Practice Self-Regulation™
Intervention Package

Joann Schladale, MS, LMFT

Table of Contents

ALL LINE ITEMS ARE LINKED - CLICK TO JUMP TO PAGE

Creating effective, sustainable programs is critical for impacting adolescent health and well-being in the long-term. Practice Self-Regulation™(PS-R) was designed for youth who have experienced trauma by program developer Joann Schladale with sustainability in mind.

PS-R for Sexual Health Program Effectiveness

A pilot study of this intervention was conducted in 2010 in South Florida involving two agencies that served adolescents who were in the process of transitioning from foster care to independent living. A total of 31 participants between the ages of 12 and 23 completed both an intake questionnaire and an exit questionnaire. Youth who participated in the program reported higher rates of talking to a trained counselor about sex and sexual health and using contraception at last sexual encounter after the program ended.

In 2015, The Policy & Research Group (PRG) received a grant from the Office of Adolescent Health Teen Pregnancy Prevention Program to evaluate the effectiveness of PS-R using a randomized controlled trial. The study took place in five states with over 100 masters-level clinicians in various therapeutic settings that serve youth ages 14-19 who have experienced trauma.

Although an impact study to assess the efficacy of PS-R was originally planned, federal funding disruptions in 2017 interrupted recruitment and enrollment efforts mid-way through the project. The target sample size for the impact study was 600 youth; this was exceptionally large because according to the program's theory of change, the confirmatory outcomes (sexual behaviors) were indirectly influenced and distal to much of the program content, which was focused primarily on awareness and regulation of affect and practice of self-regulation. However, at the end of the enrollment period only 432 participants had been enrolled. As a result, there was an insufficient number of participants for adequate statistical power to detect effects on confirmatory outcomes.

In consultation with the Office of Population Affairs, it was decided that impact findings on confirmatory outcomes could not be produced because they would not have represented a fair test of the efficacy of PS-R. Thus, data provided here come from the implementation study, an exploratory study of impact on behavioral antecedents directly targeted by the program, and a subsequent qualitative study that was conducted to better understand the challenges of conducting rigorous research of a manualized intervention in a therapeutic setting. The qualitative study reflects the perceptions of 22 therapists who participated as PS-R facilitators in the implementation study and were interviewed once the impact and implementation study had been completed.

Participant Characteristics:

The evaluation team enrolled 432 participants into the impact study. At the time of enrollment, Participants' average age was 16 years, and on average had completed 10 years of schooling. The majority of participants identified as White (45.7%), followed by multi-racial (11.1%), Black (10.2%), and another race (5.8%); 41.5% participants identified as Hispanic ethnicity. Youth in the study reported an average of 6 adverse childhood experiences (ACEs). The literature indicates that three or more ACEs are typically associated with emotional and physical impairment. On the K-6 Distress Scale, participants had an average score of 12.3, which is very close to the cut-point of 13 indicating "serious mental illness." These data demonstrate just how vulnerable youth were who enrolled in this study.

Promising data from the implementation study indicate that:

- The majority of program participants favorably rated the quality of the PS-R intervention, with large percentages selecting the words useful (71%), helpful (67%), and interesting (62%) to describe the program. Of the 167 participants who provided feedback data and received at least one PS-R session, 76% reported that they would recommend the program to other teens.
- Facilitators delivered PS-R sessions with very high fidelity, with observers reporting that an average of 93% of required activities were completed in each session.
- Participants report that they intend to use the PS-R content received in their own lives. On a scale from 1 to 5, with higher scores indicating greater agreement, PS-R participants rated the sexual health information and skills provided in the PS-R intervention as 4.4.

Promising data from the exploratory study indicate that:

Participants may experience short-term positive impacts in contraceptive knowledge, beliefs, attitudes, and self-perceived skills. Specifically, when comparing participants assigned to PS-R relative to participants assigned to the control group, we observed significant or marginally significant differences in the desired direction immediately after the intervention period had ended in:

- Contraceptive knowledge
- Intention to practice sexual self-regulation
- Beliefs regarding the malleability of emotions
- Importance of and intention to practice affect regulation
- Affect regulation self-efficacy

Promising data from the qualitative study indicate that:

Facilitators like the structure of PS-R, specifically as a way to address sexual health content. They mentioned that it helped them to "normalize" some topics that can be uncomfortable. They were attracted to it as a way to guide and empower adolescents in health decision-making processes to try and mitigate some of the riskier choices they may be inclined to make, teach emotional self-regulation, and talk about healthy relationships. Some therapists also felt that the intervention was designed in a way where it could be used either in its intended format or as piecemeal activities that they could pick and choose when relevant.

Concerns identified in each of the studies include:

- Effects of funding disruption on the impact study
- Challenges experienced in providing treatment participants with all 10 PS-R sessions during the implementation study time period which resulted in condensing materials to 8 sessions
- Attenuation of program impact on the beliefs, attitudes, and self-perceived skills of PS-R participants in the long-term, as observed in the exploratory study
- Some facilitators' discomfort in providing sexual health content to PS-R participants, expressed in the qualitative study

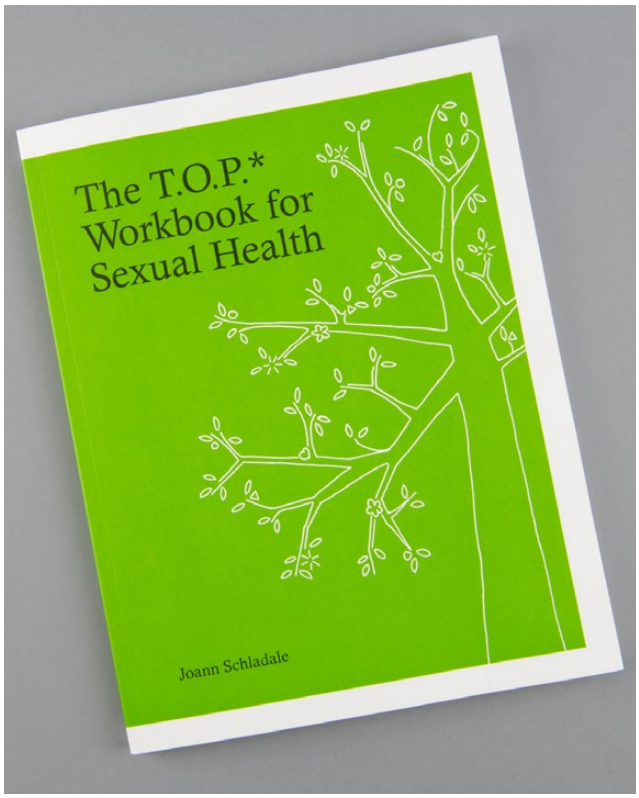
In 2016, PRG received a grant from the Family and Youth Services Bureau (FYSB) to evaluate the effectiveness of e-PS-R, the blended learning version of PS-R which involves eight on-line sessions and four facilitator meetings. This study took place in two states with juvenile justice involved youth ages 14-19. This study ended in 2020, and results will be posted when the analysis is complete in 2021-2022.

Core Components

Practice Self-Regulation™ has nine core components that make up a foundation for long-term health and well-being. The content of each component (what is taught) is listed below, followed by a description of the intervention's pedagogy (how the content should be taught) and implementation guidance (the learning environment in which the program should be taught).

1. Practice Self-Regulation™ is Trauma-Informed:
Acknowledging and understanding the impact of adverse childhood experiences and trauma on current behavior.

2. Self-Regulation: Introducing, teaching, and supporting each participant's practice of self-regulation (thoughts, feelings, physiological reactions, behavior, and outcomes). Facilitate understanding and exploration of self-regulation's relationship to, and influence on sexual decision-making.



3. T.O.P.* Workbook for Sexual Health: Youth generally complete the workbook on their own time. Some need support working on it during sessions in collaboration with the facilitator. The workbook contains self-directed activities that help simplify complex concepts related to trauma. This helps youth more easily understand and apply effective coping strategies for self-regulation and optimal sexual decision-making. The workbook provides a clearly defined and structured way of guiding youth through the therapeutic process.

4. Multi-Sensory Activities: Neuroscience indicates that multi-sensory activities enhance brain processing and executive functioning (working memory, analysis and synthesis, organizational skills, internal speech, emotional and behavioral regulation). Each session includes at least one multi-sensory activity such as guided imagery or other mindfulness practices. Other activities enhance self-awareness through drawing and/or writing, such as creating a personal shield for self-protection or a self-portrait of the person they want to be.

5. Positive Youth Development: Research indicates that focusing on strength and resources promotes therapeutic change. It also indicates that people are more likely to be successful working towards a goal (sexual health) rather than trying to avoid something negative (pregnancy, STI's, harm to self or others). This represents contrast between approach and avoidance focused interventions.

6. Self-Efficacy (autonomy): Motivational Interviewing is used as the foundational philosophical approach to promote life-long optimal sexual decision-making. This involves helping youth to understand influences on sexual decision-making, addressing discord, ambivalence, and increasing motivation to practice optimal sexual decision-making.

7. Personal Values: Youth identify personal values and refer to them throughout the process in order to move towards alignment between their stated values and behavior.

8. Uniform Session Structure: Creating and maintaining a safe, stable, and supportive environment is a foundation of trauma-informed care. Predictability is an element of stability and identifying clear expectations for change influences successful outcomes in psychotherapy. Using a uniform session structure streamlines the therapeutic process and reduces stress for both therapists and participants. After the first introductory session the following nine involve:

- Checking-in and facilitating a decision dialogue

- Monitoring progress in the workbook
- Sex education and/or multi-sensory activities
- Obtaining client feedback through Wrap Up questions

9. Future Orientation: Research indicates that future orientation is a predictive factor for positive youth development and youth violence prevention.

Pedagogy

Five pedagogical approaches are used when delivering PS-R.

1. Individual Sessions: Supporting youth healing from trauma requires safe and supportive confidential communication to promote health and well-being. It is imperative that all communication meets Health Insurance Portability and Accountability Act (HIPAA) requirements ensuring data privacy and security provisions for safeguarding mental health information.

2. Motivational Interviewing: This is a collaborative conversation style for strengthening a person's own motivation and commitment to change (Miller & Rollnick, 2013). It provides a foundation for optimally engaging participants and communicating effectively. All facilitators are expected to demonstrate competence in this philosophical approach.

3. Role Modeling: Children learn what they live. When facilitators model health, well-being, self-care, and warm, nonjudgmental, empathic, and genuine communication young people are more likely to mirror such behavior.

4. Affect Regulation: A trauma-informed approach for adolescent sexual health is predicated on affect regulation. Affect regulation has five core components: thoughts (cognition), feelings (affect), physiological reactions, behavior, and outcomes. The first three are internal processes people learn to mindfully observe as they experience external stimuli (arousal [not necessarily sexual]). These three internal elements influence decision-making that in turn influences behavior and outcomes. While cognition and behavior play a part in all therapy this approach is not limited to cognitive behavioral therapy (CBT). This model reflects tenets of trauma-informed interventions promoted through the National Child Traumatic Stress Network (NCTSN).

5. Skill Practice: People are most likely to remember what they directly experience and practice. Neuroscience indicates that humans thrive in settings that provide a variety of stimulating, engaging, and increasingly challenging experiences with enough repetition to solidify desired outcomes (Steinberg, 2014, van der Kolk, 2014). Opportunities to practice personal ideas for change allows for mistakes and poor judgment to be self-corrected with support and encouragement (Steinberg, 2014, van der Kolk, 2014).

Implementation

Population: PS-R is designed for youth aged 12 and above. Unless a 10 or 11-year-old is highly motivated and has the intellectual capacity to comprehend all elements of the intervention, it is not recommended for anyone under the age of 12. It should never be facilitated with anyone under age 10.

Facilitation Setting: PS-R should be facilitated in private and confidential individual sessions by professionals trained in the model. It is not recommended for group or family therapy, as highly sensitive topics related to trauma may be unsafe to address outside of individual meetings.

Program Duration: PS-R has structured sessions intended to promote optimal sexual decision-making. It is intended to be delivered in one-hour sessions over consecutive weeks (one session each week); however, it may be facilitated twice a week or it may take longer depending on a youth's mental health and scheduling needs.

Model Flexibility

Timing of intervention: Facilitators pace all activity in collaboration with each participant based on a youth's abilities and decisions about participation throughout the entire process. Any time a youth is unable to focus, session plan activity is suspended until the youth can competently participate again. This may occur briefly during a session, or may require suspension of one or more sessions.

Session activities a participant chooses: Youth are always invited to participate in ways that best meet their needs within the range of choices between the workbook, multi-sensory activities, and sex education. It doesn't matter whether a youth does the workbook on their own time, individually during sessions, or in collaboration with the facilitator during sessions.

Additionally, youth may, or may not participate in multi-sensory activities during sessions. If they are not interested during a specific session, they are welcome to do so at a later time. It doesn't matter if they want to do an activity not designated in a specific Session Plan. Facilitators are encouraged to facilitate the activity a youth wants

to do and wait to proceed to the next Session Plan. Participants may also repeat any activities whenever they want to.

Intensity of focus: While youth have choices among activities, collaboration between a facilitator and participant indicate the depth in which each one is addressed. Youth should never be required, pressured, or coerced into participation.

Number of activities: Youth make this decision based on personal interest and motivation.

Logic Model and Theory

Theory of Change

The theory of change for this intervention integrates current research on adolescent development and brain processing that reflects the neuroscience of decision-making and behavior (Jensen & Nutt, 2015; Steinberg, 2104; van der Kolk, 2014). While the goal is to prevent pregnancy, infection, disease, and harm to self and/or others, the means for accomplishing such a goal involves three interactive components. As a participant's knowledge about safe sex practices increases, so does their knowledge about the impact of trauma on sexual decision-making through both the T.O.P Workbook for Sexual Health (Schladale, 2016) and multi-sensory activities created to enhance memory retention and optimal decision-making.

Exploring the impact of trauma helps participants recognize harmful habits and consider motivation to change harmful behaviors. In addition to knowledge, the intervention addresses impulsivity and skills to improve affect regulation. The combination of self-awareness, skills, and motivation for change results in increased self-efficacy to both negotiate and practice safe sex. The program should result in an increase in harm-free sex, condom use, a decrease in number of sexual partners, and ultimately reduce the chance of the youth getting pregnant or impregnating a partner before age 20.

The T.O.P.* Workbook for Sexual Health Facilitator's Guide includes theoretical underpinnings for the intervention. They include theories of attachment, human ecology, family systems, and social learning.

Attachment: Attachment is an instinctual biological bond that a child has with significant caregivers. Human capacity for self-regulation develops through attachment. Secure infant attachment occurs when attuned caregivers meet a child's needs. A child learns trust through this process, which produces chemical changes in the brain that influence self-regulation. When secure attachment is threatened, significant chemical changes occur in an infant's brain. When caregivers are not consistently predictable, or responsive, infants

can fail to develop a capacity to self soothe. (Bowlby, 1988; Siegel, 1999; Applegate & Shapiro, 2005).

As youth experience secure relational connections, their belief system about relationships can change. Throughout the intervention, facilitators model benevolent connection, provide psychoeducation, support youth's exploration of attachment, and provide mentoring. When healing occurs, relationship patterns are positively changed.

Human Ecology: The narrative approach of this workbook utilizes a life course perspective based on theories of human and family ecology. Ecology is simply the relationship between a person and the various elements of their environment (Bronfenbrenner, 1979). In this case, a youth's ecology is made up of their living environment, neighbors, school, church, and broader community. Addressing challenges participants face in their day to day lives enhances potential for them to develop and practice self-awareness focused on learning to take good care of themselves.

Family Systems: Research recognizes that the behavior of a youth receiving services may reflect the pain of an over-stressed family system (Saunders, Berliner, & Hanson, 2004; Thornton, Craft, Dahlberg, Lynch & Baer, 2002; Kagan & Schlosberg, 1989). Systems theory provides a relational way of viewing behavior. It emphasizes reciprocity, relationships, context, and patterns (Becvar & Becvar, 1988).

Integrating underlying assumptions of systems theory (Hoffman, 1981) is central to this intervention. Maintaining a belief that the whole is greater than the sum of its parts illustrates the importance of engaging youth in the setting in which they live. This philosophy embraces an assumption that many people working together have a greater opportunity for success than a few working in isolation. It also illuminates the phenomenon that adults actively influence similar emotional states in children (Stein & Kendall, 2004). While negative parent-child experiences hinder development and brain functioning, positive interactions with other adults can facilitate restorative processes that promote stress reduction, memory retention, maturation, health and well-being. Such interaction has a ripple effect in which all participants can embrace a commitment for sexual health.

Social Learning: This explains how behavior is learned and maintained (Bandura, 1985). It occurs through observation of others in the context of relationships or obtained symbolically through media presentation. Witnessing violence increases childhood vulnerabilities (Groves, 2002; Dodge, Pettit & Bates, 1997). When children are raised in an environment that glorifies violence and/or models the use of violence as an acceptable way of meeting needs, they may choose to sustain relationships in a similar manner. Youth are often unable to understand complex elements of violence and abuse; hence they perpetuate it without clearly understanding the impact on self and others.

Life experiences influence brain development and trauma can cause significant impairment. Helping young people who have experienced trauma make sense of how adverse childhood experiences (ACEs) impact their relationships and sexual decision-making can influence motivation for sexual health and well-being.

Adaptation Guidance

Practice Self-Regulation™ for Sexual Health is designed to be facilitated in individual sessions with a facilitator specifically trained in the model. Due to the sensitive nature of trauma it should not be facilitated in group or family therapy. The model has nine core components promoting long-term health and well-being. While flexibility is built into the model, the following adaptation guidelines can help organizations and facilitators promote optimal effectiveness across a variety of settings.

Core component 1: Trauma-informed

Adaptation: PS-R can be facilitated in a wide variety of safe and supportive settings.

Rationale and guidance: The Substance Abuse and Mental Health Services Administration of the United States federal government has designated key elements and key principles of trauma-informed services (SAMHSA, 2014). When these elements and principles are adhered to, the intervention can be facilitated indoors or outdoors in any setting that provides private and confidential space for communication and facilitation of multi-sensory activities.

Core component 2: Positive youth development

Adaptation: Identifying, affirming, and promoting individual strengths.

Rationale and guidance: Motivational Interviewing and positive youth development have been shown to provide direct and effective approaches to change. When facilitators interact with participants in warm, nonjudgmental, empathic and genuine ways, youth are most likely to consider positive change in their lives (Duncan, Miller, Wampold, & Hubble, 2009).

Core component 3: Uniform session structure

Adaptation: Streamline session process and content.

Rationale and guidance: Predictability is a potentially calming and stress reducing experience that can lower stress hormones. When people can expect and experience familiar and generally positive interactions, the brain, mind, and body can focus better, more effectively retain information, and improve executive

functioning. When facilitators follow the uniform structure of each session, interaction becomes predictable, and participants are more likely to feel calm, competent, and confident in addressing challenges that promote positive change. Two empirically predictive questions anchor the beginning and wrap up each session.

Core component 4: Self-efficacy (autonomy)

Adaptation: Allow and support youth in making their own decisions

Rationale and guidance: Neuroscience indicates that young people thrive in trauma-informed settings that respond to their needs with flexibility and allow for mistakes and poor judgment to be self-corrected with adult support and encouragement. Even when participants are not making optimal decisions, it is imperative that facilitators respectfully accept their choices. Directing, dictating, and expecting to youth to do whatever facilitators tell them to do goes against the entire foundation of the model.

Core component 5: Personal values

Adaptation: Facilitating the Motivational Interviewing Personal Values Card Sort.

Rationale and guidance: This simple and straightforward values card sort is provided free of charge to download and use in a wide range of settings. It is an efficient tool for organizing and thinking about personal values and exploring what is most important to participants. It is highly recommended as a foundation for exploring life experiences and creating a vision for becoming the person a participant wants to be.

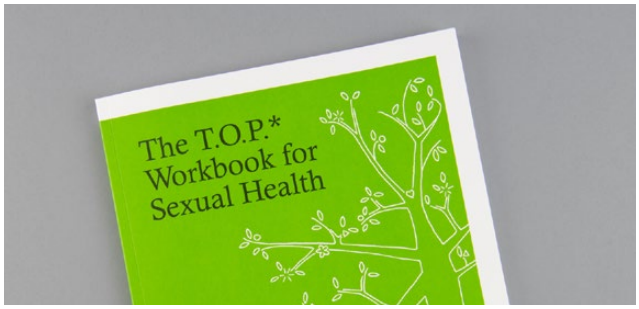
Core component 6: Affect regulation

Adaptation: Introducing, teaching, and supporting the practice of self-regulation can be done in a wide variety of ways that reflect the neuroscience of trauma and decision-making.

Rationale and guidance: Affect regulation is the central unifying element of the model. Effective programs are sequenced, active, focused, stimulating, scaffolded (demanding, but not so much that they overwhelm capability) and sustained through practice (Saunders, Berliner & Hanson, 2004; Steinberg, 2014). Intervention should involve activities to improve executive functioning (working memory, analysis and synthesis, organizational skills, internal speech, emotional and behavioral regulation); require intense concentration; mindfulness practice; exercise; and strategies to boost self-control and the ability to delay gratification (Steinberg, 2014).

Core component 7: T.O.P.* Workbook for Sexual Health

Adaptation: Reading the workbook and processing it in session.



Rationale and guidance: The workbook, a clearly defined and structured framework for healing trauma, is meant to be read and processed in sequence as each chapter builds on previous information and establishes a purposeful flow. Skipping over sections or chapters is not recommended. Participants who are motivated to complete the workbook often read it and answer questions semi-autonomously on their own. Those who are ambivalent may focus on some parts and not on others, or may read the workbook and not answer some, or all of the questions in writing. Others may want to read the workbook in session with the facilitator's support and assistance. Participants should be nonjudgmentally supported no matter how they go through it even if they are unwilling to read it at all.

Core component 8: Multi-sensory activities

Adaptation: Facilitating specifically focused activities.

Rationale and guidance: Multi-sensory activities reflect the neuroscience of cognitive and affective processing that enhance memory retention and behavioral change. They promote understanding of key concepts and help participants reduce impulsivity, learn to negotiate, and practice harm free and protected sex. PS-R activities were specifically chosen for each session in order to build on the affiliated chapter topics and sexual health information. Activities designated for the intervention are highly recommended.

Core component 9: Future orientation

Adaptation: Creating a vision for success.

Rationale and guidance: Future orientation is considered a protective factor for everyone, and especially for youth with adverse childhood experiences (ACEs). Envisioning a goal, identifying a plan and writing it down, and creating a vision for a positive future are all known to enhance potential for successful outcomes. While mindfulness activities help to ground participants in the here and now, future oriented activities can provide motivation for long-term change. Combining both maximizes neuroprocessing to enhance understanding, promote effective memory retention, reduce impulsivity, negotiate, and practice harm-free and protected sex.

Research Studies

Here are details about the randomized controlled trials for both PS-R, funded by the Office of Adolescent Health (OAH) and e-PS-R, the Family and Youth Services Bureau (FYSB) through the federal department of Health and Human Services (HHS).

Target Populations

In order to be eligible to participate in the studies, youth needed to meet the following criteria:

- Aged 14-19
- Receiving outpatient counseling services at one of the study's implementation sites (OAH), or involved in Juvenile Justice (FYSB)
- Deemed appropriate for the study by agency staff with regards to physical and mental health
- Not previously used either of the T.O.P.* Workbooks
- No previous participation in the PS-R program

Settings

The PS-R, OAH study was facilitated by masters-level licensed clinicians in New Mexico, Michigan, Maine, Louisiana, and California.

The e-PS-R, FYSB study was facilitated by non-clinically trained study coordinators in rural New Mexico and West Virginia.

Length

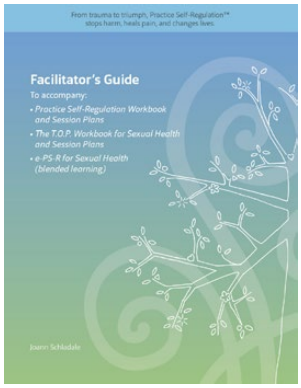
Practice Self-Regulation™ was composed of 10 structured 55-minute individual therapy sessions. For the study, therapists had 18 weeks to deliver the 10 PS-R sessions. The intervention was intended to be conducted weekly.

e-PS-R (electronic blended learning) is composed of 8 on-line sessions and four 45-minute helper meetings. Study coordinators had 12 weeks to complete the intervention on a weekly basis.

Facilitator Guide and Curriculum

Program Overview, Background, and Implementation Information: (available on the PS-R website)

- Program's Effectiveness
- Core Components
- Logic Model and Theory
- Implementation Guidance
- Adaptation Guidance
- Resources and Support



Facilitator Guide

PS-R intervention materials

Those who purchase the PS-R intervention receive the following materials:

Intervention Package: (materials for purchase) All elements of the intervention have passed the federal Medical Accuracy Review Board.

PS-R Session Plans: Laminated session plans, Sex Ed fact sheets, and flow charts for designated multi-sensory activities. Each session plan has detailed information on everything needed to successfully facilitate every element of each session.

Sex Ed Fact Sheets: These include medically accurate anatomy charts, puberty information sheet, sexual identity information, risks for pregnancy and disease, and contraception description sheets.

T.O.P.* Workbook for Sexual Health: Each intervention package includes 1 workbook for a facilitator. Additional workbooks are purchased for each participating youth as they are confidential and cannot be shared, copied, or reissued.

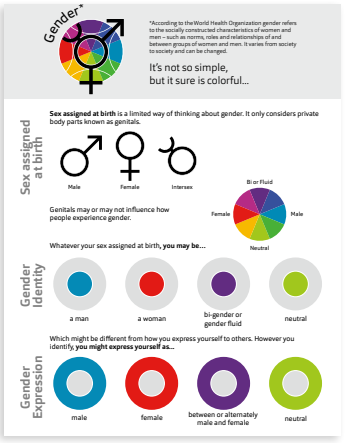
Desktop Resources for Facilitators: An electronic folder containing OAH approved resources. These include the ACE Score Calculator; tip sheets for trauma-informed, safe and supportive environments; federally authorized medically accurate websites for additional information and resources; Motivational Interviewing Values Card Sort; Expert Tips for Resilience cards; and electronic copies of laminated flowcharts if youth want their own copies.

PS-R Logo Bag: This includes all of the material listed above with hard copies of the Motivational Interviewing Values Card Sort and Expert Tips for Resilience cards, plus one box of markers, a package of 15 miniature tubs of Play-Doh,™ and a pad of drawing paper.

Fidelity Monitoring Templates:

- PS-R Participant Feedback Questionnaire
- PS-R Attendance Tracking Form
- PS-R Fidelity Monitoring Tool: Therapist Self-Report
- PS-R Fidelity Monitoring Tool: Observer Report

PS-R laminated session plans



Gender Identity chart, included with Sex Ed Fact Sheets

Training and Technical Assistance

Professionals interested in being trained to facilitate PS-R must attend a training with a PS-R certified trainer. PS-R training takes place over three and a half days with an introduction to Motivational Interviewing, an overview of the neuroscience of trauma, and in-depth practice to facilitate each session. The course ends with fidelity monitoring. At the training, attendees receive all materials needed to facilitate the intervention listed in the PS-R package section. Trainers may purchase additional training materials before or after being trained.

Organizations sponsoring training may provide continuing education credits (CEUs) or they may be purchased for training participants if arrangements are made ahead of time. This usually takes approximately 3 month's prior to training in order to complete all requirements. Whether, or not CEUs are offered, all training participants receive a certification of completion.

Many PS-R facilitators are qualified mental health professionals (QMHPs). When training participants are not clinically trained they are required to provide written documentation clarifying a formal consultation and supervision arrangement with a licensed QMHP.

Post training support is always available to answer questions and address any fidelity monitoring assistance. Session plan video summaries are provided for each trainer. All trainers have direct phone numbers and e-mail addresses for ongoing PS-R support and assistance.

Qualifications to become a PS-R facilitator

A Master's or Bachelor's degree in an allied health related field such as psychology, marriage and family therapy, social work, mental health counseling, public health, or sexual health with documented licensure, or written documentation clarifying a formal consultation and supervision arrangement with a licensed QMHP in good standing with their state's board of licensing professionals

Tools for Monitoring Implementation Fidelity and Quality

PS-R Participant Feedback Questionnaire

Paper and digital forms completed by participants at designated time periods during the study. They track participant knowledge and memory retention across the full study timeframe.

PS-R Attendance Tracking Form

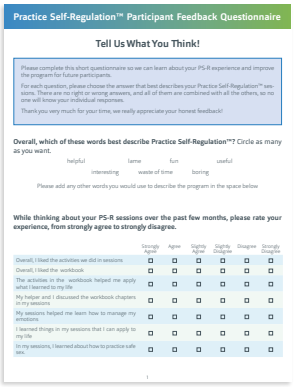
Paper and digital forms used to track participant attendance. They track the number of session each youth participates in.

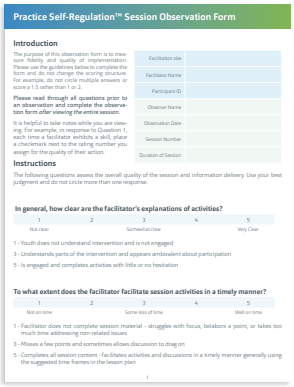
PS-R Fidelity Monitoring Tool: Facilitator Self-Report

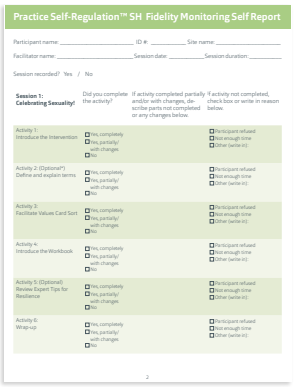
Paper form completed by facilitator at the end of each PS-R session. It tracks administrative data, number of activities completed during each session, and activities not completed.

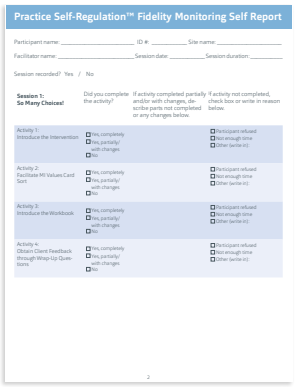
PS-R Fidelity Monitoring Tool: Observer Report

Paper and digital forms for session observers to assess both fidelity and facilitator competence for continuous quality improvement.









Fidelity Monitoring Templates

References

Applegate, J. S. & Shapiro, J. R. (2005). Neurobiology for clinical social work: Theory and practice. New York: W. W. Norton.

Bandura, A. (1985). Social foundations of thought and action: a social cognitive theory. NJ: Prentice-Hall.

Becvar, D. S. & Becvar, R. J. (1988) Family Therapy: A systemic integration. Boston, MA: Allyn and Bacon.

Bowlby, J. (1988). A secure base: Parent-child attachment and healthy human development. New York: Basic Books.

Bronfenbrenner, U. (1979). The ecology of human development. Cambridge, MA: Harvard University Press.

Dodge, K. Pettit, G., & Bates, J. (1997). How the experience of early physical abuse leads children to become aggressive. In D.T. Cicchetti (Ed.), Rochester symposium on developmental psychology, 263 Rochester: Rochester University Press. (P.277).

Duncan, B., Miller, S., Wampold, B., & Hubble, M. (Second Edition). (2011). The heart and soul of change, delivering what works in therapy. American Psychological Association.

Finkelhor, Shattuck, Turner, & Hamby (2015). A revised inventory of adverse childhood experiences. Child Abuse & Neglect.

Groves, B. (2002). Children who see too much. Boston, MA: Beacon Press.

Jensen, F. & Nutt, A. (2015). The Teenage Brain. New York: Harper.

Kagan, R. & Schlosberg, S. (1989) Families in perpetual crisis. New York: W.W. Norton.

Saunders, B., Berliner, L., & Hanson, R. (Eds.). (2004). Child physical and sexual abuse; Guidelines for treatment (revised report: April 26, 2004). Charleston, SC: National Crime Victims Research and Treatment Center

Schladale, J. (2020) Everyone Can Be Trauma-Informed: A Foundation for Practice. Resources for Resolving Violence, Inc., Freeport, ME.

Schladale, J. (2018). Practice Self-Regulation Workbook. Resources for Resolving Violence, Inc., Freeport, ME.

Schladale, J. (2015). The T.O.P.* Workbook for Sexual Health. Resources for Resolving Violence, Inc., Freeport, ME.

Siegel, D. (1999). The Developing mind: How relationships and the brain interact to shape who we are. New York: The Guilford Press.

Stien, P. & Kendall, J. (2004). Psychological trauma and the developing brain. New York: The Haworth Press.

Steinberg, L. (2014) Age of opportunity: The new science of adolescence. Boston: Houghton Mifflin Harcourt.

Thornton, T., Craft, C., Dahlberg, L., Lynch, B., & Baer, K. (rev. ed., 2002). Best practices of youth violence prevention: A sourcebook for community action. Atlanta: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Van der Kolk, B. (2014) The body keeps the score: Brain, mind, and body in the healing of trauma. New York: Viking.

Joann Schladale is a licensed marriage and family therapist specializing in trauma, violence prevention, positive youth development, sexual health, problem sexual behavior, teen pregnancy prevention, and Motivational Interviewing.

She is the developer of the federally recognized innovative and promising intervention, Practice Self-Regulation™ being studied through multi-year federal grants around the country. She has written workbooks for youth including: Practice Self-Regulation (2018), and The T.O.P.* Workbook for Sexual Health (2016, 2nd Edition), and co-authored Stop It! A Practical Guide for Youth Violence Prevention (2012). In addition to numerous academic book chapters she authored Everyone Can Be Trauma-Informed: A Foundation for Practice (2020) and A Trauma-Informed Approach for Adolescent Sexual Health (2013).

Joann, and PS-R national trainers provide extensive consultation, program development, and training promoting health and well-being. They work closely with public and private organizations throughout the United States on trauma-informed services, and teach a variety of trauma-informed courses to promote health and well-being, and prevent violence, sexual abuse, and teen pregnancy. Joann has made hundreds of presentations throughout North America, Europe, and Africa.

She is the 2018 recipient of the 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. It is jointly given by the National Sexual Violence Resource Center (NSVRC) and the Association for the Treatment of Sexual Abusers (ATSA).

Joann self-regulates at her home in Maine where she loves ocean kayaking, bicycling, and hiking with her spouse of 40+ years.

Practice Self-Regulation™

28 Marshview Drive, Freeport, Maine 04032

207-232-3195

schladale@me.com

practiceselfregulation.com