2005)

Violence reveals itself in so many ways. Some people harm others while some harm themselves. Violence can easily become a destructive habit. Sometimes it remains secret and other times it is exposed and hopefully stopped. Successful intervention creates lifelong change and alters a youth's future.

Prevention Strategies

- **Primary prevention** focuses on public education to prevent involvement in any type of violence. Optimum child development is also primary violence prevention.

- **Secondary prevention** identifies youth at risk of acting violently and directs specific efforts towards preventing such involvement. There are a huge variety of violence prevention programs for teens from school activities to church youth groups and community recreation centers for after school programming.

- **Tertiary prevention** aims to stop violence from reoccurring after any acts of harm towards self and/or others. The United States holds the dubious distinction of being the most violent industrial-

ized country on the planet. As a result this country has a tremendous range of services for youth involved in child welfare and juvenile justice. These include intensive home-based therapy, community mental health, and residential treatment services.

Gender

Teen pregnancy prevention has historically focused on female sexual decision making since young women are the ones who get pregnant and have primary responsibility for child rearing. Only recently has the United States begun to focus on the sexual health and well being of all teens. As mentioned previously, African American and Latino youth who are more likely to experience poverty, homelessness, and involvement in juvenile justice need accurate information and support about sexual decision making. When these teens feel hopeless and helpless about their future they may loose sight of how very important it is for them to learn to take good care of themselves and their dating partners.

Children of all genders may have similar childhood experiences, such as trauma and difficult family experiences that place them at risk of sexual harm. The impact of such experience greatly influences both their adult lives and the lives of their future children.

Prevention Strategies

- **Primary prevention** for all children occurs when they grow up in a stable, loving and nurturing environment as mentioned in the section on optimum child development. Teaching all children accurate sex education that is developmentally congruent is the most direct route to life long sexual health and well being.

- **Secondary prevention** for all children should focus on effective responses to early warning signs such as involvement in child welfare, bullying, negative temperament, and impulsivity. Addressing issues of trauma, victimization and the unique mental health needs of each youth promotes sexual health for these youth and future generations. Sexual health services for vulnerable youth should focus on the needs of all genders and gender identities.

- **Tertiary prevention** involves community-based mental health interventions for all young people. When young people experience early onset of sexual activity, particularly through abuse, they are in need of specialized services to prevent any further harm. This should be done through collaboration with the youth, their parents or guardians, and all service providers.

All mental health services for youth should include clearly defined and structured sexual health information as a vital component of all interventions. This should be provided in a developmentally congruent way that best meets the needs of each youth as it relates to their reason for being in therapy. When youth are in an out-of-home placement, service delivery should include sex education, individual therapy, and family therapy to address the impact of trauma on sexual decision making.

Disabilities and Neurodiversity

Neurodiversity is the range of differences in individual brain function and behavioral traits.

While the federal government uses the term *disabilities*, language now includes the term *neurodiversity* to describe different neurological functioning in people whose brains develop, or work differently from what is considered typical.

The Developmental Disabilities Act (Public Law 106-402, Section 102-8, 2000) of the United States defines developmental disabilities as "a severe, chronic disability of an individual 5 years of age or older that:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. Is manifested before the individual attains age 22;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity: self care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; and economic self-sufficiency.
5. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated, except that such term, when applied to infants and young children means individuals from birth to age 5, inclusive, who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided."

Not all disabilities are developmental. Some disabilities result from accidents or illnesses later in life. They may affect a variety of life domains such as mobility, attention, understanding, and memory. Youth with disabilities are faced with unique sexual challenges and are sexually vulnerable in a range of ways. If they have intellectual impairments they may struggle to understand their sexuality physically, cognitively, and emotionally. They may be more vulnerable to abuse due to limits in mobility and dependency on service delivery that may not ensure safety and security.

The Americans with Disabilities Act (1990) defines an individual with a disability as a person who has a

physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such an impairment.

Physical Disabilities

Physical limitations refer to any challenges a person faces in mobility or sensory functioning. People who are paralyzed may face unique challenges in obtaining sexual fulfillment while people who are blind or deaf may simply require sign language or Braille communication.

While laws specify requirements for physically addressing such uniqueness, it is important that all service providers be sensitive to both the physical and emotional needs of these individuals and families. While educating these young people respectfully asking youth what specific needs they may have and what help they want is the best way to support their sexual development and any physical and emotional challenges they may have as a result of the physical disability.

Addressing the uniqueness of each disability is the most direct route to optimum service delivery. Considering where and how services should be provided is a critical first step. Deciding where it is easiest for individuals to meet and focus on the tasks at hand can make a big difference in how each youth experiences their sexuality. Service providers who use American Sign Language for those who are hearing impaired, and have braille documents for the blind make the work a lot easier. Patiently listening and effectively responding to a speech impediment sends a clear message that everyone's voice matters.

Intellectual or Cognitive Impairment

Limited intellectual quotient, or IQ, makes learning and understanding more difficult. There are some key things to consider when helping neurodiverse youth to explore sexual health.

First, these youth are vulnerable in two ways. They are more susceptible to being victimized and are vulnerable to committing acts of violence, including sexual harm when they do not receive adequate information about moral reasoning and decision making in ways they can understand and practice.

Second, it is important to begin by adjusting expectations based on limitations and assessing reading, writing and comprehension skills. Services may take longer and require greater direction from service providers. Slowing down and providing easy to understand resources can actually streamline service delivery.

Functional assessments, which are evaluations focusing specifically on assessing the impact of disabili-

A young person who was hit by a car at age seven struggled greatly with verbal communication. Their intellectual functioning was fine but they spoke very slowly as a result of brain damage. Most people appeared impatient to hear them out and they became violent towards a dating partner. Therapy involved a tremendously slow process in which they were often only able to speak a few complete sentences in the span of an hour. Slowing down allowed them to feel respected and heard. They were able to communicate how the frustration played a major role in their violent actions and they explored creative options for change that included sexual decision making.

ties, provide critical information for accessing services. Requirements for reading and writing should be based on their ability and may need to be limited. Involving professionals who specialize in disabilities allows everyone to feel more secure about the potential for successful outcomes.

Mental Health Diagnoses

Disabilities relating to mental health involve clearly defined diagnostic categories such as anxiety, depression, post-traumatic stress, and/or attention deficits. These diagnoses are based on the Diagnostic and Statistic Manual (DSM). Disabilities relating to Autism spectrum disorders are also included in the DSM. Autism is a mental condition that comes about in childhood and causes great difficulty in communication and connection with others. Licensed mental health professionals determine individual diagnoses. The federal government requires this for all federal funding of mental health services.

Neurodiversity and Learning Impairment

Learning disabilities are brain processes that interfere with learning. They do not necessarily affect general intelligence. Learning disabilities indicate that a person's brain takes in information differently than most people. Dyslexia is an example of how some people read or experience letters or symbols differently than most others. Many young people who struggle with decision making have learning disabilities.

Comprehensive testing in early childhood is extremely important. Using results from such testing can greatly enhance a child's educational experience, self-esteem, confidence, and competency development. Educating and supporting parents helps them to further advocate for their children, which enhances attachment and optimum development. Such an approach can greatly influence a youth's positive experience of their developing sexuality.

Prevention Strategies

- **Primary prevention** strategies for addressing neurodiversity and disabilities involve teaching all children sex education, safety and protection, and respect for all living things. Optimally parents, caregivers and all service providers share information about diversity that includes these challenges. Everyone can teach all children (including those with disabilities) that differences are not less or greater than, they are simply differences that make everyone unique.

Sophia, who identifies as she/her, is a single parent of four children. She has some intellectual limitations, as do her children. Her oldest daughter, Kate has significant developmental disabilities and has been verbally violent, physically assaultive and sexually abused her little brothers. Sophia's oldest son, Mike has mild limitations, was on probation for theft and has been physically abusive towards one of his toddler brothers. The little ones have been receiving specialized services since birth in order to support optimum development.

Sophia's family received a range of services geared towards youth violence prevention in addition to public services for individuals with developmental disabilities. The family received intensive home-based family therapy to address the violence. The clinician, a family therapist, specializes in trauma, sexual harm, youth violence, and developmental disabilities. As a highly specialized service provider, that professional was designated to facilitate a formal family systems and ecological evaluation with detailed recommendations that served as a map for the treatment team which was lead by Sophia.

Intervention addressed Sophia's inability to support her daughter after Kate's biological father and the father of her three brothers sexually abused her. Family and individual therapy focused on stopping all violent and criminal behavior. Education focused on teaching the two teenagers sexual health as a foundation to stop sexual harm. While the work took about 18 months, the family has been free of violence for years and everyone is doing well. Team members from several service agencies, juvenile probation and representatives from the state department of social services collaborated effectively throughout the entire process.

- **Secondary prevention** involves open communication about the impact of these challenges on individuals and families. It is important to identify how physical, intellectual and mental health challenges impact a youth's sexuality. Helping vulnerable youth understand sexual development and how they can best take good care of themselves is vital for their well being. Neurodiversity may place youth at greater risk of harm to self or others and secondary prevention can be vital in reducing further trauma.

- **Tertiary prevention** for neurodiverse or physically disabled youth involves those who have already experienced harm through victimization and/or perpetration. A person with limited physical mobility may not be able to protect themself and get away from an attacker. Someone with speech limitations may not feel competent to communicate assertively when feeling disrespected, demeaned, harassed, bullied or assaulted. A person with intellectual limitations may know they do not understand something but may not want to look incapable so they don't tell anyone.

Living with limitations leads to frustration and anger. Such feelings lead to a higher risk of depression and suicide and may result in increased risk of harm. When youth with disabilities do not receive accu-

rate sexual health information, their sexuality is ignored, or they are taken advantage of sexually these young people experience even greater challenges and unnecessary trauma. Interventions facilitated with knowledge and sensitivity about issues young people with disabilities face, promote sexual health and well being.

Lesbian, Gay, Bi-Sexual, Trans-Gender and Questioning Youth

Youth who identify as lesbian, gay, bi-sexual, transgender, or questioning have unique needs for sexual health information. Seldom do sex education curricula provide in depth information about the unique experiences of non-binary sexual orientation. Providing material resources and support for these youth can prevent a great deal of stress and greatly enhance their sexual development and self-esteem.* Accurate sex education that includes unique aspects of all sexual orientation and addresses the impact of environment on sexual decision making is the best way to encourage health and well being.

Sexual identity is a highly controversial issue in America. People who openly acknowledge being gay, lesbian, bi-sexual, trans-gender or questioning, risk discrimination and being victimized through hate crimes. Even those who are only suspected of being so are at risk of being bullied, harassed, tormented, assaulted, or murdered and in turn may become vulnerable to becoming an offender as well. Young people being treated in such ways may also be at risk for acting out their pain through harm to self or suicide. Support for these youth and their families is tremendously important, including youth who come from homes with lesbian, gay, or transgender parents.

Providing access to services involves awareness of national alliances such as PFLAG, which stands for Parents, Families and Friends of Lesbians and Gays. The Human Rights Campaign also provides a broad array of vital services and advocacy for these youth and families.

Supporting youth and families with gay, lesbian, bi-sexual, trans-gender or questioning members can be a complex process. Individuals may not be clear about their own sexual identity development. Clinical support of such important exploration requires specialized training. Licensed mental health professionals can obtain such training through their professional affiliations such as the National Association of Social Workers (NASW), and American Association of Marriage and Family Therapists (AAMFT). These websites are also provided in the Resource Section.

* The appendix has charts to explore gender. These can also be downloaded for free at practiceselfregulation.com/resources

It is very important to understand that adolescent sexual development is a fluid process and adolescence is a time of developmental exploration in all facets of life. Just because a youth expresses a range of sexual interests does not mean their sexual identity is fully realized. Providing a great deal of patience and support for potentially high levels of confusion and possible frustration allows youth to gain education, understanding and insight into the complex reality of human sexuality. Warm, genuine, non-judgmental, and empathic support enhances potential for a successful outcome indicating life long sexual health and well being.

Personal experiences of trauma influence sexual identity development. When youth have experienced child sexual abuse it can wreak havoc on their sexual identity. If someone of the same sex abused them they may have questions about their own sexual identity. If someone of the opposite sex abused them, they may not feel safe expressing themselves sexually with others of the opposite sex for fear the same thing will happen again. Young people may not understand how their body could experience sexual pleasure, and possibly orgasm, at the same time they may have been hurt and terrified through experiences of sexual abuse. It can be very confusing for young people. It can also be very challenging for family members and service providers dedicated to helping these youngsters heal the pain.

Other types of child abuse can also impact sexual identity development. Young people who have been physically abused, or witnessed intimate partner violence may not feel safe to express themselves sexually for fear of being assaulted or raped. Verbal and emotional abuse such as using derogatory sexual terms or hearing family members promote hatred towards those who are gay, lesbian, bi-sexual, trans-gendered, or questioning may prevent young people from safely exploring sexual identity development. Clinicians addressing these challenges should specialize in both trauma and sexual identity development. These issues are addressed in the T.O.P.* Workbook for Sexual Health, which can be a resource for both youth and their family members.

Risk for Violence with Lesbian, Gay, Bi-Sexual, Trans-Gender and Questioning (LGBTQ) Youth

(Centers for Disease Control and Prevention, CDC.gov)

LGBTQ youth without supportive parents, schools and communities are more likely than other adolescents to experience difficulties in their lives such as discrimination and violence.

Negative attitudes toward LGBT youth put them at higher risk for bullying, teasing, harassment, physical assault, suicide and substance use.

LGBTQ youth can be and deserve to be happy and thriving!

When a youth clearly identifies as gay, lesbian, bi-sexual or trans-gendered they may not feel safe to come out to families for a variety of reasons. Therapy with these youth should address the pros and cons of coming out and carefully address any potential danger in doing so. Service providers may meet separately with designated family members in order to see if the youth's fears are accurate and how to best

support both the youth and their family members.

Youth who are confused, or struggle with their own family members identifying as gay, lesbian, bi-sexual, or trans-gendered may be vulnerable in a variety of ways. They may mistakenly direct confusion by lashing out through harmful language and insulting words and bullying. Hate crimes committed by youth can be extremely serious. A young man incarcerated for attempted murder told his therapist he tried to kill a man he thought was gay because his father was gay, he hated his father for it, and wanted to get back at him. Early intervention that involved evidence-based practices for youth violence prevention and included sex education may have prevented such a heinous crime. This example addresses a need to support children growing up with lesbian, gay or transgendered parents and support the teen's sexual identity development in light of this unique experience.

Prevention Strategies

- **Primary prevention**, as mentioned before, involves teaching all children sex education and to respect all living things. Parents, caregivers and educators can provide information about sexual identity development and the range of ways humans express their sexuality. Additionally youth can participate in school and extra-curricular program activities that promote human rights. Evidence-based sexual health curricula address sexual identity development as a part of comprehensive education.

- **Secondary prevention** strategies with these youth and families involve zero tolerance for discriminatory practices or hate crimes. When school personnel are notified of any harmful behavior indicating any elements of sexual identity, staff can adhere to policies and protocols created to provide immediate and effective intervention. Staff in all child serving settings can be trained to provide a protective response any time the need arises.

- **Tertiary prevention** requires knowledgeable intervention. When youth identifying as gay, lesbian, bi-sexual, trans-gender or questioning are victimized it is critical for service providers to explore all aspects of the experience in order to understand everything that happened and take immediate action to prevent future harm. If these youth misbehave it is equally important to find out what influenced a youth to commit acts of harm to self and/or others. In either case therapy focuses on exploration of healthy coping strategies for buffering the possibly life-long discrimination these youth might face. Helping them learn to celebrate their sexuality and obtain love, support and understanding are vital elements of health and well being.

Substance Use

Under-aged substance use is a huge problem in America. Young people are bombarded with messages about substance use and teenage partying often involves binge drinking, use of illegal drugs and misuse of prescription drugs. Schools have also become a primary location for obtaining illicit substances.

According to the 2022 National Survey on Drug Use and Health (SAMHSA, 2022) involving respondents aged 12 and above, 59.8% of all ages used tobacco products, vaped nicotine, used alcohol, or an illicit drug in the last month:

- 7.3% of adolescents aged 12-17 (1.9 million people) used tobacco products or vaped nicotine
- 15.1% (5.8 million people) young people aged 12-20 used alcohol
- 29.5% (10.3 million people) of binge drinkers were young adults aged 18-25, and 3.2% (834,000 people) were youth aged 12-17.
- Marijuana was the most commonly used illicit drug, with 38.2% (13.3 million people) of young adults aged 18-25, and 11.5 % (2.9 million people) of youth aged 12-17, using it in the last year.
- Opioid use was not broken down by age groups and was reportedly used by 3.2% (8.9 million people) in the past year.
- Substance use disorder was highest among young people aged 18-25 (27.8%, or 9.7 million people), and by adolescents aged 12-17 (8.7%, or 2.2 million people).
- While Fentanyl misuse was not broken down by age group, it's misuse through either prescription or illegally made fentanyl was identified by .4% (991,000 thousand people).

The same survey identified adolescents aged 12-17 in 2022 with a past year major depressive episode (MDE) were more likely that those without a past year MDE to have used most illicit drugs in the past year.

- An estimated 26.1% of adolescents in this age group used illicit drugs compared with 11.5% of those not experiencing an MDE.

Suicidal thoughts and behavior were reported by 13.4% (3.4 million people) of adolescents, while 6.5% (1.7 million people) made a plan, and 3.7% (953,000 people) attempted suicide in the last year.

Under-aged substance use influences dangerous decision making. When youth are drunk, or high, they are vulnerable to behaving badly, and/or being victimized. The media is filled with stories of poor decisions, victimization and perpetration in which illegal substances were involved. Getting drunk or high wreaks havoc on sexual decision making. Sexually, young people under the influence are at risk of: not using contraceptives; being unable to provide informed consent; not accepting rejection; not being able to defend themselves physically; not being able to recall events; experiencing sexual trauma that effects the rest of their life.

Prevention Strategies

- **Primary prevention** occurs when adults model responsible substance use. It also involves childhood education. While the Substance Abuse and Mental Health Services Administration (SAMHSA) continually supports research on this topic challenges remain in primary prevention. One program, DARE (Drug Abuse Resistance Education) was used in schools across America but was found to be ineffective. It is extremely important that community collaboration require evidence-based practices. While it is awesome that schools and law enforcement are collaborating to teach kids about the dangers of substance use, it's a waste of time, effort and money if it doesn't show positive results.

Primary prevention must be developmentally congruent. Programs for young children should be concrete with simple messages. Middle and high school substance-use curricula should provide more detailed information and address decision making. For youth with developmental disabilities, curricula needs to be presented in a way that meets individual learning styles. This is addressed in the section on Assessing Strengths and Needs.

Primary prevention for substance use also involves screening. Pediatricians, early childhood development programs like Headstart, child care programs, and schools can all provide very simple effective screening in order to identify potential vulnerabilities.

- **Secondary prevention** involves early intervention when universal screening for children detects vulnerabilities towards substance use. Child serving agencies can create policies and protocols outlining a uniform response for addressing concerns. Agencies can provide written information that includes facts and resources. Such resources should also include information about the impact of substance use on sexuality and sexual decision making. Staff can be trained to confidentially provide resources and services for both youth and family members.

- **Tertiary prevention** can initially focus on least restrictive substance abuse services such as community interventions and court diversion programs for youth when detection indicates serious concerns. Diversion is the process of diverting, or keeping youth away from juvenile justice, or more restrictive levels of care in order to reduce potential for further harm. Court diversion programs are used when youth come before a judge for the first time, or for minimal problems that can best be served through less restrictive services. Diversion is very important when substance abuse services can be used to help youth understand the dangers, address the problems, and enhance motivation for change.

Substance abuse services can be effective in helping youth to both stop substance use and stop all harm to self and others. All community health and diversion programs for adolescent substance abuse should include information about the impact of substance use on sexuality and sexual decision making. When sexual harm occurs in conjunction with substance use therapeutic services for both victims and offenders are necessary and should be provided by specially trained licensed mental health professionals. If community counseling and court diversion programs are not successful, residential substance abuse services may be necessary.

Donna (they/them) was sexually abused by their father and brother. Donna would use alcohol to try to numb the pain. When Donna was under the influence, they consistently made bad decisions that placed them at risk of further sexual harm. They were raped twice while out drinking, had a great deal of difficulty in dating relationships, and had to be treated for sexually transmitted infections. Only through intensive therapy did they learn to consider taking good care of themself sexually.

Foster and Adoptive Families

As mentioned in the introduction, youth transitioning out of foster care are 71% more likely to have unplanned and unwanted pregnancies than young people who are not in foster care. Foster and adoptive families are in a unique situation with youth invited into their homes and families. Seldom do they know much about a child's pre-natal, physical and emotional experiences with their biological parents. In addition to being adopted, or in foster care, these youth may have a host of special needs relating to many of the other topics addressed in this chapter.

While many states and private agencies work diligently to provide adequate training and resources for foster and adoptive families, fiscal limitations can greatly restrict such important efforts. In focus groups many of these parents report high levels of concerns about their children's life experiences. They identify feeling inadequately prepared to support the youth effectively. Providing foster care and adoptive parent training that includes messages about the importance of a trauma-informed approach to sex education and compassionate support for adolescent sexual decision making may greatly influence sexual health for these vulnerable children. The National Campaign to Prevent Teen Pregnancy has an excellent document entitled "Fostering Hope" that addresses teen pregnancy prevention with youth in foster care (Love, McIntosh, Rosst, & Tertzakian, 2005).

Prevention Strategies

- **Primary prevention** for adopted youth and those in foster care involves all of the same things

identified in all previous primary prevention sections. We want them educated about sexual health and well being along with all other children. Unfortunately for children whose parental rights were terminated because of abuse, primary prevention didn't work and they had to be removed from their homes.

- **Secondary prevention** is automatically required for adopted and foster care youth. This involves monitoring through pediatric and mental health services that provide screening for physical and mental health needs, and other early childhood services that assess all facets of development. These youth may be at risk of developing a range of disorders so it is important to support youth, adoptive or foster parents, and siblings in modeling and maintaining healthy relationships.

Public and private agencies providing adoptive and foster care services often have resources to help both youth and foster or adoptive families adapt to placement. It is critical that all youth and families have easy access to such resources. Youth in foster care will remain at higher risk for poor sexual decision making if they are not given additional services and support to address their complicated life circumstances.

- **Tertiary prevention** for these youth addresses additional challenges they may face in coming to grips with being in foster care or adopted. They may struggle with differing levels of pain about being removed from their families. The age and circumstances under which they were removed greatly influence their ability to make sense of and manage the experience. Issues of grief, loss and shame may be overwhelming. These youth are more likely to have developmental disabilities and to struggle with complex trauma related symptoms that require a range of services to enhance their sexual health.

Pregnant and Parenting Teens

Teen pregnancy changes the lives of young parents forever. According to renowned specialist, Claire Brindis, (2011) many come from multiple generations of teen parents who have experienced poverty and other risk factors in their family backgrounds that include inadequate health care. Teen parents have often been exposed to substance abuse and violence, experienced child abuse, sexual assault, early sexual activity with numerous sexual partners and involvement in child welfare. They often struggle academically and drop out of school. Risk factors for teen fathers include: delinquency, substance abuse, aggression and violence, unemployment, and lack of involvement in service provision (Brindis, 2011). We also know that the children of teen parents are more likely to end up in prison.

Prevention Strategies

> "Hope is a powerful contraceptive. The way you help young people avoid pregnancy is by providing them with real evidence that good things can happen in their lives."
>
> — Michael Carrera

- **Primary prevention** for pregnant and parenting teens involves sexual health curricula for school-aged children of all developmental levels. The federal government and organizations such as the Sexuality Information and Education Council of the United Stated (SIECUS), Healthy Teen Network, Annie E. Casey foundation, Planned Parenthood and the Guttmacher Institute all work diligently to prevent teen pregnancy.
- **Secondary prevention** with this population involves working closely with teen parents to stop the intergenerational experience of premature, unplanned and unwanted pregnancies. It also includes supporting young fathers in a variety of ways that include cultural values and beliefs about fatherhood, sexual decision making, employment and independent living skills, and reducing vulnerabilities for involvement in any type of violence.*

Camilla, (she/her), is 19 and the mother of two-month-old, Leah. Leah's father, Graham is also 19. Both parents struggle with drug addiction. During Camilla's pregnancy she assaulted Graham during a fight they were having. The police were called and the parents were ordered to have no contact until the designated court date several months away. They violated the court order and began living together at Camilla's mother's home. Camilla decided to participate in therapy in an attempt to keep her child, stop using drugs, stop the violence, and prevent further criminal charges. Camilla and Graham both continue to struggle with drug use and the relationship is very unstable. Leah is being detoxified through specialized medical services since she became drug addicted in utero. Camilla stopped participating in all therapeutic activities after her therapist reported a recent physical assault to authorities and Graham was served with a protection against abuse order. Camilla has been unable to remain drug free and continues to be monitored by local child protective services. She is at high risk for a rapid repeat pregnancy and intergenerational passage of violence, abuse and teen pregnancy to her children.

- **Tertiary prevention** for pregnant and parenting teens can be quite complex and challenging. It can be hard to engage teen fathers in service provision, especially when either or both parents have behaved violently. In addition to everything needed for optimum young parenting, a trauma-informed approach for services must include exploration of sexual decision making. The federal government is supporting such service delivery through demonstration projects funded by the

* Young United Parents (YUP!) is a holistic health and wellness mobile website co-created with young mothers and fathers using human-centered design. Information about the program is available at youngunitedparents.org.

Department of Health and Human Services, Office of Population Affairs and Office of Adolescent Pregnancy Programs.

According to the Children's National Medical Center (2011) expert policy recommendations for parenting teens involve:

- Creating comprehensive medical homes for adolescent parents and their children
- Adapting counseling to the developmental level of adolescent parents
- Encouraging positive parenting
- Closely monitoring development of both parent and child
- Encouraging positive involvement of baby's father and extended family
- Providing family planning services
- Encouraging educational achievement
- Serving parents in their home, school, community and medical settings

Across all examples of uniqueness lie vulnerability for early onset of sexual activity, unprotected sex, unplanned and unwanted pregnancies, and sexual harm through coercion or assault.

Taking all aspects of uniqueness into consideration can make service providers feel overwhelmed. A clearly defined comprehensive trauma-informed approach for adolescent sexual health can help individuals, organizations and communities share a balanced effort that does not overload any single service, or the youth themselves.

A broad range of service providers specialize in all sorts of unique characteristics in youth and families. When these folks provide leadership, supervision and training everyone involved can understand how to provide effective services for all young people. The best outcomes are achieved when everyone works collaboratively to streamline services and maximize outcomes. It is also vitally important to implement federally established best practices supporting people with developmental disabilities or any designated special needs.

A Resilience-Based, Trauma-Informed Approach

The Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States is a primary source for trauma-informed practice. The three key elements of their definition provide the foundation for this document.

A resilience-based, trauma-informed approach for adolescent sexual health is vital to promoting life long sexual health and well being for youth who have adverse life experiences. Such an approach takes into consideration all of the challenges previously mentioned that can impede optimum sexual decision making. It also takes into consideration how sexual health can enhance a meaningful and productive life through development and maintenance of intimate relationships and effective communication.

Education does not necessarily equal change. Understanding body parts and biological functioning does not guarantee that youth will make healthy sexual decisions. Helping young people understand how traumatic experiences can impact sexual decision-making has potential to go a long way in reducing confusion that creates barriers to sexual health.

The last decade has seen tremendous promotion of resilience-based, trauma-informed sexual health information. The federal government now expects grantees studying effective programming to include neuroscience-based interventions that focus on promotion of executive functioning, which involves: working memory, analysis and synthesis, organization, internal speech, and emotional and behavioral regulation (Schladale, 2020). Additionally, organizations such as Power to Decide, The Sexuality Information and Education Council of the United States, and the Annie E. Casey Foundation work diligently to promote evidence-based support throughout the country.

A resilience-based, trauma-informed, inclusive, and intersectional approach for health promotion is guided by empirical evidence relating to:

- SAMHSA Key Assumptions, Key Principles, and Implementation Domains for Trauma-Informed Services (2014)
- Factors promoting and enhancing program engagement, responsivity, and adherence, while reducing and alleviating distress, and diminishing barriers to meaningful participation
- Neuroscientific factors that influence engagement, learning, memory retention, decision-making, and effective behavioral change
- Strategies for implementation

So what constitutes a resilience-based trauma-informed approach for adolescent sexual health? The foundation begins with accurate sexuality education embedded in a therapeutic process of evidence-informed best practices for childhood trauma. Successfully promoting sexual health requires equal focus on both components.

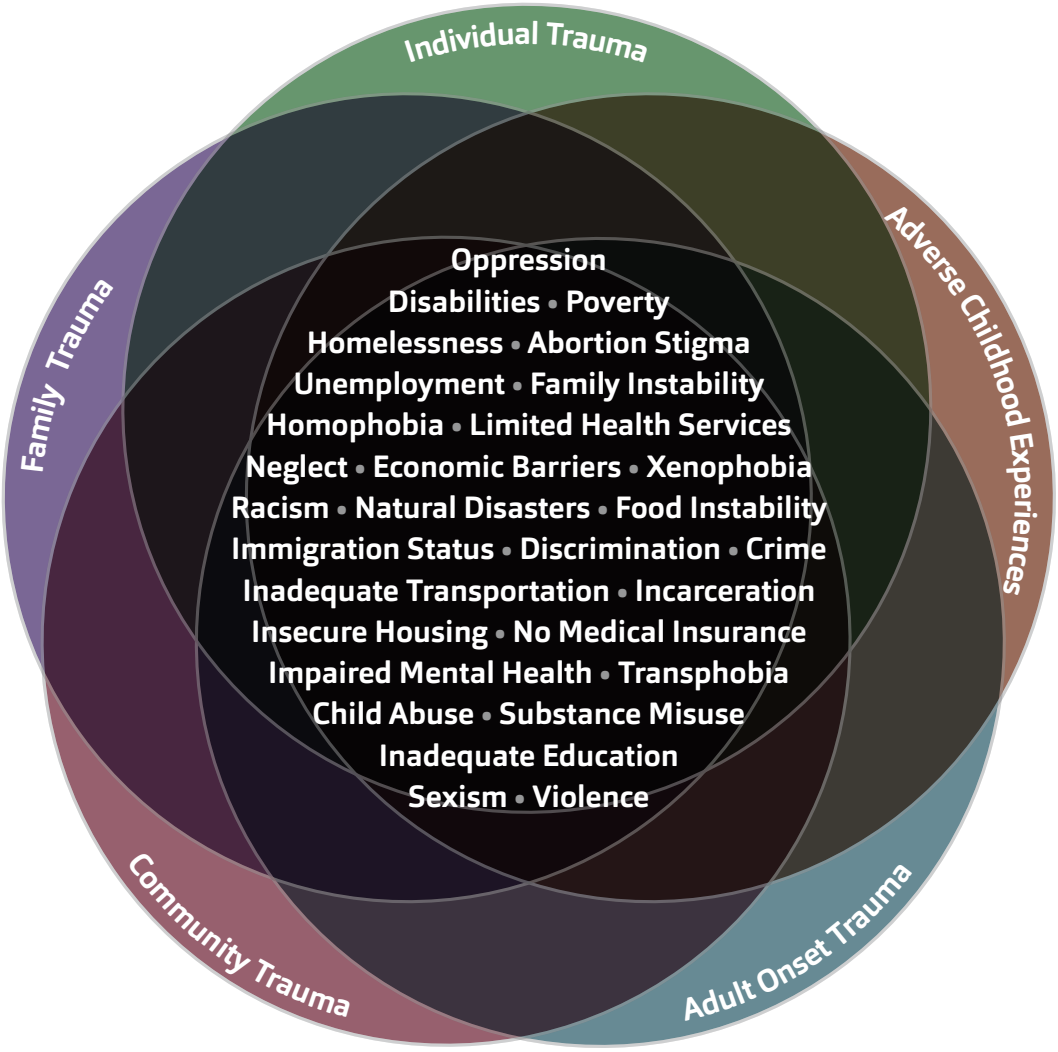
Evidence-based sexual health curricula effectively delay onset of sexual intercourse. Professionals hope a trauma-informed approach for sexual health will also prevent further trauma. This approach is too new

to have achieved evidence-based status but many professionals in the field of sexual health are working diligently to make it happen.

Complex Trauma

Complex Trauma is multiple traumatic events that occur within the care giving system.

While there are a wide variety of experiences that may constitute trauma the term is often divided into two components. They are trauma, which is defined here as a deeply distressing or disturbing experience that has a lasting effect on a person's life, and complex trauma which according to the National Child Traumatic Stress Network (NCTSN) reflects a child's experience "of multiple traumatic events that occur within the care giving system" (Cook, Blaustein, Spinazzola, & van der Kolk, 2003, p.5).



When children experience adequate child development and something very bad happens they may experience it as traumatic, receive parental support, heal and manage the pain, and go on to lead a healthy life. Such an experience may or may not impact their sexual development and sexual decision making. If the trauma is sexual in nature it is more likely to impact their sexual health and decision making. An optimum response by parents and service providers can greatly diminish the negative effects of trauma on children. According to the National Child Traumatic Stress Network (NCTSN) "The response of the child's support system, and particularly the child's mother, is the most important factor in determining outcome, more important than objective elements of the victimization itself" (Finkelhor & Kendall-Tackett, 1997, p. 16).

Like a natural disaster, we can:

- Predict that bad things happen
- Prepare for them
- Often survive them
- Assess their impact
- Act on behalf of ourselves to best manage them
- Work hard to prevent future harm.

Just because children grow up in poverty or minority cultures, experience violence, have disabilities, are lesbian, gay, bi-sexual, transgender, or questioning, are adopted, grow up in foster care, or are teen parents does not mean they suffer from complex trauma. It does mean they deserve a trauma-informed approach when learning about sexual health in order to explore the impact of life experiences on their sexual decision making.

Many young people involved in child welfare, juvenile justice, and those who are homeless do suffer from complex trauma. The term usually refers to the "simultaneous or sequential occurrences of child maltreatment…that are chronic and begin in early childhood… and often lead to subsequent trauma exposure" (Cook et. al., 2003, p.5). Complex trauma can result in multiple domains of impairment that include problems with: affect regulation, attachment, anxiety, addictions, aggression, social problems, eating disorders, physical health, sexual disorders, and revictimization.

Assessing Strengths and Needs

The federal government of the United States and many state statutes use the term "qualified mental health provider (QMHP)" to designate clinically trained mental health counselors who are licensed to facilitate evaluations, assessments, and provide therapy. Generally there are five categories: psychiatrists, psychologists, marriage and family therapists, social workers, and clinical nurse specialists. Many licensed mental health professionals are specially trained to provide trauma services for individuals and families. In some states licensed mental health agencies must meet very specific criteria in order to be referred to as a designated trauma-informed agency. When young people are referred for trauma services

they are evaluated, or assessed in order to gain an understanding of any traumatic experiences they may have had and to plan services that promote healing.

Based on the fluid nature of child development it is recommended that evaluations be considered valid for a maximum of one year. A lot can change in a year's time and it is important to have up-to-date information about those receiving services. Evaluations should be facilitated by licensed mental health professionals knowledgeable about current trauma research, interpersonal violence, and family systems who document understanding of the child's life.

Screening: A systematic way of looking at an identified population in order to consider needs for intervention. This is primary prevention.

Evaluation: A process of documenting a comprehensive review and accumulation of information regarding a specific youth's status at a given time. The process involves face-to-face interviews with youth, family members, and designated others such as pertinent extended family and service providers. The purpose is to collect information for initial, or transitional service planning. Objective measures, when available, should be used. Holistic evaluation includes all areas of a youth's life.

Assessment: An ongoing process of face-to-face interactions, and observations of youth and family members in order to collect information for ongoing service delivery. Assessment is the continuous process of monitoring a youth's status in order to thoughtfully plan and intervene in the most effective manner across all service delivery. Objective measures, when available, should be used.

Assessment Scales: Scientific tools used for identifying specific information to help understand strengths and needs. Assessment scales must be valid and reliable (as proven through research) in order to accurately show what they claim to measure. Examples include topics such as intelligence levels, depression, trauma, etc.

Protocol: A specific procedure and/or process required by research findings, organizations and legal entities. Protocols can be found in all levels of prevention

Both evaluation and assessment are secondary and tertiary prevention.

What does it really mean to assess strengths and needs, and what does it have to do with sexual health and well being? We know that focusing on strengths and positive youth development is the best way of getting kids to consider taking good care of themselves. Everyone responds better to praise than to criticism. The object of assessing strengths and needs is to focus on what young people are already doing well and to build on those strengths in order to promote health.

When people are good at something they are more likely to enjoy doing it, potentially more easily motivated to practice, and in turn, get better at it. Like sports, doing well in school, or expression through art drama, dance, or music, when young people build on an natural talent they just keep getting better and better. Learning to feel good about their sexuality and receiving support to practice good sexual decision making can make a tremendous difference in the lives of young people who have experienced trauma. They gain competence through sex education and confidence through supportive practice with corrective feedback.

Exploring strengths is the bedrock for building more strengths. Asking, "what do you think has worked well so far?" and "what do you think might help?" supports teens in both identifying their unique strengths and ways they might build on them.

Clarifying needs is a way individuals direct service delivery. By asking questions like, 'what do you think is important for us to be thinking about?' and 'what do you think needs to change?' tells service providers what a youth thinks is needed to best help with positive sexual decision making.

Strengths are a solid foundation on which health and well being are built. Needs are a blueprint that shows where extra support is required to construct a solid foundation for sexual health hopefully lasting many generations.

Service providers not involved in therapeutic interventions for these youth seldom need any detailed information. It is usually enough for sex education practitioners to know that youth in the

A Midwestern program for youth with intellectual disabilities who committed acts of sexual harm strongly believed in a strength-based and trauma-informed approach with a foundation for sexual health and well being. They contracted with the local Planned Parenthood affiliate to provide sex education for the teens once a week in a group format and youth knew they were expected to participate. The clinical and direct care staff at the program collaborated with Planned Parenthood facilitators to maximize the effectiveness of the services. When needed Planned Parenthood staff would sit in on treatment team meetings to provide feedback about the youth receiving services. This set up provided optimal communication among all service providers and information was shared in a confidential manner and on a need to know basis. Both organizations have enjoyed a long and valued collaboration to serve these youth who so desperately need vital and accurate information and therapeutic support.

audience may have experienced trauma and to have information provided in the Appendix to respond effectively if concerns about a traumatic experiences arise during sex education. If it is necessary to share evaluations or records a signed Consent to Release Records document is required from the youth and their legal guardian.

When an evaluation meets the goal of providing a foundation for service delivery, ongoing assessment naturally begins. All service providers are encouraged to track progress, or lack thereof, by monitoring the extent to which the evaluations' recommendations are being followed, and if so, how successfully. This can be done informally and/or formally through team meetings when sexual health is being provided as part of a multidisciplinary effort. Part of the ongoing assessment of progress towards goals involves checking in with all core team members to obtain everyone's perspectives. Ongoing assessment involves monitoring safety, treatment progress, team communication and relationship building. It provides a foundation for overall health and well being of which sexual health is a vital component.

Factors that Influence Successful Outcomes

When children have experienced trauma resilience is assessed and monitored through a variety of protective factors that research indicates can diminish the chances of harm occurring again. According to the National Child Traumatic Stress Network (NCTSN) critical factors for promoting resilience involve: positive attachment and connections to emotionally supportive and competent adults; development of cognitive and self-regulation abilities; positive beliefs about one-self; and motivation to act effectively in one's environment (Cook et. al, 2003).

When young people make poor sexual decisions understanding resilience can help parents and service providers assess and support a youth in overcoming the negative effects of the decision and move on with life.

Positive Youth Development is a term used to describe a strength-based approach for interventions with children and adolescents.

Positive youth development is based on the premise that focusing on resilience, strengths, resources, and protective factors is more likely to result in successful outcomes than pathology-based interventions that highlight what is wrong, rather than what is right about a youth and his, or her family (Butts, Mayer & Ruth, 2005; Torbet & Thomas, 2005). Current evidence shows that most effective interventions are based on a non-judgmental attitude, empathy, genuineness, and warmth, communicated with a sense of hope and expectation for change (Duncan, Miller, Wampold, & Hubble, 2022; Miller & Rollnick, 2023). Additionally, recent studies indicate that successful outcomes in psychotherapy are based on four factors. They are: therapeu-

tic technique (15%); creation of hope and expectation for change (15%); the therapeutic relationship between service providers and clients (30%); and client characteristics including strengths, resources, social support, and living environment (40%) (Duncan, Miller, Wampold, & Hubble, 2009).

If you want to promote health and well being, treat young people with respect for who they are, and how they came to be this way. Get to know them, provide hope and clear expectations for change, and provide support along the way.

Research on youth violence prevention indicates five core competency domains. They are: social skills (cognition, interaction, and self-control), moral reasoning, academic, work force development, and independent living skills (Torbet & Thomas, 2005). A trauma-informed approach for adolescent sexual health can focus focuses primarily on the domains of social skills (cognition, interaction, and self control) and moral reasoning. Academic,

Protective Factors to Reduce Violence:

- Effective roles models for healthy copies skills
- Family, care giver, and consistent prosocial relationships with trusted adults
- Ability to discuss problems with trusted others
- Academic achievement and aspirations
- Positive social orientation, friendships, and involvement in prosocial activities
- Healthy relationships and social skill competencies

Competency development is the process by which juvenile offenders acquire the knowledge and skills that make it possible for them to become productive, connected, and law abiding members of their communities (Torbet & Thomas, 2005, p.3).

workforce development and independent living skills should be addressed in other areas of service delivery.

It is important to distinguish between competency development and treatment. "Competency development is not treatment. Youth do not become competent just because they complete a treatment program" (Torbet & Thomas, 2005, p.5). Affect or self-regulation strategies, often learned in therapy, are necessary for competency development.

A youth's ability to manage emotions without causing harm (Schore, 2003) includes their capacity to regulate thought, emotion, impulse, attention, appetite, and task performance (Baumeister, DeWall, Ciarocco, & Twenge; 2005). Affect regulation is a complex process rooted in biological and neurological chemistry. Self-regulation competencies focus on four areas: affect, cognition, physiology, and behavior. Research on this topic is often integrated into studies on childhood trauma and will be addressed in the section on Effective Strategies.

In summary, a framework of positive youth development that promotes resilience through competency development leads to affect regulation, which is required for enduring change. Youth must be able to integrate knowledge into consistent practice. Demonstration of optimum sexual decision making indicates successful outcomes.

As mentioned in the introduction, integrating research on optimum child development, accurate sexual health information, trauma, resilience, competency development and affect regulation are the key components of a trauma-informed approach for adolescent sexual health. Effective strategies require a multidisciplinary effort among service providers supporting youth, their parents or guardians, and members of each youth's social support network.

Such strategies may actually be easier to implement than many people think. Thanks to the diligent work by a tremendous number of professionals a range of empirically informed and evidence-based practices are available to help streamline cost effective efforts and improve outcomes. This section begins with a focus on accurate sex education followed by therapeutic services that promote healing through optimum sexual decision making that fosters benevolent touch.

Benevolent means well meaning, kind and good.

Comprehensive Sex Education

Experts agree on what constitutes a minimal foundation for sex education. Since 2008, professionals specializing in sexual health have been meeting through an initiative entitled the Future of Sex Education (FoSE) "to provide clear, consistent and straightforward guidance on the essential minimum, core content for sexuality education that is developmentally and age-appropriate for students in grades K-12" (Future of Sex Education Initiative, 2012, p. 6). This ongoing effort strives to integrate all existing research-based information on the topic and has resulted in the publication of National Sexuality Education Standards (Future of Sex Education Initiative, 2012). There are four vital elements to the Standards:

1. Intent of the Standards, or explanation of what they are designed to do;
2. Identified characteristics of effective sexuality education;
3. Designated topics; and
4. Designated standards.

The Intent of the Standards

The Intent of the Standards is to designate core minimum information necessary to promote competency development for sexual health. The hope is that they will to be used in a planned and sequential way and should be evidence-informed and developmentally congruent. The information should be "highly relevant to students…[and presented] as a normal, natural, healthy part of human development" (Future of Sex Education Initiative, 2012, p. 6).

While these standards are designed for traditional school settings this information remains vital for pro-

fessionals serving youth who have experienced trauma. The intent of theses standards reflects a basis for presenting sexual health information in any setting.

All adults serving these youth should know what baseline information is necessary to create a foundation for sexual health. Information should be presented in a planned and sequential way that enhances learning and memory retention. Presentation involves multi-sensory information that reinforces relevance and pertinence for each youth. Promoting the information within a framework of positive youth development helps reduce shame and embarrassment for youth whose sexual confusion and/or life experiences have involved trauma.

Characteristics of Effective Sexuality Education:

According to the standards, these include the following 13 criteria, which are followed by more detailed information about their application. They are:

- specific behavioral outcomes
- individual values and group norms promoting healthy behavior
- understanding dangers of engaging in risk behaviors
- reinforcing protective factors
- social pressure
- personal competencies
- accurate information
- developmentally congruent information
- culturally inclusive material
- adequate time for instruction
- skill building
- positive connections with others
- professional development and training for facilitators

(Future of Sex Education Initiative, 2012, page 9)

This information can make service delivery easier for professionals, parents, guardians, and the youth themselves.

Specific Behavioral Outcomes

Everyone wants traumatized children to heal pain and experience life-long health and well being in all facets of their lives. Identifying specific behavioral outcomes in sex education with youth who have experienced trauma involves optimum sexual decision making that prevents harm to self or others. This is no different than the desired behavioral outcomes for all youngsters. This is primary prevention.
When a vision for health and well being is the foundation for all service delivery and specific behavioral

outcomes focus on sexual health, therapy and sex education become intricately interwoven. For vulnerable youth this is secondary and tertiary prevention depending on their unique life experiences.

Individual Values and Group Norms Promoting Healthy Behavior

Promoting values and norms that influence healthy behavior is part of cognitive restructuring. Trauma-focused cognitive behavioral therapy (TF-CBT) is an evidence-based practice for child abuse that involves cognitive restructuring. Exploring values and beliefs that promote sexual health and those that can influence sexual harm (Abbey, 2005) can create a clear distinction between the two and help young people and their family members understand the differences and help them to consider embracing those that promote optimum sexual decision making. The values and beliefs identified by Abbey are described in the section on Violence and Aggression on page 18.

Cognitive restructuring means changing the way a person thinks.

It is critical for a trauma-informed approach to clearly address individual values and group norms and explicitly explore the challenges that negative and potentially dangerous values and beliefs have on sexual decision making. It may also take psychotherapy to help youth consider and effectively eliminate negative values and beliefs in order to prevent further harm.

Understanding Dangers of Engaging in Risk Behaviors

This characteristic is already a core component of trauma therapy although not limited to sexual risk taking. While therapeutic services for these youth inherently involves exploration of the impact of harm to self or others it doesn't always include topics such as contraceptive use and/or sexually transmitted infections. Focusing on the full range of identified risks for these youth, including those involving all facets of sexuality, can enhance their understanding of the broader range of risks associated with sexual decision making and promote a more holistic view of sexual health.

Reinforcing Protective Factors

Assessing protective factors is a foundation of positive youth development already recommended for a trauma-informed approach for adolescent sexual health. Helping youth focus on and further develop their strengths and skills to reduce risk is vital for all young people. It is also competency development.

Social Pressure

Peer pressure and media messages about sex are everywhere! Addressing social pressure, preferably before it becomes relentless can play a huge part in prevention.

Personal Competency

Competency development is a universal challenge for sexual health. All children need to learn accurate information about their bodies, relationships, and optimum sexual decision making. When young people have adverse life experiences the importance of competency development is even more pronounced as they have to use personal strengths and skills to overcome the potentially negative effects of trauma. The core competency domains identified in the section on Factors that Influence Successful Outcomes can easily be used as a foundation for competency development and optimum sexual decision making. A Likert scale for assessing competency development for court involved youth is provided in the Appendix.

A thirteen-year-old, self-identified male was referred for treatment after sexually abusing his five year old sister. He reported being taunted by his peers with statements such as "you're a faggot", "you couldn't ever get a girl" and "if you're not gay prove it to us." He said the only way he thought he could prove it to them was to have sex with a girl and the only one around was his little sister. When asked specifically what he did to his little sister he replied "sodomy." When asked what that meant he indicated he had no idea and stated, "that's what the judge said."

Addressing the impact of social pressure was an important part of his therapy. In addition to sex education about definitions of sexual practices, the young man was challenged to explore: 1. The specific taunting he experienced; 2. Social pressure to have sex in general; and most importantly, 3. How he might learn to practice withstanding tremendous social pressure to stop all sexual harm.

Accurate Information

Due to the inordinate amount of myths about human sexuality and the potential damage of inaccurate information it is critical that youth who have experienced trauma, especially sexual harm, receive accurate information. Obtaining such information is both free and easy. Website resources included at the end provide a wealth of information about evidence-based curricula that can be implemented in a variety of settings. There is no excuse for inadequate and inaccurate information and there is no need to reinvent the wheel when it comes to sexual health information.

Developmentally Congruent Information

The first section explaining all facets of child development lays the foundation for developmentally congruent information for all children. One size does not fit all when it comes to sex education. Child development is greatly influenced by brain maturation and little children simply cannot comprehend the complexity of sexual development as it evolves throughout puberty and into adulthood. Little children can however understand key elements of their sexual development and how it influences behavior. The more developmentally congruent information children have the less likely they are to be confused about their body and sexual behavior. The National Standards for Sexuality Education provide a very user friendly framework that illustrates what information should be included for identified grade levels. When young people are impacted by trauma, developmental and/or

learning disabilities information can be adapted to best meet the unique needs of each youth.

The T.O.P.* Workbook for Sexual Health (Schladale, 2010) provides a framework for supporting teens who have experienced trauma to make sense of the impact of adverse life experiences, heal pain, and explore optimum sexual decision making. T.O.P. stands for trauma outcome process. The workbook is an example of developmentally congruent information created specifically for adolescents who have experience trauma.

Culturally Inclusive Material

Everyone's sexuality is influenced by culture. Race, ethnicity, socio-economic status, gender, sexual identity, religion, geography, and nationality all influence sexual development. Youth need gender and identity specific information preferably in their native language. Race, ethnicity, and nationality inform individual, family, and community values and beliefs about people and sexual behavior. Religion plays a much more influential role in sex education in the United States than in many western industrialized nations.

Attempting to provide sexual health information without culturally inclusive material is fraught with problems. A lack of cultural competency in addressing sexual health can result in alienating participants by causing offense and indicating a lack of consideration for their unique life experiences.

Adequate Time for Instruction

Of all the characteristics of effective sex education this may be the most misunderstood for mental health professionals. When professionals think sex education is something unrelated to therapy, or adds a lot of time and effort to the process, they are unlikely to be motivated to provide such important information.

Many therapists have overwhelming caseloads and highly limited timeframes for service delivery. If they think trauma work does not include sexual health they may view it as an excessive luxury. In reality, the amount of overlap between characteristics of effective sex education and characteristics of effective interventions with traumatized youth is remarkable. The challenge is not adding time in a system of care that already places a premium on time through limitations often associated with managed care. The real challenge is to think creatively about maximizing the effectiveness of sex education so information meets the unique needs of each youth and motivates them to practice optimum sexual decision making. Adequate time for instruction simply means maximizing interventions by effectively integrating accurate information into a therapeutic process. This is not nearly as hard to do as many professionals think.

Skill Building

Personal competency is the result of skill building. This effort involves repetitive practice with corrective feedback, which is one of the core approaches to all evidence-based practices for child abuse treatment (Saunders, Berliner & Hanson, 2004). Skill building for youth who have experienced trauma involves: giving them accurate sexual health information in a user-friendly way, helping them explore ways to implement the new information in their lives; monitoring how they practice such implementation; and providing non-judgmental feedback to enhance competency development.

Positive Connections with Others

Supportive relationships and pro-social interaction with peers are vital components of optimum child development and all youth violence prevention (National Research Council & Institute of Medicine, 2001; Office of the Surgeon General, 2001; Torbet & Thomas, 2005; Thornton, Kraft, Dahlberg, Lynch & Baer, 2002). The same goes for sexual health. When children and teens have supportive others who can provide accurate information they receive necessary information and develop supportive relationships in which they can explore all aspects of their sexuality.

Professional Development and Training for Facilitators

This characteristic of sexuality education appears to be a significant barrier to implementation within organizations addressing childhood trauma. Individual and agency values and practices often reflect societal biases against teaching sex education and promoting sexual health. In some cases fear of opposition and/or liability play a part in neglecting or refusing to provide such important information through mental health service delivery. It is a senseless and harmful omission.

All child serving professionals can easily master core competencies for facilitating effective trauma-informed sex education. Basic training that provides accurate information and resource documents is easily integrated into new worker orientation or in-service training. Professional development is enhanced through practice and ongoing supervision. When sex education training and professional development are provided through core competency training for all personnel, standard operating procedures promoting sexual health become fully integrated into day-to-day practice.

The 13 characteristics of sexuality education are easily implemented into a trauma-informed approach for adolescent sexual health. Such information is vital for youth, their parents or guardians, and professionals providing trauma services.

Designated Topics

Seven topics provide agreed upon content as the basis for all sex education. They are:

- Anatomy and physiology
- Puberty and Adolescent Development
- Identity
- Pregnancy and Reproduction
- Sexually Transmitted Diseases and HIV
- Healthy Relationships
- Personal Safety

(Future of Sex Education Initiative, 2012, page 10)

A wealth of information is available on each of these topics throughout many of the listed resource websites. Additionally, evidence-based curricula provide specific modules with lesson plans for easy implementation.

Designated Standards

Finally, the national health education standards laid out in the Future of Sex Education document are:

- Core concepts that students will understand
- Analyzing influences that include family, peers, culture, media, and technology
- Accessing information
- Interpersonal communication
- Decision making
- Goal setting
- Self management
- Advocacy for self and others

(Future of Sex Education Initiative, 2012, page 11)

These standards reduce barriers to providing sex education for these youth by decreasing the amount of work professionals and parents alike have to do to prepare and present sexual health information for children. The easier it is to access accurate, user-friendly information the easier it is for adults to provide information necessary for promoting health and preventing harm.

Therapeutic Services

In addition to providing sex education, encouraging sexual health with these youth may involve thera-

peutic services addressing childhood abuse. Evidence-based practices include Trauma-Focused Cognitive Behavior Therapy (TF-CBT) and Parent Child Interaction Therapy (PCIT). Empirically supported treatment protocols share common principles. They tend to be goal directed, structure their approach, focus on skill building to manage emotional distress and behavioral disturbance, and use techniques that involve repetitive practice of skills with feedback (Saunders, Berliner, & Hanson, 2004).

Skills Common to all Evidence-Based Practices for Child Abuse
(Saunders, Berliner, & Hanson, 2004)

- affect regulation
- anxiety management
- cognitive restructuring
- problems solving

There are times when evidence-based practices may not be an option for service delivery. When this occurs it is ethically imperative that only empirically informed interventions be provided. The National Child Traumatic Stress Network (NCTSN) is an excellent resource to help service providers obtain knowledge about the most current effective research-based treatment.

There are four key skills common among empirically supported treatment for youth. They are: emotional (or affect) regulation, anxiety management, cognitive restructuring, and problem solving (Saunders, Berliner, & Hanson, 2004). Additionally, empirically supported treatments include components that address the young person's environment (Henggeler, 2009; Saunders, Berliner, & Hanson, 2004; Kauffman Foundation Best Practices Project, 2004).

Multi-Sensory Applications

Experiential learning greatly enhances memory retention. Research on child development indicates that children learn best through physical activity (Pollack, 1998). Clinical literature on healing trauma indicates that symptom reduction is achieved through multi-sensory therapies (Stien & Kendall, 2004; van der Kolk, 2004; Kagan, 2004; Levine, 1997; Rothschild, 2000). Examples of multi-sensory activities include: exercise and body movement, healing touch, art, drama, dance and music, and narrative trauma scripting.

The use of creative processes such as art, dance, drama, music, and poetry provide youth with a right brain dimension for self expression. Youth who have been traumatized may have difficulty with organization and synthesis of the right and left hemispheres of the brain. These youth often lack ability to self regulate and problem solve, which is a left-brain function. Multi-sensory activities utilize the right brain, which is biologically impacted by disorders of attachment (Applegate & Shapiro, 2005). Expressive arts allow youth to utilize a broader range of skills that synthesize both hemispheres of the brain (Stien & Kendall, 2004).

The T.O.P.* Workbook Facilitator's Manual provides a wide variety of multi-sensory activities that have

potential to improve outcomes. Such activities assist in blending the cognitive, affective, and physiological elements of the workbook experience. Facilitation of the T.O.P.* Workbook combines aspects of the following concepts in order to promote health and well-being in the lives of young people.

Affect Regulation

As mentioned previously, affect regulation is the ability to manage emotions without causing harm to self or others (Schore, 2003). It is the core of all healthy coping strategies. When young people have not been taught pro-social ways to manage upsetting emotions they are at risk of behaving in harmful ways. Dysregulation occurs when emotions, or feelings, are managed in ways that cause harm to self or others. Affect regulation and dysregulation are not user-friendly terms. It can be hard to remember both the terms and what they mean. Affect regulation involves: affect, or emotions; cognition, or thinking; physiological reactions; and behavior.

Affect

Memories can stir up distressing feelings about trauma. Service providers can prepare youth and family members for emotional discomfort by teaching them how to use multi-sensory self-soothing activities. These are behaviors designed to help manage discomfort and reduce anxiety. Some examples are deep breathing, guided imagery, doodling, playing with something like Play Doh, listening to soothing music, and most any exercise or body movement. Using such activities provides physiological outlets for managing difficult situations and symptoms related to unresolved trauma and post-traumatic stress. They can also decrease potential for dysregulation that can get in the way of optimum sexual decision making.

When young people can thoughtfully plan for sexual activity that promotes sexual health, they can learn to monitor their feelings in a way that enhances pleasure and satisfaction that lead to optimum sexual decision making. They can role play scenarios with trusted others about how to deal with social pressures they may experience relating to their sexuality.

Cognition

How people think about trauma plays a big role in managing it. Training youth to use multi-sensory self-soothing activities can stimulate cognition, boost memory, and help to organize brain processing (Stien & Kendall, 2004). Promoting cognitive restructuring in youth by using multi-sensory self-soothing activities may influence significant long term change.

Felicia, they/them, was a victim of child sexual abuse. They told their therapist that they struggled with sexual decision making because whenever a partner began caressing their breasts they "zoned out" and the next thing they knew they were having intercourse or had finished having intercourse. They worked hard in both therapy and in their intimate relationships to learn to slow down foreplay so they could pay attention to their feelings and make decisions about if and how they wanted to proceed sexually.

Sexually, this usually means learning how to slow down thinking processes so young people can pay better attention to their thoughts about whatever is going on with them at the time. They can practice thinking through what they like and don't like, and practice communicating such important information to their partner.

Physiology

Physiology is the way in which body parts function. Physiological arousal is the way in which the human body responds to a stimulus. One example is surprise. When people are surprised their heart rate changes and their body is alerted to potentially strong feelings such as joy when the surprise appears to be pleasant, or fear when there is a real or perceived threat of danger. Physiological arousal influences behavior. When people are surprised they may be startled and their body may jerk in response. This is a reflex. Traumatic experiences influence physiological arousal and reflex reactions (Kagan, 2004; Schore, 2003; van der Kolk, 1994). Educating youth about both non-sexual and sexual arousal can help them learn to identify it and use multi-sensory self-soothing to enhance both healing and optimum sexual decision making. (Stien & Kendall, 2004).

Managing arousal can be confusing in a variety of ways. Sexual arousal may be straight forward when a young person is attracted to another and they both agree to engage in some form of sexual expression. It can get confusing when emotions, such as fear, that are not usually associated with sexual arousal come into to play. When young people who have experienced trauma are not informed about the complexities of physiological arousal they may be caught off guard and not understand what's going on with their body. Such confusion may get in the way of optimum decision making if they ignore their fear response and place themselves in harm's way.

Behavior

Youth can learn to manage trauma in ways that lead to optimum sexual decision making and result in an ability to enjoy and celebrate their sexuality. Exploring and practicing multi-sensory coping strategies unique to the youth's interests, skills, and abilities can help them develop life-long patterns that promote health and well being. Such developmental skill building promotes safety, stabilization, and symptom reduction (Stien & Kendall, 2004).

Celebrating sexuality involves:

- Maintaining a personal commitment to safety and self-care

- Practicing affect regulation in all areas of life (home, school and community)
- Assessing and monitoring optimum sexual decision making

Disturbance of Arousal, or Getting Upset and Feeling Out of Control

Disturbance of arousal is another term that is not user friendly. A disturbance of arousal occurs when a person gets upset in response to something that's going on around them. When people get upset they have thoughts, feelings and physiological reactions that influence behavior. Behavior then influences outcomes. Disturbance of arousal is an experience that tests a person's ability to manage their feelings, or affect. Affect regulation promotes positive outcomes and dysregulation is likely to result in negative outcomes. When they understand what's going on youth may feel more in control and able to use healthy coping strategies when they experience a disturbance of arousal.

> If Pete, he/him, arrives at school in a bad mood because Mom was yelling at him before school he has to work to stay calm, and he needs skills to do this. If he dysregulates and misbehaves the outcome may be suspension. If he uses healthy coping skills, regardless of the conflict with mom, the outcome may be behaving well, completing classroom work, and having a good day.

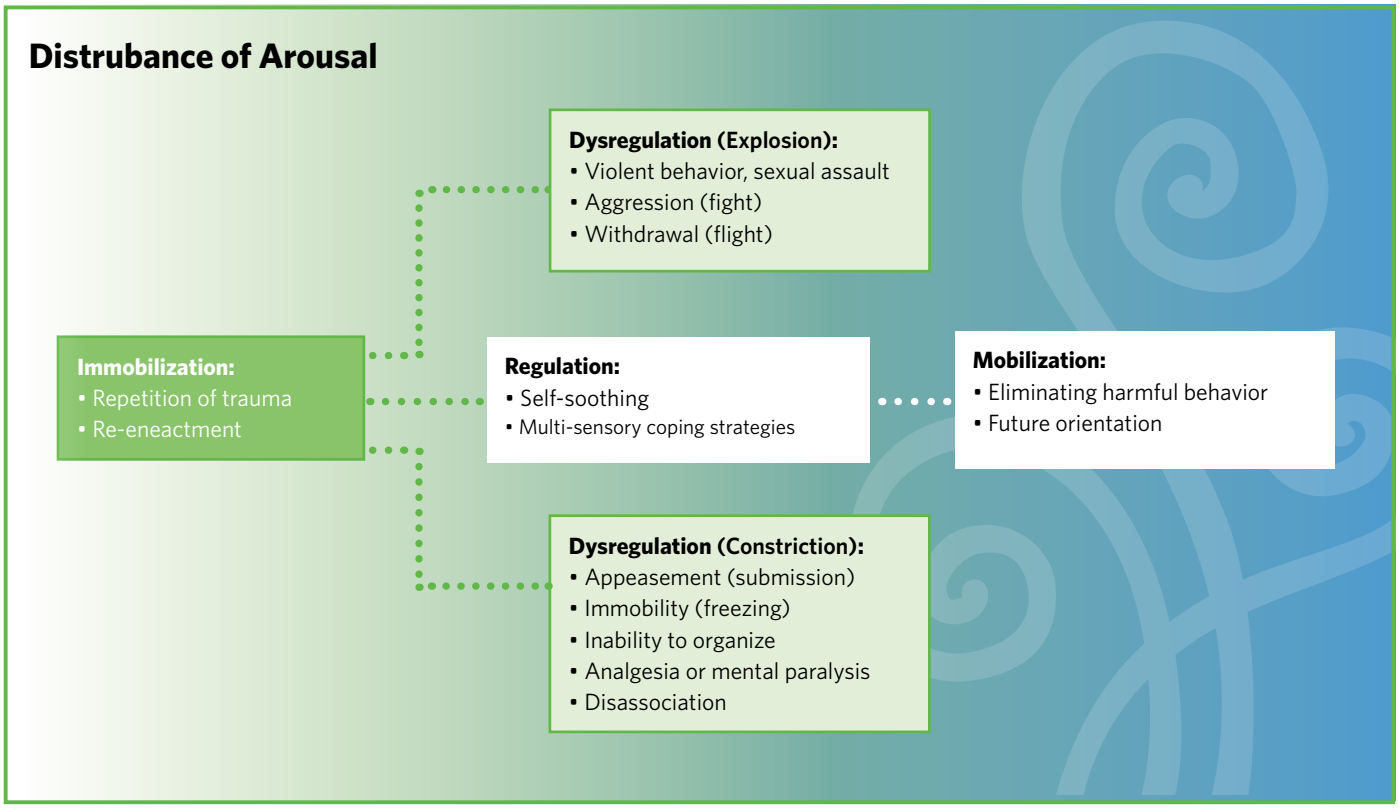
When asked what comes to mind when hearing the word 'arousal' most Americans say "sex." Arousal means to evoke or awaken a feeling, emotion, or response. Humans experience many forms of arousal. A range of stimuli, including, but not limited to pain, hunger, thirst, temperature, love, sex, loneliness, fear, and/or terror can all influence arousal. Everyone is challenged to manage or regulate arousal in pro-social ways. This is affect regulation.

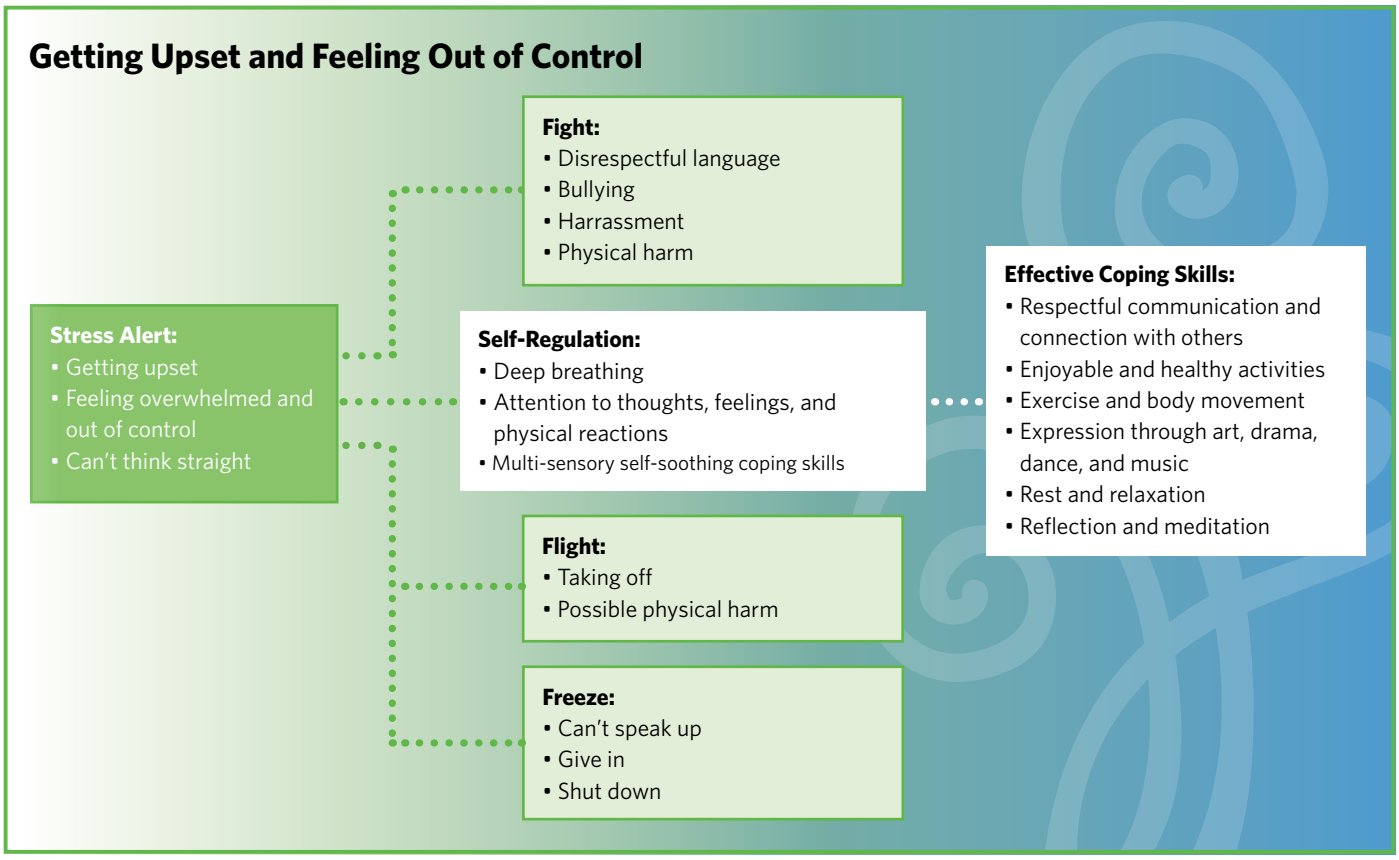
Disturbances of arousal can occur when a stimulus brings up uncomfortable, unsettling, and unwanted reactions. Managing such arousal in ways that cause harm to self or others are examples of dysregulation. Understanding how a disturbance of arousal can lead to dysregulation provides a foundation for intervention. When a person sees or hears something upsetting, they may yell or become aggressive, or they might shut down or freeze up. These are examples of dysregulation.

A range of life experiences can influence dysregulation. They include sickness or injury, family problems and break-ups, natural disasters, poverty, discrimination, violence, school problems, social problems, child abuse, substance abuse, terrorism, and death. Brain injuries and mental health disorders can also play a part in dysregulation.

The flowcharts on the follow page provide an illustration for intervention. The first one shows how research identifies a range of responses that influence different behaviors and the second one is for youth and families.

When people experience trauma and do not receive effective support for managing the impact of it


Distrubance of Arousal
Dysregulation (Explosion):
• Violent behavior, sexual assault
• Aggression (fight)
• Withdrawal (flight)
Immobilization:
• Repetition of trauma
• Re-eneactment
Regulation:
• Self-soothing
• Multi-sensory coping strategies
Mobilization:
• Eliminating harmful behavior
• Future orientation
Dysregulation (Constriction):
• Appeasement (submission)
• Immobility (freezing)
• Inability to organize
• Analgesia or mental paralysis
• Disassociation


Getting Upset and Feeling Out of Control
Fight:
• Disrespectful language
• Bullying
• Harrassment
• Physical harm
Stress Alert:
• Getting upset
• Feeling overwhelmed and out of control
• Can't think straight
Self-Regulation:
• Deep breathing
• Attention to thoughts, feelings, and physical reactions
• Multi-sensory self-soothing coping skills
Effective Coping Skills:
• Respectful communication and connection with others
• Enjoyable and healthy activities
• Exercise and body movement
• Expression through art, drama, dance, and music
• Rest and relaxation
• Reflection and meditation
Flight:
• Taking off
• Possible physical harm
Freeze:
• Can't speak up
• Give in
• Shut down

they are at risk of becoming immobilized by the experience. Immobilizations can lead to repetition of trauma or re-enactment of it. Generally dysregulation occurs through explosion or constriction and the chart further describes specific types of each. Different paths are identified as fight, flight, submission or freezing, or multi-sensory self-soothing. Affect regulation through self-soothing can lead to mobilization, elimination of pathological patterns and future orientation which are vital for healing and moving forward in life.

This second chart is a user-friendly version to help youth and family members explore ways of handling difficult situations. The flow chart helps youth identify how problematic coping strategies prevent healing, and provides a visual map to begin learning how to take good care of one's self.

These flowcharts can help youth and family members make sense of trauma in their lives and explore how to develop healthy coping strategies. Successful affect regulation involves maintaining a personal sense of safety and stability; using exercise and body movement, healthy touch, and expression through art, drama, dance and music for self-soothing and relaxation; and skill building to manage pain without causing harm (Stien & Kendall, 2004).

Promoting affect regulation

Everyone requires a safe and stable environment in which to celebrate their sexuality. Sound familiar? This is the first element of

When Tenisha, she/her, was four years old her mother divorced her father because of his alcoholism and violence. Her mother decided to go back to college so she could better support her family as a single parent. Tenisha then lived with her grandparents most of the time until she was eight years old while her mother worked part time and went to school.

During that time Tenisha was unable to communicate how she longed for more of her mother's attention. Her mother also missed Tenisha but was focused on building a better life for the family and was relieved that Tenisha could spend time with her grandmother. Tenisha adored her grandmother and when she wasn't thinking about missing her mother, she was having fun with her grandmother.

When Tenisha reached adolescence, her resentment toward her mother began to show in indirect ways. She ignored her mother's curfew rules and had friends at home when she wasn't supposed to. Tenisha stopped letting her mother know where she was going after school and began getting into trouble with friends her mother didn't know. Tenisha had police contact because of fights she was getting into after school. One time, when the police picked her up, Tenisha had marijuana in her purse. She had a hard time taking any responsibility for her behavior.

In family therapy, Tenisha revealed deep resentment toward her mother for what she thought was abandonment. Her mother listened to her daughter's views about the past, including Tenisha's feelings of abandonment. She was able to share her intentions about that time and accept responsibility for what unintentionally caused her daughter trauma. Tenisha then began to take more responsibility for her own behavior as her resentment toward her mother diminished and their relationship began to heal.

Key Factors for Affect Regulation
Stien and Kendall (2004)

1. Safety and stabilization
2. Multi-sensory activities that reduce dysregulation:
   - Exercise and body movement
   - Healing touch
   - Expression through art, drama, dance and music
   - Narrative trauma scripting (Trauma Focused Cognitive Behavioral Therapy)
3. Developmental skill building (competency development)

optimum child development: physical and psychological safety. If people are not physically and emotionally safe they cannot focus on health and well being because so much energy is used for protection and harm reduction. When humans are in a physically safe place and feel safe emotionally they can gain support and begin planning how to take good care of themselves. A stable environment provides predictability and a sense of security. These are important factors that help people regulate their emotions.

Talking about trauma in a safe setting is crucial. Real or perceived mistreatment or rejection by loved ones greatly affects behavior and relationships. Communication and new understanding produce cognitive restructuring of past events and can stop violence.

Healing trauma is important for everyone to begin to see a need to take responsibility for harm. This process may need to include individual sessions with the youth and parents separately. Individual therapy gives each family member a chance to sort through feelings and various perspectives in a safe way while gaining a better understanding of other people's experiences. Family sessions can then focus on reconciliation and restoring loving connection.

Tasks for Harm Reduction after Trauma
(van der Kolk, 2004)

- Mindfully observe internal experience
- Stay organized in the threat of psychological upheaval
- Change body activity when addressing pain
- Learn to state success
- Remember survival techniques
- Celebrate survival resources
- Honor life!

In Tenisha's example on the previous page, individual sessions allowed her mother time to process the pain her behavior had caused and to understand complications of misunderstood intentions. It is important to assist parents in looking at a situation from the child's point of view and considering what it might be like to lose such important parental support particularly after witnessing violence, substance abuse and parental divorce.

Another important step is helping parents to see that a youth's harmful behavior may be a reaction to unaddressed pain that was caused years ago. Assisting parents and children in listening to each other, and explaining the past, can create greater understanding and more respectful behavior in the future.

When people learn to think differently, change their brain processing and improve memory, symptoms of trauma can be reduced (Groves, 2002). A part of trauma focused cognitive behavior therapy (TF-CBT) also uses something called narrative trauma scripting which helps people write

about the trauma in order to better manage it. Developmental skill building, another term for competency development, helps heal pain from trauma. The more skills children learn the more likely they are to successfully practice affect regulation.

Starting to see a trend? Research from multiple sources is consistently showing similar findings relating to overlapping issues such as optimum child development, affect regulation, and prevention of harm. Important stuff!

Affect regulation involves mastering tasks for harm reduction (van der Kolk, 2004). These tasks involve teaching youth and family members to pay attention to their thoughts, feelings, and physiological reactions that influence both behavior and outcomes. Van der Kolk refers to this as, 'mindfully observing internal experience' another term that is not user friendly, but is a very important part of affect regulation. When people learn to track thoughts, feelings, and physiological reactions they can change behavior accordingly, and prevent negative outcomes by behaving respectfully.

When youth learn to mindfully observe their internal experiences the next task is to learn how to stay organized in the threat of psychological upheaval, another term for disturbance of arousal. This involves stopping to think in order to make good decisions. Stopping to think is the critical turning point at which a person chooses affect regulation versus dysregulation. People stay organized through disturbances of arousal in a variety of ways. Deep breathing can help as well as positive internal self-talk like saying 'you got this', 'slow down', 'stay calm', 'take it easy', etc.

Tommy, they/them, experienced multiple traumas and abuse during their early childhood. They were tied to a bed at night by one of their mother's boyfriends. When the man untied them in the morning Tommy recalled being given bananas for breakfast. While they were in residential treatment because of their own criminal behavior, Tommy was physically restrained by staff after "going off' when they saw bananas in the cafeteria and sent them and the bowl they were in flying across the room. Tommy later told staff they felt like it was happing again. The resulting dysregulation (out of control behavior) alerted staff and the outcome was a physical restraint, loss of privileges, and restricted movement around the facility due to unsafe behavior. Unfortunately nobody handled the situation in a good way and it wasn't until staff were trained and Tommy learned about affect regulation that the situation improved.

Slowing down brain processing helps youth learn how to change their body state when addressing their deepest pain (van der Kolk, 2004). They can learn how to handle disturbances of arousal without misbehaving. Helping youth explore ways to substitute harm with healthy activity can take a lot of practice, and in fact requires life-long commitment. Youth and adults do this through multi-sensory self-soothing. When youngsters get upset and feel out of control, instead of misbehaving, they can quickly do some-

Multi-sensory self-soothing is a way of using any of the five senses (sight, sound, smell, taste, and touch) to remain calm in difficult situations.

thing like listen to soothing music, go for a run or bike ride, or call someone they trust.

While youth continue to practice these tasks they learn to talk about personal success by acknowledging their improved behavior. Youth who experienced abuse have often been disrespected and demeaned in a lot of ways. They have often been made to feel badly about themselves. Focusing on success is a vital part of positive youth development. Many young people feel uncomfortable with this at first, but most learn to enjoy legitimate praise and support for a job well done.

The next task is to remember how they survived. Some youth have literally been in life-threatening situations and may never have been asked to recall such important information. Like the previous task of learning to state success, remembering how they survived through trauma can greatly influence a youth's sense of competency and self-confidence.

Optimum sexual decision making requires both competency and confidence. A person can be competent to handle a difficult situation, but if they do not have confidence in their ability to do so, it may prove too difficult an undertaking. On the other had, they may have confidence to manage something and find out they are unable to do so. Successful task completion requires a realistic balance between competency and confidence. Positive youth development and mentoring aid in building competency and confidence when children have not had opportunities to do so.

When John, he/him, was asked to describe how he survived being stabbed multiple times, he reflexively put his hands to the wounds and said, "I remembered that you're supposed to put pressure on wounds to get them to stop bleeding, so I just kept pushing my hands against any blood I saw spurting out." He clearly remembered what he did to survive.

Once youth learn to talk about their success and remember how they survived, they are encouraged to celebrate their survival skills. While some of those skills may not serve them well now, or may be illegal, it is very important to acknowledge how crucial survival skills were at the time. For example, stealing food to help feed a family is illegal, but it helped prevent starvation. Some youth from financially impoverished homes recall stealing food, not only for themselves, but for family members as well. Acknowledging that stealing is a crime and honoring their efforts on behalf of their family provide a responsible way of honoring their life, which is the final task for harm reduction (van der Kolk, 2004).

A trauma-informed approach for adolescent sexual health requires an understanding that these youth have often weathered tremendous difficulties in their young lives. They may have experienced demoralizing and dehumanizing ordeals involving disgrace and dishonor. They are often met with high levels of criticism and little warmth or consideration. To honor their life provides an avenue for creating a new story about overcoming adversity that promotes resilience. When young people experience adults as warm, non-judgmental, empathic and genuine, they learn how to develop these attributes themselves.

While it is important to experience the kindness and compassion of others, healing trauma requires an ability to nurture and honor one's self. When youth honor their own life they create a path to life long health and well being.

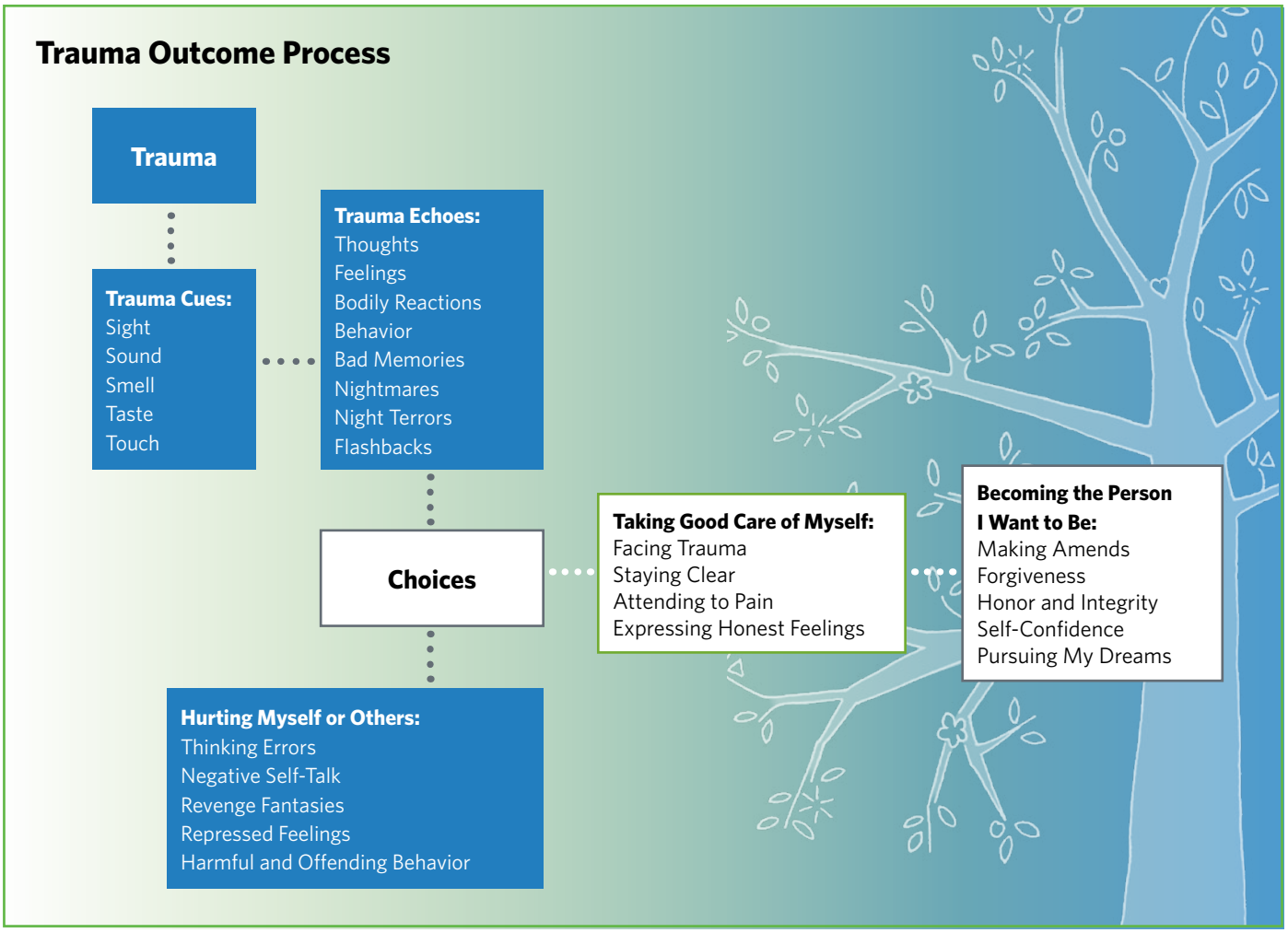
Healing trauma involves learning how to address painful life experiences. Youth and family members may be extremely fearful of facing trauma. Children who have witnessed violence may struggle to learn healthy coping strategies for managing the pain. They may desperately try to put it out of mind, or misbehave in an effort to keep bad memories at bay (Groves, 2002). People often try to cover up pain in an effort to hide vulnerabilities. Such behavior can be especially challenging.

The United States government supports state initiatives to provide evidence-based practices for children receiving services through child welfare, mental health, and/or juvenile justice. In Maine this initiative is called Thrive. It is the statewide clearinghouse for trauma-informed service delivery. Licensed mental health agencies must be certified in a trauma-informed approach in order to receive state contracts and funding for trauma-informed services. Everyone involved in a trauma-informed approach for adolescent sexual health should find out about government supported efforts that make everyone's job easier and result in more successful outcomes.

Trauma Outcome Process

The trauma outcome process is a conceptual framework (Rasmussen, Burton & Christopherson, 1992) designed to simplify how painful life experiences impact feelings (affect), thoughts (cognition), physiological reactions, and behavior. The trauma outcome process is used to create a better understanding of traumatic life events and how to stop harm through competency development. The goal is to help young people make sense of past trauma in order to prevent future problems. It provides a way of tracking behavior, planning for success, taking good care of one's self, and behaving respectfully.

Illustrating a conceptual framework, as we have done on the following page, naturally creates limitations and exceptions. The trauma outcome process doesn't necessarily occur in a stepwise fashion even though the flowchart looks that way. In reality, making sense of trauma does not always fit into categories. The trauma outcome process is simply a way to help youth understand and organize experience in order to promote affect regulation and healing. In order to stop harm, each youth and their social support network can look at events, thoughts, feelings, physiological reactions and behaviors that created a need for services. The trauma outcome process can be used as a map that leads to self-care and becoming



the person they really want to be. It involves building confidence to pursue and realize personal dreams.

The trauma outcome process is used to help people understand the ongoing effects of trauma and promote self-regulation. Youth learn to regulate, or manage their own reactions to trauma through partnership (attachment and connection) with nurturing adults. The model is designed for collaboration among youth, trusted others, and/or staff trained in a therapeutic response to trauma. It provides a way to generalize skills across all aspects of life and helps youth to connect with others in meaningful and benevolent ways.

While doing this work, service providers report hearing youth say things like, "Wow, I'm not crazy after all!" They begin to understand the effect trauma has had on how they treat themselves and others. With this important insight, healing starts to takes place. Individuals come to accept the good and bad things they have done in life and begin pursuing their dreams in order to create a brighter future.

Once youth have come to understand their trauma outcome process and consistently practice healthy coping strategies and optimum sexual decision making it's time to get on with life. Youth are invited to

create a plan for success that details how he or she will practice self-care. Creating the plan takes place with the guidance of trusted adults. This plan becomes the framework for life-long prevention. Practicing the plan requires dedication and commitment. Everyone involved in the youth's life can encourage a youth to stick to their plan for success. This involves consistent affect regulation when responding to disturbances of arousal.

Touch

Sex education and sexual decision making inherently involve values and beliefs about touch. While the focus is not specifically sexual in nature the values are applicable to sexual expression. The following list is a handout given to young people and families to provide a framework for benevolent touch, particularly after anyone has experienced any type of harmful touch such as physical or sexual abuse. Individuals and families can then address challenges they face in practicing respectful touch using the list as an easy reference point.

All touch:

- Is well meaning, kind and charitable
- Is developmentally congruent: It is appropriate for the child's age, intelligence, and mental capacity
- Is based on permission: The person being touched gives permission before it occurs
- Is related to the context in which it is given: It is related to what is going on at the time
- Is clearly communicated: Everyone is able and willing to talk about it
- Models good boundaries: It promotes emotional and physical safety
- Provides comfort and promotes health and well being

Conclusion

Developing skills needed for both teaching accurate sex education and responding to youth with adverse life experiences involves knowledge, integration of information, practice providing a trauma-informed approach, and ongoing supervision.

Successful outcomes are dependent upon a youth's commitment to behave respectfully towards themselves and others. This commitment can be honored and witnessed by people who have supported the youth throughout the healing process. Such support helps young people build confidence for a successful future.

Having a clear picture of how services work makes everyone's job a lot easier and more successful. Planning for success with youth involves a clearly defined structured approach for both sex education and treatment, and sometimes a broad array of additional services. Using a research-based approach helps youth and families heal pain that created a need for services.

Knowing what to look for, or how to create effective services is vital to implementing a successful community-wide trauma-informed approach for adolescent sexual health. A collaborative, multidisciplinary approach focusing on cognitive restructuring, affect regulation, and competency development streamlines efforts and is cost effective. When everyone involved knows what services youth need teen pregnancy rates will further decline; sexually transmitted infections and disease will be reduced, and sexual harm through coercion and/or assault will diminish. Investing in the future of all children in this way is rewarding for everyone!

Recommendations for Responding to Trauma in Sexual Health Courses

A Trauma-Informed Approach for Responding to Problem Behavior, Questions and Disclosures In a Sexuality Program

By Pamela Wilson & Joann Schladale

Background Information for Facilitators:

Participants in a sexual health program may have experienced trauma and sex education information can cause trauma cues for some youth. Trauma cues are simply something that reminds a person of a past bad experience.

Trauma can cause specific symptoms. Youth may exhibit behaviors such as agitation, spacing or tuning out, moving around constantly, misbehaving, and/or struggling to regulate their emotions. This behavior is often misinterpreted as disrespect or negative behavior when it is really a physiological response to prior trauma that is called a trauma echo.

A Safety Plan for Success is a tool that can be used with youth who exhibit a lot of symptoms or disruptive behaviors during the program. The Safety Plan can help them identify ways to manage their behavior during the sessions and to identify adults who can support them in being successful. An example is provided in Appendix B.

Youth may disclose personal experiences with trauma during or outside of the group sessions.

Guidelines for Facilitators:

1. Have a prepared script for introducing the issue of trauma with participants at the beginning of your program:

   Many people have experienced a range of traumatic experiences in their lives. Trauma means bad things that have a lasting effect on your life. Trauma can influence sexual decision making in a variety of ways. Everyone can heal pain caused from trauma and go on to enjoy satisfying and productive lives.

   If you're struggling with memories of past trauma during our time together, please speak with us before or after the session so we can share resources that have helped a lot of young people like yourself. If you bring up personal experiences about trauma during our sessions, we'll ask you to talk with us privately after the session.

2. Be honest about the limits of confidentiality when developing your group contract or ground rules:

   While our time together is confidential, if anyone shares information that indicates harm to self or others, we are bound by law to report such information. That means we have "limited confidentiality.

3. If a participant discloses problem behaviors, such as using drugs or stealing, during the group session:

   I'm so sorry to hear this. Can I speak with you after we finish today and help you explore solutions for staying out of trouble?

   If they persist in talking about it:

   We can't spend time on that issue in this program but I'm happy to help as soon as we finish up today's session.

4. When responding to disclosures and making referrals, use the young person's first name in a gentle and compassionate tone.

5. If a participant discloses engaging in unsafe sexual behaviors during the session:

   That sounds very unsafe.

   Can I speak with you after we finish today and help you explore solutions for safety and health?

6. If a participant privately discloses that they're engaging in unsafe sexual behavior such as having unprotected sex with an older partner, respond as follows:

   You must be concerned to bring this up to me today. I'm so glad you did. What are your concerns?... Can I share my concerns?... I'm worried about two things: 1. Unprotected sex any time and with anyone is unsafe; and 2. There can be a range of concerns about older partners. I'm concerned about your safety and worry about you being coerced or forced in any way...

7. Discourage personal disclosures during the group. However, if a participant discloses trauma during the session, respond in the following manner:

   I'm so very sorry that happened to you. It's also happened to many other young people we've worked with. Let's talk about it more after the session. Will that be alright?

   If the person appears agitated and is disrupting the process:

   How can I help, or What do you need to feel okay right now? Are you able to stay in the class and sit quietly or do you need to leave the room for a few minutes? (When co-facilitating, one partner can accompany the participant outside of the room and provide support.)

   If they say no:

What do you need to keep yourself safe right now?

8. If a participant discloses a past trauma outside of the session, respond as follows:

   I'm so very sorry that happened to you. You're not alone. It happens to a lot of people and can affect your life and sexual decision-making in a lot of ways. Talking to someone you trust about bad things like this (whatever the specific trauma is) can help you heal pain and get on with life. I can get you connected to a trained therapist who can help you find healthy ways to manage your pain without harming yourself or others. How would you feel about that? I'm happy to sit with you while you make the call.

   If you notice fear or hesitation—use the person's first name in a warm tone:

   Sometimes people are nervous about therapy and decide not to keep the appointment. I really hope you'll go so you can feel better sooner. Is there anything I can do to help make sure you keep the appointment?

9. If a participant privately discloses something potentially harmful going on with a friend, such as a youth being forced into prostitution, respond as follows:

   Your friend is in a tough situation and needs help. What do you think might be helpful for them right now?... May I share my concerns?... I can imagine you're very frightened for your friend. Are you afraid for yourself also? What are you most afraid of? Are you willing to give me your friend's name and information about the situation? I'm bound by law to report this information. How can I help you and your friend stay safe? Are there adults we should contact who can help?

   Write down a simple safety plan so the participant has something concrete to leave with.

10. Manage referrals effectively (see Appendix C: Making Referrals):
    - Have a pre-arranged agreement with one or more therapist trained in a trauma-informed approach. Ideally, these therapists will be housed in the agency where the program is being held.
    - Let the therapist(s) know when you're beginning the program and that they might be receiving referrals.
    - Establish a protocol with the therapists.
    - Therapists agree to see participants immediately or within one day of the referral.
    - When a therapist is in house and available, facilitator will walk with the participant to the therapist's office and make the referral in person.
    - If the appointment is not for the same day, facilitator will offer to call the participant that evening to see how they are doing and find out if they need any support to keep their appointment.
    - Therapist will call or email the facilitator within 24 hours to indicate whether the young person kept the appointment.
    - Facilitator will follow-up with participants who don't keep their appointment to find out how they can support them in keeping a new appointment.

Safety Plans

Safety plans can be very simple and can be initiated by a facilitator or a therapist. Typically the plan includes: 1. Healthy coping strategies a youth can use during the sexuality program; and 2. People they can contact when they are struggling with trauma cues. A safety plan should include a statement that the youth agrees to the safety plan as a commitment to prevent harm to self or others and provide their signature and the signatures of those willing to support their success. An example is below.

My Safety Plan for Success

I am a wonderful young person and I want to make proud and responsible sexual decisions that promote my health and well being. This is my plan to make it happen.

If I get upset (experience trauma cues) during class I will:

1. Chew gum or suck on a peppermint.
2. Take deep breaths to help me think clearly.
3. Do something with my hands that is quiet and does not disturb others or disrupt the class, such as using Play Doh or doodling.
4. Sit next to someone I like and trust.
5. Participate to the best of my ability.

When I'm upset outside of class I will:

1. Talk to people I trust about managing the situation in ways that do not cause any harm.
2. Listen to music that helps me feel calm.
3. Exercise regularly even if it's just walking down the hall.
4. Think about calm and soothing things that I like.
5. Participate in therapy if I'm in need of professional help.

I know it can be hard to make good sexual decisions and I agree to practice taking good care of myself. My name and signature are here as proof that I want to be successful.

People care about me and want to help me succeed. Their names and signatures are here so I can remember that they support me, and my good decision making.

Optimum Referrals

Making Referrals for Addressing Trauma
When Identified by Participants in a Sexuality Program

Identify local agencies and/or individual therapists that advertise specialized services for addressing trauma in general and sexual trauma specifically. Ask questions to make sure these agencies are actually providing trauma-informed services based on empirical data and research. If the state requires special credentials that qualify the agency or individual to identify themselves as a "trauma-informed agency (or professional)" ask them for proof of this designation.

Create a directory of providers with contact information. Make sure all clinical providers are licensed Qualified Mental Health Providers (QMHP). If available from providers, include brochures and/or website information.

Establish an agreement with specific providers to have them offer counseling/therapy for youth participating in the sexuality program.

Ideally, clinical providers will be housed in the same agency where the program is being offered. When a mental health provider is not on site, ask the therapist to inform facilitators within 24 hours whether or not a youth showed up for their appointment.

If providers do not indicate whether participants kept their appointments within agreed-upon time, facilitator should contact them before the next group session.

When a safety plan is indicated, ask provider to give facilitators a copy of the plan.

Gender

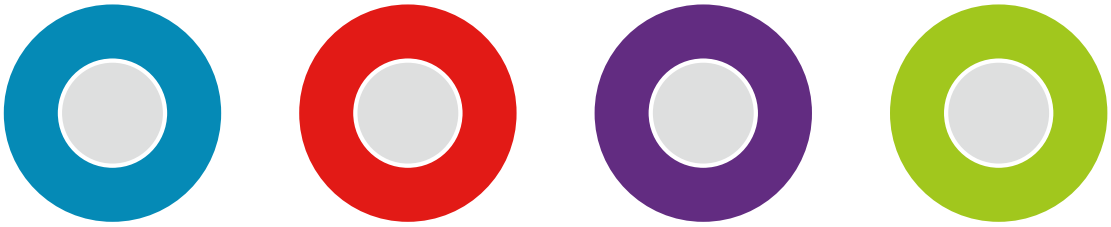
Sex assigned at birth is a limited way of thinking about gender. It only considers private body parts known as genitals.

Whatever your sex assigned at birth, **you may be…**

Gender Identity

Which might be different from how you express yourself to others.
However you identify, **you might express yourself as…**

Gender Expression

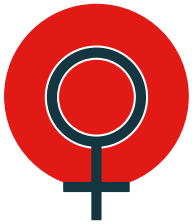


Who are you attracted to?
Regardless of your sexual identity and expression, you may be sexually and emotionally attracted to men, women, a combination, or no one.

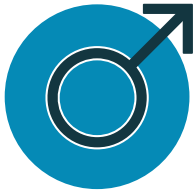
Sexual attraction

Emotional attraction

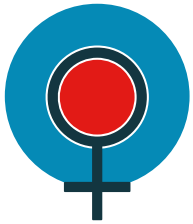
Gender Identity & Expression - Examples



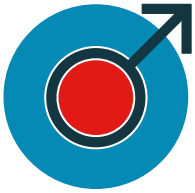
Many people are born female, and identify and express themselves as female.



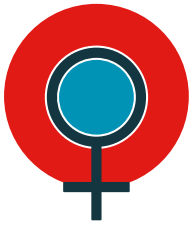
Many people are born male, and identify and express themselves as male.



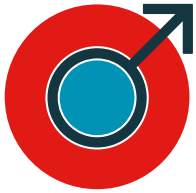
Some people are born female, identify as female, and express themselves as male.



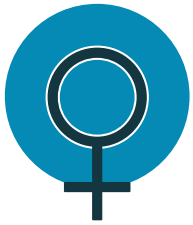
Some people are born male, identify as female, and express themselves as male.



Some people are born female, identify as male, and express themselves as female.



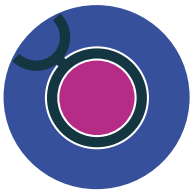
Some people are born male, identify as male, and express themselves as female.



Some people are born female, identify as male, and express themselves as male.

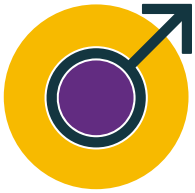
Some people are born male, identify as female, and express themselves as female.

Gender is much more than just being male or female. Here are some examples:



Someone born intersex might identify as somewhat female and express themselves as somewhat male.

Someone born female might identify as male and express themselves neutrally.



Someone born male might identify as both male and female and express themselves as somewhat female.

Sexual & Emotional Attraction - Examples

You might be emotionally attracted to men and gender-fluid people, but sexually attracted to only men.

You might be emotionally and sexually attracted to only women.

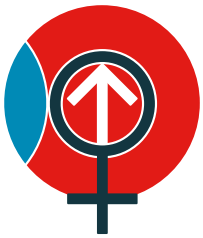
You might have no interest in emotional connections and be sexually attracted to anyone.

You might feel emotionally attracted to anyone and be sexually attracted to no one.

Sex assigned at birth, gender identity, and gender expression can all influence attraction.
There are many possibilities because we are all unique.

Gender Identity & Expression with Sexual & Emotional Attraction - Stories

I was born male and I like women. I am a man all the way, baby! I don't mean to say I'm better than others. Live and let live, right?

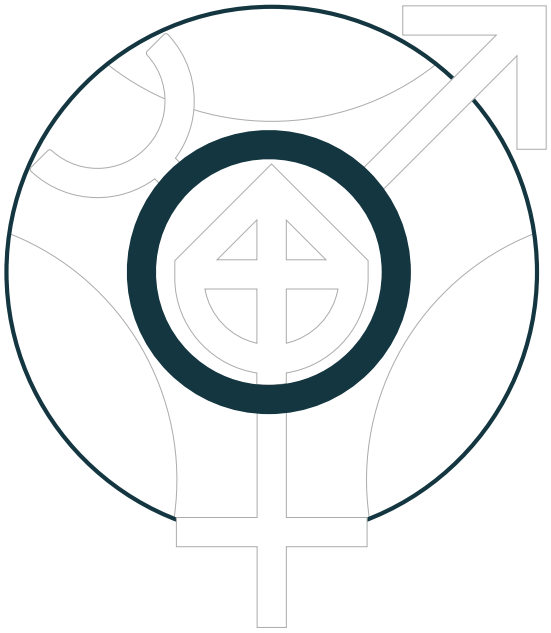


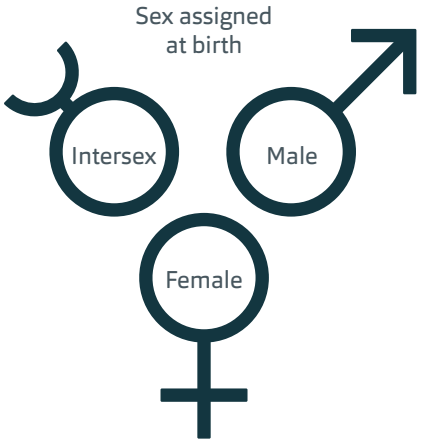
I'm a pretty traditional girl. I'm only attracted to men. I have both male and female friends, but I wouldn't say I'm "emotionally attracted" to them.

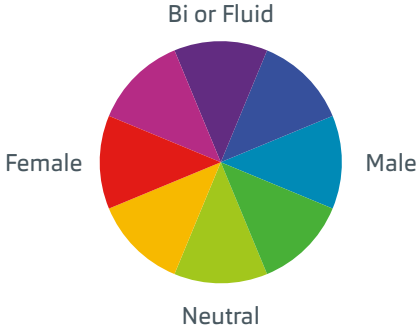
I have male and female genitals. When I was born doctors thought I was male, but I've always felt like a girl. Now I can be the woman I am. I'm attracted to all kinds of people.

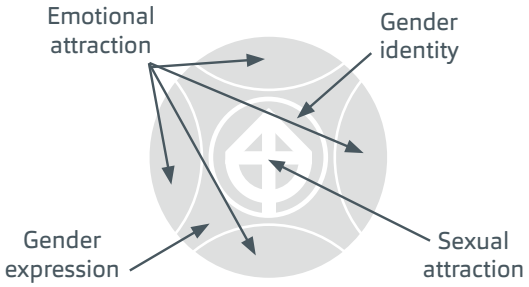
I feel a little like a female, but really, I just feel like a human being, like gender isn't important. I'm not into sex, but I love to connect with people.

With some markers, you can create your own









Advocates for Youth: www.advocatesforyouth.org

Centers for Disease Control and Prevention: www.cdc.gov

Cornell Research Programs on Self-Injurious Behaviors: www.crpsib.com

Federation of Families for Children's Mental Health: www.ffcmh.org

The Future of Children: www.futureofchildren.org

Future of Sex Education Initiative: www.futureofsexeducation.org

Guttmacher Institute: www.guttmacher.org

Harvard University: www.developingchild.harvard.edu

Healthy Teen Network: www.healthyteennetwork.org

National Campaign for Prevention of Teen and Unwanted Pregnancy: www.thenationalcampaign.org

National Child Traumatic Stress Network: www.nctsn.org

National Crime Victims Research and Treatment Center: www.academicdepartments.musc.edu/ncvc

National Research Council and Institute of Medicine: www.nationalacademies.org/nrc

National Technical Assistance Center for Children's Mental Health: www.gucchd.georgetown.edu

Office of the Surgeon General: surgeongeneral.gov

Parents, Families, Friends, and Allies United with LGBT (PFLAG): www.community.pflag.org

Planned Parenthood: www.plannedparenthood.org

Resources For Resolving Violence, Inc.: www.resourcesforresolvingviolence.com

Rutgers University: www.answer.rutgers.edu

Safe Youth: www.safeyouth.gov

Search Institute: search-institute.org

Self Injury: www.selfinjury.com

Sex Education Library: www.sexedlibrary.org

Sexuality Information and Education Council of the United States: www.siecus.org

Stop Bullying Now: www.stopbullyingnow.hrsa.gov

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Joann Schladale is a licensed marriage and family therapist, resilience, and health promotion specialist focusing on positive development across the lifespan, trauma, violence prevention, sexual health, problem sexual behavior, teen pregnancy prevention, and Motivational Interviewing.

She developed the innovative and promising intervention, Practice Self-Regulation™ (PS-R) studied through multi-year federal grants around the country. Her most recent publication is Everybody Gets Upset Sometimes, a children's book for little ones aged 3-8. Additionally, Everyone Can Be Trauma-Informed: A Foundation for Practice (2020)was written early in the COVID pandemic. She co-authored Stop It! A Practical Guide for Youth Violence Prevention, (2012) and has written the workbooks Practice Self-Regulation (2018), and Practice Self-Regulation for Sexual Health (2021, 3nd Edition) for youth aged 12 and above.

She is the 2018 recipient of the international Gail Burns-Smith award for significant contributions to preventing sexual violence through partnerships between victim/survivor advocates and professionals working with those who have caused sexual violence awarded by the National Sexual Violence Resource Center (NSVRC) and the Association for the Treatment of Sexual Abusers (ATSA).

Joann is now semi-retired and supports a small diverse and highly specialized team of PS-R national trainers providing resilience-based, trauma-informed services through training and consultation around the United States.

Brittany Howell-Abbate, LPCC is a licensed mental health therapist and clinical supervisor in Albuquerque, NM. She specializes in working with children and families impacted by trauma and adversity and is a rostered Child Parent Psychotherapy (CPP) clinician and supervisor. She is passionate about establishing positive family interactions, healthy decision making, and providing psychoeducation about the importance of self-regulation and nurturing relationships.

Brittany provided vital leadership in a 5-year federal grant evaluating Practice Self-Regulation™ with vulnerable youth and was directly involved in model development, pilot, facilitation, supervision, and training of new facilitators. Brittany is dedicated to promoting intergenerational family support that builds protective factors to enhance all family member's resilience and motivation for life-long health and well-being.

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practiceselfregulation.com
info@practiceselfregulation