Integrating Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Racial Socialization for Black Youth and Families: An Implementation Manual

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FOREWORD

This manual addresses strategies for implementing an evidence-based trauma treatment for youth and families, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT, Cohen, Mannarino & Deblinger, 2012, 2017), for self-defined Black youth ages 3-17 years and their parents and/or other caregivers who experience racial-related stress or trauma as well as other types of significant trauma. (As with TF-CBT generally, these strategies may also be applicable for some transition age Black youth, between 18 and 25 years old). The information in this manual was conceptualized by following an empirically supported systematic framework, the ADAPT-ITT Model (Wingood & DiClemente, 2008) that emphasizes maintaining core elements of an existing treatment while integrating the culture of at-risk populations in order to increase treatment relevance, acceptability, and sustainability of evidence-based interventions. This model is described in more detail below (pp 54-55). Through a Substance Abuse and Mental Health Services Administration (SAMHSA) grant for the National Child Traumatic Stress Network (https://nctsn.org) to the Allegheny General Hospital Center for Traumatic Stress in Children and Adolescents, a year-long Learning Community was conducted to evaluate and refine strategies for integrating TF-CBT with Racial Socialization initially proposed by Metzger and colleaguse (2021).

It is also important to acknowledge that the Learning Community occurred in the context of the COVID-19 pandemic which disproportionally impacted families of color, and followed several high profile killings of Black individuals. These contributed to urgency for purposeful action towards anti-racism within and beyond the NCTSN.

The Learning Community initiated to train and collaborate with clinicians on the use of the culturally-informed strategies included 28 members from eight NCTSN funded or affiliated organizations, listed below. Clinicians presented TF-CBT cases during monthly calls and provided de-identified data for assessment, shared resources about TF-CBT implementation for Black youth and families who had experienced racial-related stress or trauma, and discussed how the TF-CBT model should be modified to address racial-related stress or trauma for Black youth and families, incorporating principles and strategies of Racial Socialization.

All participants had previously received TF-CBT basic training (described below). The goal of this project was to then apply that knowledge for Black youth and their parents or caretaking adults who had experienced racial-related stress and/or trauma. Users of this implementation manual are similarly assumed to have a working knowledge of the basic TF-CBT treatment model and principles (Cohen, Mannarino & Deblinger, 2017) and of how the model is implemented for youth with complex trauma (e.g., Cohen, Mannarino, Kliethermes & Murray, 2012).

The Learning Community began with a participatory training about the compounding impact of interpersonal trauma and racial trauma on Black youth, the role of Racial Socialization in fostering resilience and positive racial identity, and strategies for integrating racial socialization both within and between sessions for Black youth and their caregivers while maintaining fidelity to TF-CBT (Metzger et al, 2020). The foundational training following the ADAPT-ITT Model were taken together with the lessons learned from the NCTSN Learning Community to contribute to the development of this manual, thus positioning clinicians who utilize it to help trauma exposed Black youth more effectively.

We strongly recommend that therapists complete the TF-CBT basic training prior to implementing the TF-CBT applications for Black youth and families who experience racial trauma or stress described in this manual. This includes 1) initial web-based TF-CBT training (available at https://tfcbt2.musc.edu), 2-day face-to-face or 3-4 day TF-CBT virtual training by an approved TF-CBT national trainer; and at least 12 consultation calls provided by an approved TF-CBT national trainer or TF-CBT consultant (https://tfcbt.org/training) or supervision by an approved TF-CBT supervisor. Alternatively, therapists may complete a TF-CBT Learning Collaborative that includes one or more approved TF-CBT national trainers.

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The following individuals participated in the TF-CBT for Racial Trauma Learning Community (listed alphabetically by program). We thank each one of these participants for all of their dedication and important contributions, both to our learning community, and to helping to improve the lives of trauma-impacted young people. Most importantly, we are deeply grateful to the trauma-impacted Black youth and families who have received TF-CBT treatment, from whom we have learned so much and who have made this Implementation Manual possible.

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INTRODUCTION

Black youth in the United States experience higher rates of trauma (e.g., polyvictimization) and higher rates of racial stressors (e.g., microaggressions) than youth of other racial backgrounds. Given that Black youth also face higher rates of negative mental health outcomes (e.g., depression, anxiety, PTSD) and because they are less likely to access treatment, mental health treatment should be tailored to meet the needs for those at highest risk.

Trauma Focused Cognitive-Behavioral Therapy (TF-CBT)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based short-term (8 to 25 sessions) trauma-focused treatment for youth between the ages of 3 and 18 years who experience traumatic life events and their parents or caregivers (note, hereafter this manual will use the term "caregivers" in recognition that often the primary adult caring for the youth will not be a birth parent) (Cohen et al., 2006; Cohen et al., 2017). Briefly, TF-CBT consists of 9 components summarized by the acronym PRACTICE; these include *Psychoeducation* about trauma impact; *Parenting Skills* to help caregivers to address behavioral trauma impacts and to support the youth in trauma recovery; *Relaxation Skills* to reverse physiologic trauma impacts; *Affective Modulation Skills* to regain emotional regulation; *Cognitive Processing Skills* to recognize and challenge negative thinking patterns; *Trauma Narration and Processing* to speak about and make new meaning of traumatic experiences; *In vivo Mastery* to manage overgeneralized fears of innocuous trauma reminders; *Conjoint child-parent sessions*, for enhancing general communication and skill building with youth and caregiver and for youth to share their trauma expeiences directly with the caregiver when clinically appropriate; and *Enhancing Safety and Future Development,* to address safety concerns and optimize the youth's safety and developmental trajectory going forward. Gradual Exposure (GE) is integrated into each of these components, (except Cognitive Processing) to help the child and caregiver slowly get comfortable with discussing and being reminded of the traumatic experiences endured. For example, the issue of racism may be discussed in the abstract during psychoeducation, whereas specific racial trauma experiences endured would not be elicited until later in treatment after the child has been gradually exposed to related discussions and developed coping skills to assist with the distress such memories might raise. In general, it is important to note that each component is implemented in relation to and tailored to the youth's individual trauma experiences. The components are provided within three phases, namely a stabilization phase consisting of the PRAC skills; a trauma narration and processing phase; and an integration phase consisting of In vivo Mastery, Conjoint Sessions and Enhancing Safety components. More detailed information about each component and phase is provided later in this manual and elsewhere (e.g., Cohen, et al, 2012; Cohen, et al, 2017; https://tfcbt2.musc.edu).

Evidence-based psychotherapies such as TF-CBT are the first line treatment for youth with PTSD and related difficulties (Cohen, 2010); however, Black youth are up to three times less likely than white youth to either initiate or be retained in trauma treatment (Lester et al., 2010; Kilpatrick et al., 2003; Weiner et al., 2009). Despite its utility in treating interpersonal trauma, prior to this learning community, TF-CBT had not been applied specifically to address racial trauma as an impetus for treatment and had not systematically integrated racial factors (e.g., reliance on religious beliefs, system mistrust, stigma, racial socialization practices) that are likely to influence Black families' willingness to engage in treatment for trauma (Coard et al., 2004; Phipps & Thorne,

2019). As such, we believed that n TF-CBT treatment for Black youth may need to be tailored to meet cultural, developmental, family and individual needs for those most at risk.

Few trauma-focused therapies have identified culturally-informed strategies that address both interpersonal and racial trauma for Black youth, which may explain some findings that document poorer treatment engagement and outcomes among this population (APA TF, 2008). It is important to note that these findings are mixed. For example, all of the TF-CBT studies that have examined outcomes by race have demonstrated that TF-CBT was equally effective for Black youth as for youth of other races. Other researchers have similarly found no differences between TF-CBT and other trauma-focused treatments for Black youth as for other racial and ethnic groups (e.g., Huey, 2021). In contrast, some studies indicate that at least for some segments of the Black youth population, evidence-based psychotherapies (if not TF-CBT specifically) are less effective for Black youth. For example, one recent meta-analysis that did not include trauma-focused treatments, found that evidence-based psychotherapies tested with samples of majority Black youth were significantly less effective in states with higher (versus lower) levels of anti-Black cultural racism, suggesting that anti-Black cultural racism may be one contextual factor that can contribute to differences in treatment effects (Price et al, 2022), and supporting the idea that evidence-based treatments such as TF-CBT could benefit from the addition of Racial Socialization strategies.

TF-CBT has been culturally modified for some ethnic minority groups (e.g., Latinx, Native American) to increase therapist self-efficacy and client engagement (de Arellano et al., 2012). Also, researchers have demonstrated effectiveness in different delivery modalities with African American youth (e.g., telehealth; Stewart et al., 2021). There also exist suggestions for group administration of TF-CBT to address racial trauma among Black Youth (Phipps & Thorne, 2019). However, at present, few treatment applications exist for TF-CBT that specifically focus on addressing both interpersonal traumas and racial stressors that are experienced by Black youth at higher rates (Metzger et al., 2021). As such, this manual provides evidence-based practice solutions that explore and utilize protective factors specific to Black youth engaging in TF-CBT that are are sorely needed (Bigfoot & Schmidt, 2010; Sue et al., 2015; Weiner et al., 2009).

As suggested by Metzger et al in a 2021 manuscript focused on "Healing Interpersonal and Racial Trauma", in addition to receiving continued education on race and racism, it is necessary for clinicians to have efficacy in having related discussions throughout the course of treatment. Subsequent sections of this manual will emphasize the practice and use of vocabulary that are both inclusive and transparent. This manual will discuss, for example, that in building rapport early on in the therapeutic relationship, clinicians should be comfortable discussing aspects of their identity that impact the lens that they bring to therapeutic settings (e.g., a white clinician discussing their position of power and/or privilege). The current manual is also designed to foster clinicians' comfort discussing issues including stigma and system mistrust, and better prepares clinicians to identify themselves as an ally or advocate, and to set clear intentions to help clients better understand, navigate, and thrive despite individual, organizational, systemic, and structural experiences with racism. In addition, this manual will emphasize the need for clinicians to discuss their role as a service provider, including mandated reporting and limits of confidentiality, within the context of discussing relationships with other parts of the system (e.g., law enforcement, social services). This TF-CBT application also describes how to integrate discussions of race, racism and

strategies of addressing these through Racial Socialization throughout each PRACTICE component.

This implementation manual provides therapists with guidance and information about how to implement TF-CBT with appropriate cultural considerations for Black youth and families who have experienced interpersonal and racial stress or trauma. However, it is important to note that this manual is not restrictive to youth who have identified specific racial traumas, but that it is also applicable and relevant for all Black youth who qualify for TF-CBT treatment due to any remembered trauma experience; any of these youth can benefit from racial socialization and other culturally protective processes that can be integrated into TF-CBT.

Interpersonal Stress and Trauma in Childhood and Adolescence

Childhood trauma is the experience of a dangerous or frightening event by a child that is emotionally painful or distressful, which involves or threatens violence, serious injury, or death, and often results in lasting adverse mental and physical effects. Adverse childhood experiences (ACEs) that can lead to trauma reactions include being a victim of sexual abuse, assault, or exploitation, being victim/witness of violence (e.g., domestic/physical abuse), emotional abuse, neglect, failure to protect, endangering a child, unexpected death of a loved one, motor vehicle accidents, natural disasters, medical trauma, fleeing war as a refugee, and experiencing or watching on the news an act of terrorism. By the age of 16, over 60% of children and adolescents have experienced at least one traumatic event and reports estimate 1 in 7 of them have experienced neglect and/or abuse (SAMHSA, 2022). Black youth are disproportionately impacted by trauma, with 61% reporting they have experienced at least one ACE, which is 10% to 38% more than their Hispanic, white, and Asian counterparts (Sacks & Murphey, 2018). Additionally, while 50-70% of youth experience or witness more than one adverse event (known as polyvictimization; Finkelhor, 2011; Finkelhor, 2013), Black youth report significantly more polyvictimization than their white counterparts (Finkelhor et al., 2011; Andrews, Metzger, et al., 2015; Andrews, et al., 2019; Maguire-Jack, et al., 2019; Pumariega, et al., 2022).

Consequences of Trauma Exposure

Black youth in the United States are more likely than youth of other races to report adverse emotional and behavioral sequelae to interpersonal trauma exposure, including poor mental health (Andrews, Metzger et al., 2015), decreased well-being (Neblett, et al., 2008), substance use (Danielson et al., 2006), and risky sexual behavior (Lester et al., 2010; Lalor & McElvaney, 2010). Specific internalizing problems associated with traumatic event exposure include depression/sadness, anxiety, fear, worry, numbing/dissociation, anger, low self-esteem, self-injury, sleep problems, hyperactivity, and suicidality (Kilpatrick, et al., 2003; Andrews, Metzger et al., 2015; Danielson et al., 2006; Hodges et al., 2013). Externalizing problems that may result from experiences with interpersonal trauma can be seen in the form of aggression, sexualized behaviors and unsafe sex, oppositional behavior, defiance, substance misuse, and delinquency (Lester et al., 2010; Lalor & McElvaney, 2010; Kilpatrick et al., 2003; Danielson et al., 2006).

Social and academic consequences of trauma include changes that occur in family relationships. Family relationships may significantly change or even decay as a result of trauma. For example, youth may distance themselves from typical family dynamics if abuse is present in the home. Due

to the aforementioned behavioral problems, parents may also notice a difference in their ability to effectively discipline their youth.

Outside of the family, youth may exhibit symptoms similar to that of depression. They may have trouble focusing, experience hopelessness about their life and future, or disengage from their academics by no longer paying attention, skipping school, or even by dropping out. Socially, they may interact less with their friends and instead become involved with individuals who encourage deviant activity (like drug usage or delinquency). Physically, youth may raise more concerns about their own health issues, like a higher frequency in headaches or stomach aches.

Trauma exposure is inherently negative to multiple aspects of wellbeing, socially, academically, and physically. However, there are several more ways trauma exposure can affect more internal aspects of well-being. Mental health issues and emotional damage are often associated with having experienced traumatic events, but there can be a larger process behind how that occurs that is worth understanding.

Trauma and the Cognitive Behavioral Triangle

Trauma impacts the Cognitive Behavioral Triangle, which refers to the interdependent processes between an individual's thoughts, feelings, and behavior (APA, 2017). Trauma can induce inaccurate and unhelpful thoughts. Individuals may try to find reasons within the trauma experience(s) to cope or feel distrust towards people or things that act as a reminder of the trauma—even when they are not harmful. These thoughts lead to negative feelings or low self-esteem or a loss of identity. When individuasl think and feel differently and negatively about themself or their situation, they may engage in risky behaviors. This includes substance use (alcohol and drugs) for coping, isolating oneself from friends and family, and may even change how they take care of themselves (e.g., changes in appetite or sleep).

With regard to cognitive changes, individuals may develop faulty logic as a method to cope with their trauma(s). For those that were impacted by sexual abuse, they may begin to believe that love is shown physically and sexually, with no other way to display affection. Their self-esteem and self-worth may become deeply entwined with whether their partners sexually benefit from the relationship. In turn, these individuals may engage more in risky behaviors, like unprotected sex or more sexual partners to boost esteem.

Individuals exposed to or in a physically abusive relationship may begin to believe that love is displayed through hitting or other forms of physical aggression. This may lower self-worth and esteem, contribute to emotional regulation, and/or lead to the potential acceptance of violence in relationships as the norm. In turn, they may unintentionally seek abusive relationships or become the abuser themselves after adopting abusive modeled behaviors. Before intervention, clinicians should take the time to understand and assist clients in understanding the ways in which trauma can lead to issues with inaccurate thoughts, harmful feelings, and problem behaviors. In doing so, both clinician and client are better equipped to address underlying causes of trauma.

Posttraumatic Stress Disorder

To receive a PosttraumaticStress Disorder (PTSD) diagnosis, according to the DSM-5 (APA, 2013), there must first be a stressor. This includes *threats of* or *exposure to* death, serious injury, sexual violence or other traumatic and stressful events. This stressor will, in turn, affect the

individual with intrusion (recurrent distress in various forms like dreams or memories), arousal and reactivity (negative behavior changes like irritability, hypervigilance, and sleep issues), negative changes in thoughts and mood (reduced interest, detachment, or a loss of pleasure), and avoidance to thoughts, feelings, and reminders of the event. Children experience trauma at high rates: approximately two-thirds of all children will experience at least one traumatic event before the age of 16 with a third experiencing multiple traumas (SAMHSA, 2022). While most children are resilient after trauma, many respond in a manner than changes their behavioral, mental, or physical health (eg. sleep issues, depression, or losing weight (APA, 2011), and up to 15% of girls and 9% of boys will receive a full PTSD diagnosis (US Department of Veteran Affairs).

Demographically, Black youth are more likely than their white and Hispanic peers to experience trauma—including physical, sexual, domestic, and community violence. This is perhaps because, in addition to facing interpersonal trauma, Black youth are also likely to experience negatively charged encounters of racism and discrimination that are potentially harmful. Cases of interpersonal and vicarious racism may be especially prevalent due to the recent social climate surrounding Black Lives Matter and the COVID-19 pandemic (APA, 2020; Poulson et al., 2021; Forscher & Kteily, 2020; Isom et al., 2021; Laurencin & Walker, 2020), as well as social media exposure to traumatic scenes, like police brutality (Tynes et al., 2019; Krieger, 2020). Childhood trauma is more likely to lead to negative mental health outcomes like depression, PTSD, anxiety, suicide (Andrews, Metzger et al., 2015), and unsafe behaviors like risky sex, aggression, delinquency, and substance abuse for Black youth (Neblett, et al., 2008; Lester et al., 2010; Lalor & McElvaney, 2010; Danielson et al, 2006). Black youth could benefit from culturally responsive treatment that addresses ethnicity in order to see improved outcomes, like culturally-tailored TF-CBT that acknowledges the importance of racial socialization and identity development in Black youth.

Black Racial Identity Development

Black identity is thought to develop in stages, and it describes a process from when youth are largely unaware of race, experiencing one's first racist encounter, retreating into one's own culture for protection, becoming secure in one's Blackness, and ultimately giving back to the Black community. Specifically, identity development begins with *pre-encounter*. In this stage, Black individuals hold values of the dominant white culture, while remaining largely unaware of race or discrimination. In children and youth, this may be because they are unable to identify themes or acts of racism on their own, or have not experienced it directly. Development then moves, however, into *encounter*, the stage in which a racist experience makes one realize they belong to a group that is discriminated against. It is important at all stages of development, but especially when facing discrimination, that caregivers and providers give youth tools to identify and cope with racist events. Facing discrimination will lead youth toward *immersion/emersion*. They will begin to surround themselves with people and symbols of Blackness while also avoiding those of whiteness. This stage fosters identification with one's racial group and discovering what that means in terms of society and the larger picture. As individuals grow more secure in their Blackness, they enter the *internalization* stage. Here, their pro-Black attitudes become more expansive, open, and less defensive. This openness and understanding of what Blackness means to oneself and society leads people toward *internalization-commitment*. Black people may begin to develop plans of action with a commitment to concerns of the Black community. Activism, political and environmental advocacy and involvement may be more prominent in this stage as a

Black identity extends beyond oneself and toward the larger community. Understanding how Black identity develops and the experiences that shape such development for Black youth, like discrimination and trauma, are the first steps in creating sustainable interventions to address the impact of racial stress and mitigate its possible outcomes, like PTSD.

Racial Stress and Trauma

Exposure to racial stressors is not foreign to Black adolescents. In fact, it is suggested that they experience approximately five daily instances of racial stressors (English et al., 2020). Additionally, about 38% of Black adolescents experience six instances of racism within one year (Sellers et al., 2003), with the percentage increasing when including discrimination exposure vicariously (eg. social media) (Priest et al., 2014; Tynes et al., 2019; English et al, 2020). Racial stress can occur on a spectrum and includes experiences with, individual racism, microaggressions, internalized racism, vicarious racism, institutional racism, environmental racism, and structural racism—though the specific terms may vary across the literature. Racist events may also overlap in type; eg. structural racism may also be environmental racism and microaggressions may be a result of individual racism. Exposure and experience with racial stressors can lead to mental, behavioral, and even physical health problems (Kilpatrick et al., 2003; Danielson et al., 2006; Lester et al., 2010; Lalor & McElvaney, 2010; APA, 2011; Andrews, Metzger et al., 2015; Bailey et al., 2017; SAMHSA, 2022), which is best described as racial trauma—the outcomes and problems related to those stressors. Understanding the types of racially charged messages and events is an important aspect of understanding how Black youth experience racial stressors and trauma, and experience the world.

Individual racism is a person's own beliefs about or behaviors towards other racial and ethnic groups and typically occurs between people (also called *interpersonal racism;* Neblett, 2019). An example of this would be a woman clutching her purse when she spots a group of Black people or crossing the street to avoid getting near that group. People may or may not be aware of the prejudices they hold, but the effects of it are detrimental all the same.

Microaggressions are subtle derogatory slights toward an individual or group of a different racial background, typically a marginalized one, and can be intentional or unintentional (Sue, et al., 2007). An example would be saying something like "You're pretty for a Black girl." Adding a person's racial group as a modifier to a statement, such as the example, implies that a racial group is lesser than the group the aggressor belongs to. Some common microaggressions imply that Black people are inherently unattractive, or not as intelligent as their counterparts. Microassults are direct microaggressions (e.g., calling someone a racist slur), microinsults are veiled compliments or jokes (e.g., commenting on how well-spoken someone is)), and microinvalidations degate a person's identity (e.g., refusing to pronounce their name).

Internalized racism refers to the derogatory beliefs one holds about their own racial and ethnic group and/or their own self worth due to their racial identity (Neblett, 2019). These beliefs may have been instilled within an individual from various sources, like racist experiences and events or even family members who hold similar beliefs. Internalized racism is seen in the Black community through colorism which suggests that lighter skin and more Western features are preferred beauty standards. Corporal punishment is also a form of racism as Black parents may

spank their kids to protect them from the potentially deadly consequences of non-compliance and delinqency in society.

Vicarious racism occurs when individuals in a marginalized racial/ethnic group witness negative or traumatizing events happening to other members of their racial community (Neblett, 2019). For example, social media and news outlets have exacerbated vicarious racism by sensationalizing police brutality and the murders of Black individuals (Hardy, 2013; Tynes et al., 2019).

Institutional racism are the policies and behaviors that discriminate against marginalized racial groups by organizations, like businesses; governments; educational systems; and the justice system (Bailey et al., 2017; Neblett, 2019). This type of racism is often *systemic,* meaning it is rooted in the foundation of how those organizations function. Institutional racism is historically prominent in the housing market as racially marginalized homeowners often receive unfair and undervalued loans or investments on homes (Mendez et al., 2014). Dress codes and unfair discipline practices are also examples of insitutuional racism that Black youth often face.

Environmental racism refers to the lack of environmental protection efforts that disproportionately affect marginalized communities. A real world example of this is the Flint Water Crisis, which was the introduction of lead-poisoned water to a predominantly Black community in 2014 that continues to negatively impact the health of the community (Bailey et al., 2017; Allgood, et al., 2022). Black youth experiencing neighborhood violence due to limited resources is also a form of environmental racism that should be explained to youth, in addition to the effects of a lack of natural foods stores, and an abundance of pollution or liquor stores that are often seen in urban areas. Confederate flags and statues are also forms of environmental racism that continue to impact southern youth even in recent times.

Structural racism—sometimes referred to as *systemic racism* in the literature—refers to the overarching racist ideologies, histories, cultures, and systems of a society as a whole that gives one racial group more power than another (Bailey et al., 2017; Neblett, 2019). The best example is the disempowerment of Black people that is entrenched in the foundation of the United States with the creation of the 3/5ths compromise, enslavement, and the creation of police and prison systems. These levels of racism interact with and reinforce one another often (Bailey et al., 2017). For example, the justice system as an institution is biased in favor of white people, but the reason behind this is structural in nature. Environmental racism issues could be mitigated by housing and financial agencies (institutions) should the culture of disenfranchisement be alleviated (systemic and structural). As noted, discussing limits of confidentiality and requirements for mandated reporting is also necessary to overcome structural racism that clients face and to encourage treatment engagement and service utilization.

The potential negative toll of experiencing a high level of racism is immense. Racially stressful and traumatic events are unpredictable, uncontrollable, and violating. The effects of racial stressors are similar to abuse and assault in that racial stressors violate an individual's personhood, leaving the victim feeling disempowered. The disproportionate impact of trauma on Black youth is further compounded by unique racism-related stressors that can be overt/direct (e.g., being suspiciously followed around a store by security) or vicarious/indirect (e.g., watching the videotaped murder of a Black teen on the news or on social media) (Hardy, 2013; Tynes et al., 2019). Recent preliminary data demonstrate significant associations between negative racial experiences and negative mental health outcomes that are severe and similar to post traumatic stress reactions (e.g., anger &

depression; Jernigan & Daniel, 2011). Subtle acts of racism may also have more negative effects than overt racism, as the recipient may linger on whether the event was racist, if it was intentional or not, and if responding to the event would be considered an overreaction (Sue et al., 2007) possibly resulting in feelings of ridicule and dismissal. To mitigate the effects of racial stressors that are potentially traumatic, Black youth may benefit from assistance with coping and healing.

The good news is that parents and trauma clinicians can help youth deal with racial stressors as they form their identities. When conveying psychoeducational messages to youth and caregivers, clinicians should be sure to ask clients whether they have experienced any racial stress or discrimination that continues to bother them. Identifying the type of racial stress and discrimination (eg. institutional or individual) may also help clinicians determine the best course of treatment and action.

Racial Socialization

Racial socialization is the protective process of transmitting cultural behaviors, attitudes, and values to prepare youth to cope with stressors associated with their ethnic minority status, and is associated with positive outcomes including increased resilience, coping abilities, and decreased problem behaviors and anxiety in Black youth (Hughes et al, 2006; Lesane-Brown et al., 2005). Racial socialization-adapted interventions are promising (Coard et al., 2004; Brody et al., 2006; Murry et al., 2007) but until now have not been applied to trauma-focused treatment to improve therapists' self-efficacy, increase client engagement, and directly mitigate the impact of interpersonal and racial trauma for Black youth. There are standalone, in-person often group-administered racial socialization interventions (Anderson et al., 2018; Anderson & Stevenson, 2019; Coard et al., 2004); however, given the benefit of racial socialization in addressing interpersonal stressors and the growing need for clinicians in community mental health to address racial trauma for Black youth, it is important that practitioners gain experience in utilizing racial socialization as an effective strategy for making progress towards cognitive and behavioral healing in response to racial stressors.

Most Black families are already engaging in racial socialization, in a process commonly referred to as "The Talk" (Anderson et al., 2022). Racial socialization is a series of conversations and interactions (e.g., participating in cultural activities, role playing responses to microaggressions) between ethnic minority caregivers and youth. In addition to orally communicating racial socialization messages, adults participate in racial socialization when they pass on the values and practices of their ethnic group, and when caregivers help youth prepare for and heal from negative racial encounters. How a family engages in racial socialization is based on the needs and desires of each family.

Racial Socialization Messages

Researchers emphasize seven primary types of racial socialization messages (Neblett et al., 2016; Saleem, et al., 2016). Each message focuses on a different aspect of racial identity, like culture, discrimination, and group relations. There is no one message better or worse for youth to receive, and no right or wrong way to communicate them. However, knowing each type might help a family identify what's important to them and give the family more tools to use in helping youth cope with trauma.

Specifically, *racial pride messages* teach children about Black heritage, history, and culture to promote group unity and combat negative experiences. Similarly, *racial equality,* or *egalitarian* messages emphasize diversity and co-existence with different cultural groups by teaching children that all races are equal and should live together peacefully. *Racial barrier messages*, however, focus on preparing for, coping with, and healing from experiences with discrimination and racism. Similarly, socialization messages can also *promote mistrust* in other racial groups, emphasizing the differences between racial and ethnic groups and encouraging youth to remain close to the group they belong to and avoid others. Parents may also discuss, *racial achievement messages* that focus on academic and individual achievement and the need for Blacks in America to work twice as hard as other groups to be awarded the same opportunities. Likewise, *self-worth and development messages* encourage individual excellence, achievement, and worth within the broader context of one's racial group. It is important to note that these messages are not mutually exclusive of each other, and that caregivers can promote pride and achievement messages, while also preparing youth for discriminatory experiences with barrier messages.

Socialization behaviors are also important to development, but do not focus explicitly on the racial climate of society. Examples include encouraging involvement in race-related activities, like buying from Black-owned businesses or supporting Black-made art and literature. Messages may also include the appreciation of extended family involvement. This message emphasizes the importance of others (e.g., grandparents and fictive, non-blood relatives) in child rearing and family management while also giving youth other resources and outlets alongside their immediate caregivers. Additionally, spirituality/religious messages teach about religion and/or spirituality to promote strength, resilience, and empowerment. All three messages and behaviors encourage beneficial coping skills for the future, turning to higher powers and people within their community for support, guidance, and comfort.

It is also important to convey that *silence* on racial identity and coping mechanisms is inherently a socialization message—not necessarily the lack of one. Silence about these topics can teach children to remain quiet themselves, not seek help, and that their identity and interaction with the world is "less than" children of other races . That is not to say keeping some realities from youth is wrong, but to encourage some discussion (comfortable for families) about navigating the world as a Black individual.

Communicating Racial Socialization Messages

The most obvious form of socialization is through oral communication. Discussing beliefs and values within one's family and racial group assists youth to solve problems related to their racial identity. Caregivers may also model behavior to youth. By demonstrating ways to respond to discrimination, showing pride in one's history and Black culture, or engaging with one's community, youth learn to place importance in similar things. Communicating these racial socialization messages can be done in multiple ways, and is not limited to one specific type of message (like equality or barrier messages). In fact, combining and covering multiple messages (depending on what is important to the family's values) may be beneficial in diversifying youth's preparedness to identify and cope with traumatic events. Additionally, while parents and caregivers are a primary agent of socialization, youth may also benefit from positive learning experiences outside of the family. Academic institutions (like schools and museums) or peer groups can transmit values about one's racial group and their role in society (Lesane-Brown,

2011). It is important that caregivers pay attention to youth's behaviors and interests, encouraging racial socialization through things like youth activism and involvement in politics or their future.

Social media can also serve as a potent positive force for communicating positive racial socialization messages. In spite of some of its potential ills, social media can be a force for good as a positive space for youth connection to Black community and Black spaces, especially for some Black youth who may grow up in predominantly white spaces and environments. Some specific positive sources of online Racial Socialization messages are provided later in this Implementation Manual under specific TF-CBT components.

Racial Socialization and Racial Identity Development

As previously discussed, racial socialization assists in developing resilience, positive coping strategies, and reducing anxiety and behavioral issues in Black youth. These messages also positively contribute to racial identity development by positively impacting the sense of self, others, and before and after experiences of negative racial encounters.

Socialization messages that focus on racial pride or spirituality, for example, can instill positive values toward African ancestry and encourage celebrating historical and recent accomplishments of Black people in America. These "wins" and positive perspectives towards the Black community teach youth of their importance in the world, the care they should take to preserve their well-being and history, and the impact they have on others. Additionally, understanding the difficulties of being Black in a White-majority society allows youth to develop a stronger sense of others, thus preparing youth to navigate potentially negative encounters. Combined, having pride and being empowered promotes resilience and gives caregivers, providers, and youth tools to respond to and heal from racism, further allowing them to build and prepare for a better future.

Other Benefits of Racial Socialization

Racial socialization not only prepares youth for identifying and coping with traumatic events, but it benefits overall identity development and emotional stability. Racial socialization boosts self-esteem, perseverance, resilience, healthy coping, and racial identity. Healthy views of self and one's racial group (and of others) fosters communication between caregiver and child, allowing guardians more opportunities for support and guidance (Gaylord-Harden et al., 2012). Strengthening these aspects of development may aid in preventing negative emotions, behavior problems, and health difficulties after stressful life events. By giving youth coping tools and bringing them closer to their families, there is more opportunity for good decision making. Through racial socialization, youth are better prepared to make decisions about abstaining from drug and alcohol use, risky sexual behaviors, delinquency, and making smart decisions about peer-groups.

Racial Socialization in TF-CBT for Trauma

Racial socialization is how youth form thoughts about themselves that are different from negative messages underlying racist encounters. What youth think affects how they feel, and how they feel impacts what they do. Racial socialization utilizes the cognitive-behavioral triangle to influence feelings about oneself and one's racial group, thus informing emotions, thoughts, and behaviors

about one's worth and towards the larger society. Racial socialization fits in the TF-CBT framework of trauma treatment that addresses the needs of children with PTSD and depression, and other difficulties related to traumatic life experiences. Racial socialization messages provide unique and culturally tailored messages toward Black youth that assist in developing coping and communication skills personally and within the family. Using racial socialization in TF-CBT treatment for trauma may help treatment providers and patients identify and correct inaccurate/unhelpful thoughts, distressing feelings, and harmful behaviors. Together, provider and patient can work to form more helpful thoughts about oneself and other Black people, keep positive and/or calm feelings during and after racist events, and develop healthy behaviors that help the patient and the Black community. Additionally, using racial socialization as part of the clinical intervention provides opportunities for families to get involved with trauma interventions at home. In doing so, providers are allowing for more sustainable, longer lasting, and beneficial treatments to youth who are receiving support from multiple sources during development. Importantly, the cognitive triangle works bi-directionally, that is, in addition to more helpful, accurate or balanced thoughts leading to more positive feelings and behaviors, racial socialization messages can contribute to more positive behaviors and/or feelings that can also lead to more accurate, helpful or balanced thoughts.

Theory of Mechanisms of Action: RECASTing Racial Socialization and TF-CBT

The American Psychological Association emphasizes the importance of considering the well-being of Black youth within the context of racially relevant protective factors (APA TF, 2008). The Racial Encounter Coping Appraisal and Socialization Theory (RECAST; Anderson & Stevenson, 2019; Stevenson, 2014) posits that transmission of racially-specific coping strategies helps to fortify cognitive and behavioral strategies inherent in resolving stressful racial encounters. RECAST integrates the stress, trauma and racial socialization literatures with the applied skills inherent in cognitive-behavioral therapies designed to reduce negative outcomes from experiencing trauma. Integrating racial socialization into TF-CBT may provide Black children and youth with practical cognitive, emotional, and behavioral strategies that could enable them to notice/attend to, make meaning of, and contend with the racial events they have encountered. Thus, racial socialization fits well within the cognitive behavioral framework (Carlson & Dalenberg, 2000), which seeks to identify and correct inaccurate/unhelpful thoughts, distressing feelings, and problematic behaviors. Clinicians can utilize the suggested intervention strategies to help foster realistic and helpful thoughts, positive and calm feelings, and the promotion of constructive and adaptive behaviors that can protect against risky behaviors. Because parents transmit messages about one's self (e.g., racial pride messages focusing on one's African ancestry and accomplishments of Black Americans), others (e.g., messages about the difficulties of being Black in a White-majority society), and one's future (e.g., barriers youth might face due to their ethnic minority status), racial socialization is a protective communication process that impacts youths' cognitions, emotions, and behaviors (Neblett et al., 2008; Wang et al., 2020) and could improve engagement and effectiveness of TF-CBT.

Special Considerations:

In addition, it is important to note the racial aspects of interpersonal trauma. Recent scholars have coined the term Cultural Betrayal Trauma to underscore the additional burden of consolidating the change to one's worldview and racial identity that can occur when victimized by someone from one's own ethnic group or cultural background (Gomez, J. M., 2019). When Black youth

experience physical or sexual abuse, or witness DV or CV perpetrated by a Black individual—either in the community or in one's own family—as opposed to someone of another race, clinicians should inquire with the client and caregiver the meaning they place on being abused/witnessing violence by a Black perpetrator and the implications for their worldview and future experiences.

For example, consider a Black father who might feel guilty that, while he prepared his child for every potential threat by white people, he failed to anticipate or prepare her for danger within his own family. It is essential for clinicians to both 1) use TF-CBT with cultural applications (e.g., RS) to engage this family; *and* to 2) implement TF-CBT for sexual trauma individually with youth and caregiver, and refer the caregiver for individual therapy as necessary. In these cases, the caregiver can then focus on sexual abuse, which includes understanding and processing. As such, the caregiver and youth should use TF-CBT with RS as described herein to process their trauma and their sense of betrayal by their family member, or a member of their cultural group, as necessary.

ASSESSMENT AND ENGAGEMENT STRATEGIES

Assessment of General Trauma Exposure and Impact

As with all youth, a complete youth mental health assessment includes inquiring about the full range of potentially traumatic experiences that youth may have had exposure to, as well as potential negative mental health outcomes of such experiences. As described above, Black youth are at increased risk of experiencing a number of typical traumas in addition to racial-related stress and trauma. Therapists should carefully assess youth for all of these potential experiences, both during their clinical interviews with the youth and parent, respectively, and through using standardized instruments. Instruments that assess exposure to typical traumas and trauma symptoms include the UCLA PTSD Reaction Index for DSM-5 (RI) and the Child PTSD Symptom Scale for DSM-5 (CPSS). The Traumatic Experiences Structured Interview for Children (TESI-C) specifically assesses just trauma exposure. Instruments that more specifically assess racial-related stress and trauma experiences and responses are described below.

Therapists should also carefully assess Black youth for the presence of PTSD symptoms and disorder, while also recognizing that typical of youth with complex trauma, many traumatized Black youth will initially minimize both reporting their trauma exposures and responses; and that many youth will have trauma responses beyond typical PTSD symptoms (e.g., depressive, anxiety, substance use, other problematic behaviors, etc.). As with other youth, Black youth not not need to meet full PTSD criteria in order to receive TF-CBT. For TF-CBT to be appropriate, youth should have: 1) exposure to at least one remembered trauma; 2) significant trauma-related symptoms (e.g., PTSD, depressive, anxiety, cognitive, interpersonal, behavioral symptoms) that will be the focus of the youth's TF-CBT treatment, determined through the use of clinical interview and at least one standardized trauma assessment instrument such as the RI, the CPSS, the Trauma Symptom Checklist for Children (TSCC) or another developmentally appropriate, validated, standardized instrument; and 3) youth's and (if appropriate) parent's agreement to participate in trauma-focused treatment.

Assessment of Racial Trauma Exposure and Impact

There are several assessment instruments available for youth experiencing symptoms of racial stress and trauma. The best tools available for clinicians will be discussed. It should be noted that most of these instruments have been validated for teens or adults; to date there are no specific instruments to assess racial stress and trauma for younger children.

The Race-Based Traumatic Stress Symptom Scale (RBTSSS; Carter et al., 2011, Carter et al, 2013), consists of 52-items across seven scales (Depression, Anger, Physical Reactions, Avoidance, Intrusion, Hypervigilance/Arousal, and Low Self-Esteem) to identify traumatic stress symptoms in Black youth. The RBTSSS assesses feelings resulting from racist encounters on a 5-point Likert scale. Though this scale does not diagnose racial trauma, it may be useful to clinicians using the DSM-V diagnostic criteria for PTSD to identify client reactions to racially stressful and traumatic experiences.

The UConn Racial/Ethnic Stress and Trauma Survey (UnRESTS; Williams, et al., 2018) is a clinical interview designed to determine if the client's reactions to racial stressors meet the diagnostic criteria for PTSD as defined by the DSM-5. While not validated for children and

adolescents, this assessment aids in understanding whether the client's experiences with racism and discrimination have contributed to clinically significant distress. UnRESTS is broken down into six primary sections: Introduction to the Interview; Racial and Ethnic Identity Development; Experiences of Direct Overt Racism; Experiences of Racism by Loved Ones; Experiences of Vicarious Racism; and Experiences of Covert Racism. This assessment also explores the socialization messages clients have received throughout their life, the coping mechanisms they commonly utilize, and existing systems of support.

The Adolescent Discrimination Distress Index (ADDI; Fisher et al., 2000) is a fifteen item instrument designed to measure discrimination and associated distress in institutional, educational, and peer contexts. This instrument can provide insight to clinicians regarding client's experiences with racial stressors and their perceptions (impact rated on a 5 point Likert scaled) of prejudice and discrimination.

The Daily Life Experiences Scale (DLE-R) is an 18-item subscale of the Racism and Life Experiences Scales (RaLES; Harrell, 1997; Harrell et al., 1997; Seaton et al., 2009) that is used to measure the stress related to everyday experiences with racial discrimination with self-reported reactions ranging from "No problem at all" to "Very much a problem". Prompts include items describing discrimination like, "Being ignored, overlooked, or not given service (in a restaurant, store, etc.)" and "Being disciplined unfairly because of your race."

Case Conceptualization

Before starting TF-CBT, the therapist needs to organize the information gathered during the evaluation into a coherent understanding of the youth's presenting problems (case conceptualization and diagnosis). This information is shared with the caregiver as well as the youth (in a developmentally appropriate manner), in a way that integrates the assessment with the proposed plan for working together to achieve the agreed upon treatment goals (treatment plan). For TF-CBT treatment cases, the therapist's conceptualization is that trauma is at least one underlying core cause of the youth's presenting problems. If this is not the case, TF-CBT would not be indicated.

Within this trauma conceptualization, the therapist understands the youth's presenting problems—affective (e.g., depression, anger, hopelessness), behavioral (e.g., suicide attempts, school truancy, risky sexual behaviors, running away, substance abuse), cognitive (e.g., self-blame for racial-related stress or trauma responses; belief that the world is always or only dangerous; no one can be trusted), social (e.g., withdrawing from peers, affiliating with deviant peers), etc.—as being responses to traumatic memories and specific trauma reminders that occur in the youth's daily life and that remind the youth of the original trauma(s). Therapists should integrate youth's age and developmental understanding of race into their conceptualization, which should guide intervention selection and decision-making

It is important to understand that for many if not most Black youth, racial-related stress or traumas are ongoing (e.g., being ostracized or bullied by peers). Particularly with ongoing traumas, trauma reminders are frequent, and the youth's trauma responses also occur frequently if they are not almost constantly present. The therapist explains this to the youth and parent (typically at the assessment) when explaining the rationale for providing TF-CBT (the treatment plan) which will

address the youth's problems by developing alternative strategies for managing and responding to trauma reminders.

Conceptualizing the youth's presenting problems in a trauma and Racial Socialization framework –i.e., as an expected response to racialized, frightening, potentially life-or safety-threatening experiences, rather than as a serious mental health problem—is often a relief to Black youth and parents, and may be a highly effective strategy for engaging youth and parents in treatment.

Engagement Strategies

Engaging youth and families in TF-CBT begins with initial intake and assessment and continues throughout therapy. As with all families, engaging Black families in treatment requires that the therapist enters the relationship with cultural humility, i.e., "an ongoing process of self-exploration and self-critique combined with a willingness to learn from others…with the intention of honoring their beliefs, customs, and values, acknowledging differences and accepting the person for who they are" (https://inclusion.uoregon.edu/what-cultural-humility-basics). Therapists should not assume that they know anything about an individual youth's or family's values, beliefs, experiences, faith, parenting practices, or any other aspects of their culture based on their being Black, but instead should start from a stance of wanting to learn, understand and get to know the youth and family and the impact of trauma generally, and racial stress and trauma specifically, within their family and cultural context. It is important for therapists to ensure the spaces in which Black families will receive therapy are culturally affirming, for example, with art work, pictures, images, quotes from diverse folks, etc. Consistently, therapy materials should be culturally affirming/congruent and include diverse color representational content (e.g., TF-CBT resources developed by the first author and her colleagues that are cited later in this manual). An excellent resource for starting a conversation about intersecting identities and experiences with racism and race-related traumas "Learning About You" (family and therapist forms available), has been developed by the first author and her colleagues and can be accessed at https://ishametzger.com/research . This handout provides a script for therapists to engage youth and families in this type of conversation during the assessment process or early in treatment. This can be followed by using a standardized instrument to assess the youth's experiences with racism as described above.

Just as many youth and caregivers display initial trauma avoidance and minimize or even deny their trauma experiences and/or the negative impacts of these experiences, Black youth and caregivers may have different levels of trust and readiness to engage in discussions about racial stress and trauma experiences, or about Racial Socialization during the initial assessment. This is not a reason for clinicians to avoid raising these topics during initial evaluations, but it is important to meet the youth and caregiver where they are, and respect their need to move at their own pace in gaining trust in discussing these topics that are often difficult, serve as trauma reminders, and/or may have in the past actually been unsafe to address openly. This may be particularly true if the therapist is white (i.e., may serve as a trauma reminder of past racial traumas or stressors). It is important for the therapist to intentionally introduce race as well as look and listen for organic cultural opportunities to support racial socialization once a relationship has been developed, both intentionally and organically in the context of session content. It is also important to acknowledge and assess for intersecting identities, such as culture/acculturation status, ethnicity,

religion/spirituality, sexual orientation, gender and/or gender identity, etc, and their impact on the child's and/or caregiver's trauma experiences, rather than solely focusing on race as the youth and caregiver's only important identity. Other evidence-based engagement strategies have been described by McKay & Bannon (2002) and include acknowledging past negative experiences with service providers, inquiring about potential barriers to accessing care and attempting to address these; being flexible with scheduling; openly addressing differences in background and culture between provider and family including differences of power and privilege; and not shaming or blaming the family for trauma experiences.

Since Black families often have had the experience of discrimination in health care and related microaggressions, it is critical that the clinician convey the utmost of respect for the family, particularly the parents/caregivers. Also, the clinician needs to inquire as to what the family is hoping to obtain from treatment so that the goals of TF-CBT can be aligned with those of the family. Clinicians often forget that the primary goal of the initial appointment is engagement so that the family returns for the next appointment. To paraphrase Maya Angelou, families may not remember what a clinician has said or done but will remember how the clinician made them feel. And that is the major task of engagement; helping families to feel respected and have a sense of true compassion from the clinician so that they will return.

It is also important for clinicians to recognize that providing effective trauma-related interventions (i.e., those that help the child and/or parent to overcome difficulties related to the child's trauma experiences) are in themselves effective engagement strategies (i.e, nothing works better for effective engagement than true improvement in symptomatology).. Conversely, clinicians may spend weeks or months focused on developing a trusting relationship with the family, but if they fail to effectively address the problems the family came to therapy for, over time the family will likely lose trust in therapy and the clinician. It is therefore critically important to concurrently provide evidence-based engagement and trauma-focused interventions.

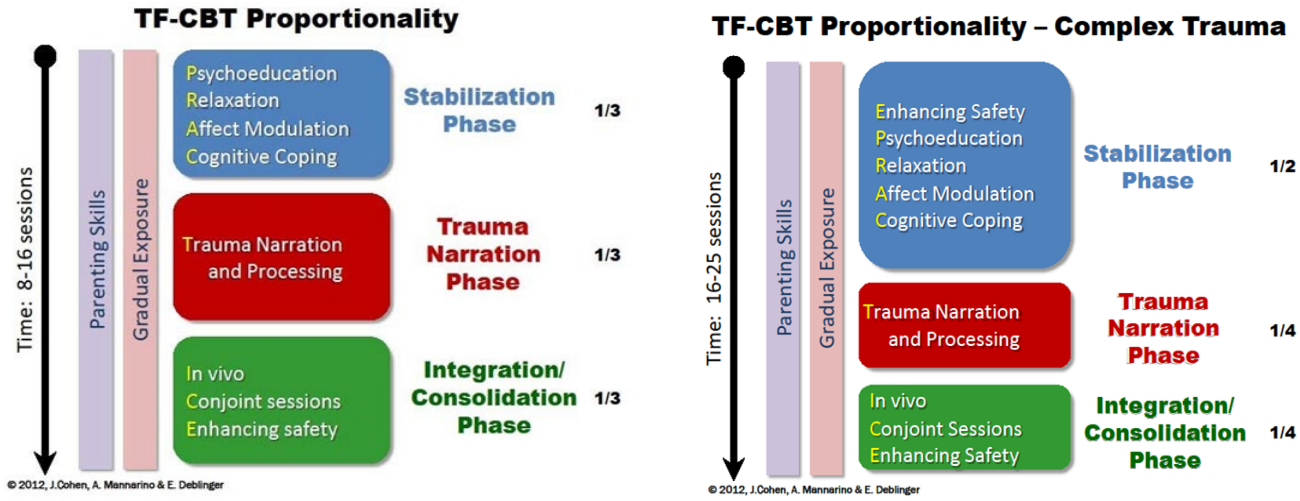
TF-CBT Applications for Youth with Complex PTSD

Although complex PTSD (sometimes referred to as "complex trauma") is not included in the DSM, it is increasingly familiar to child and adolescent mental health clinicians and is included in the International Classification of Diseases, 11th Version (ICD-11). The ICD-11 criteria for complex PTSD include that: 1) the individual experienced chronic trauma; and that 2) in addition to core PTSD features of intrusion, avoidance and hyperarousal, there must be prominent symptoms of affective dysregulation, negative self-concept, and interpersonal disturbances. Youth with complex trauma may benefit from trauma treatments that are specifically designed or modified for complex trauma. TF-CBT applications for complex trauma are available (Cohen et al., 2012; Kliethermes & Wamser, 2012). Many trauma-impacted Black youth have clinical presentations that are consistent with complex trauma. For these youth, therapists should be familiar with complex trauma TF-CBT applications. Briefly, these include the following:

1) Adjusting the length of TF-CBT treatment (from 8-16 sessions for typical PTSD to 16-25 sessions for complex or ongoing trauma, although some youth with complex trauma complete TF-CBT in 16 or fewer sessions);

2) Adjusting the proportionality of TF-CBT phases: specifically, for treating typical PTSD, 1/3 of TF- CBT sessions are spent on each TF-CBT phase. For complex PTSD, up to one-half of the TF-CBT treatment sessions are spent on the initial stabilization phase due to these youth having increased affective and/or behavioral dysregulation and needing more time to start trusting the therapist. The other phases each receive approximately one-fourth of TF-CBT sessions. See Figure 1: TF-CBT for Typical vs. Complex PTSD;
3) Recognizing the therapist as a potential trauma reminder since trauma was often perpetrated by caregivers or other attachment figures;
4) Safety first: since many youth with complex trauma develop unsafe coping strategies, introducing the Enhancing safety component at the start of TF-CBT treatment and continuing to emphasize this component throughout TF-CBT is critical. This is illustrated in Figure 1;
5) Focusing on overarching trauma themes that integrate the youth's chronic/multiple trauma experiences (e.g., "the people who should have protected me, abused/hurt me"; "people like me get bullied or even killed, so it's not safe to trust anyone," etc.); and
6) Including traumatic grief and separation TF-CBT components at the end of treatment when indicated, since many of these youth experience repeated loss of important attachment figures.

Figure 1: TF-CBT for Typical vs. Complex PTSD



However, therapists should also be aware that many youth with complex trauma presentations respond very well to standard TF-CBT treatment without these modifications. A recent study documented that standard TF-CBT treatment provided during 12 treatment sessions using equal proportionality for the three treatment phases led to significant improvement in both typical and complex PTSD symptoms (Sachser et al., 2016) and that the improvement in PTSD was equivalent between youth with typical and complex PTSD (Goldbeck et al., 2015). Clinical judgment should be used in deciding whether to use complex trauma modifications of TF-CBT for a particular Black youth.

Enhancing Safety

Consistent with this conceptualization, therapists should evaluate each Black youth individually, both with regard to the presence of a complex trauma presentation and the need to use complex PTSD modifications in implementing TF-CBT. Because of the pervasive nature of racial-related stress and trauma, therapists should incorporate safety considerations into psychoeducation at the start of and throughout TF-CBT treatment, adjusting the intensity of this to be appropriate to the individual youth and family's situation and need.

Manual Framework

The remainder of this implementation manual describes clinical applications of the TF-CBT PRACTICE components for Black youth and families who experience racial-related stress or trauma. For each component, the manual will: 1) provide a brief statement of the goals for that TF-CBT component; 2) briefly summarize typical implementation strategies for that component; and 3) describe Racial Socialization implementation considerations for Black youth and caregivers. Therapists will note that for much of the model, the integration of Racial Socialization does not lead to dramatic changes in how to implement TF-CBT; rather, Racial Socialization provides additional strategies and skills to complement what TF-CBT therapists are already providing throughout the PRACTICE components. All components with the exception of the Conjoint Youth-Parent Sessions are typically provided in parallel individual sessions to youth and parent, respectively, with approximately half of each session being provided to the youth and half of the session to the parent (Cohen et al., 2017).

PSYCHOEDUCATION

Goals: The goals of TF-CBT psychoeducation are to provide information about, validate and normalize for youth and parent, the impact of the youth's trauma experiences on different domains of functioning and provide information about the value of treatment and hope for recovery.

Typical Implementation: Typically, the TF-CBT therapist provides information about the full range of the youth's trauma experiences and common trauma reactions (including biological, emotional, behavioral, cognitive, social, etc.), connecting these to the youth's personal trauma responses. The therapist also provides psychoeducation about trauma reminders and encourages the youth to start to identify personal trauma reminders. Additionally, the therapist provides psychoeducation to the parent in this regard, as well as common parental responses to a child's trauma experiences. Providing information about neurobiology responses to trauma and how treatment can address these (e.g., practicing relaxation skills every day reverses these changes) is often helpful for explaining the rationale of TF-CBT to youth and parents. Resources for this include the handout Trauma and the Brain (https://tfcbt.org/trauma-and-the-brain-handout-mclaughlin-2014/)

Racial Socialization Considerations: When introducing TF-CBT and starting psychoeducation, therapists often find it helpful to start by introducing themselves and, depending on the youth's developmental level and other clinical considerations, perhaps sharing some selected aspects of their own identity to the extent that this is comfortable or clinically appropriate (e.g., gender, race, ethnicity, sexual orientation, etc.), and inviting the youth to do the same. (If the therapist conducted the initial assessment, this would be a helpful strategy for beginning the assessment also). This can be the start of exploring different aspects of the youth's intersecting identities including racial identity (e.g., student, sibling, daughter/son, Black person, etc.) As noted above, it is important for therapists to engage in self-reflection about their own comfort level in engaging in racial conversations, acknowledge that they may feel intimidated to start these conversations, and to be humble about lack of knowledge and/or personal experiences with racial traumas. It is also important for the clinician to carefully consider the appropriateness of sharing different aspects of their personal identity, and the reasons for doing this in a clinical setting, assuring that this is for the purpose of helping the client (i.e., appropriate boundary crossing).

An important step in introducing psychoeducation about racial stress, trauma or racial socialization, is to provide information about what these are. Racial stressful or traumatic experiences can be described as frightening or upsetting experiences where youth are treated differently because of their skin color; traumatic experiences are associated with perceived or actual danger (Metzger, et al 2021). These frightening experiences may cause youth to feel helpless, overwhelmed, and unable to cope (Metzger, et al, 2021). A few helpful resources to educate Black youth on the definition of racial stress and trauma include the following: What is Racial Stress and Trauma? (see Appendix 1); the Four Levels of Racism; What are Microaggressions?; What are the Common Reactions to Microagressions?; and Coping with Racial Trauma Handout. These handouts can be accessed at https://ishametzger.com/research. For young children psychoeducation about racial socialization might start by reading a book the includes multiracial characters. For example, while reading a therapy book to a 5-year old client, the therapist and caregiver intentionally pointed out

the differences in skin color and hair styles of the characters in the book, the therapist, the caregiver, and the client, normalizing and embracing/celebrating their differences.

It may also be helpful to provide information about the prevalence of racial stress and trauma, for example, by providing the statistics presented earlier in this manual or in the handouts available at https://ishametzger.com/research . When providing such information, therapists should take the time to process the youth's thoughts and feelings surrounding these prevalence rates. For many Black youth, these statistics may validate or affirm their prior experience with racial trauma, while for others it may be a new revelation that is interesting or upsetting.

After educating Black youth on racial stress and trauma, it is important to inquire about whether the youth had any prior personal experiences with racism. Although the therapist (or another clinician) may have asked about this during the initial assessment, many youth may not have fully understood the meaning of racial stress and trauma, or have been reluctant to fully disclose this due to avoidance and/or lack of trust in the clinician (e.g., because the clinician was white or due to other perceived differences between the clinician and the youth). Additionally, the therapist should not assume that racial trauma is not the only type of identity-related trauma that the youth has experienced. For example, the youth may have experienced traumas related to sexism, sexual orientation, gender identity, religion, ethnicity, etc., that were previously unknown to the therapist and/or caregiver and that need to be addressed in TF-CBT. For these reasons, it may be helpful to start by inquiring about more general identity-related traumas. For instance, therapists can ask, "Have you ever been called names, threatened, been hurt or traumatized due to any aspect of your identity, ethnicity or race?" If the youth says yes, it is important to explore this further to understand the nuances of intersectional identity-related traumas. For example, a gay Black youth disclosed that his father (from whom mother was divorced for many years), had repeatedly physically abused him (of which mother was aware) while saying things like, "You aren't even Black, there are no Black faggots.". Thus, this youth experienced intersectional colorism and family rejection. Therapists can then ask more specific questions related to racial stress and trauma; for example, "Has there even been a time where you felt treated differently because of your skin color? If so, how did you feel? How did you respond?" Now that the youth more fully understands what racial stress and trauma encompasses, it may be appropriate to administer (or re-administer) one or more of the questionnares specific to assessing racial stress and trauma described above in the Assessment section.

It is important for therapists to be aware of, inquire about and provide psychoeducation about (when clinically appropriate), some particular issues that Black children may experience, including 1) the intersection of racism and sexism experienced by Black females (e.g., early sexualization of young Black females, the powerlessness of Black men may be transmitted to Black women through high rates of interpersonal violence); 2) the potential for racism to be perpetrated by parents or other family members (e.g., as illustrated by the case above, or inadvertently via microaggression as in the case of white parents who transracially adopt Black children): and 3) the potential for Black children to have personal and/or vicarious (i.e. via media or extended family members) highly negative, frightening and/or traumatic interactions with police, educators and other authority figures. In all of these situations there is high potential for maladaptive cognitions, cognitive dissonance and/or gaslighting because the youth's beliefs are contrary to what someone

in power, someone they trusted or loved, or what society in general likely will expect that they "should" believe (see below under Cognitive Processing).

Even after providing the above psychoeducation and administering (or re-administering) one or more of the racial trauma assessment instruments, some Black youth may deny having experienced racial stress or trauma that the therapist and/or caregiver perceive as such. For example, one young girl experienced ongoing name-calling in school that included racial epithets such as "monkey" or "gorilla", which she attributed to "kids just being mean, they call other kids mean things too". In such situations, it is more helpful for the therapist to explore more about the youth's experiences to gain a more nuanced understanding about the situation and the youth's responses to it, rather than insisting that the youth adopt the therapist's and/or caregiver's perception about the racist nature of the experience. For example, this child did not fully understand (and possibly her offending peers did not either) the racial context for these statements, and they also said mean things to her as well as to many other children (Black and white) that were not racial in origin (e.g.,, they called her and a white girl "beanpole" because of their thin stature). This child wanted to be liked by her peers, and also had experienced some colorism in her own family (being taunted by older siblings for being darker than them), and said "I don't want to get in trouble for being dark". In this situation, in addition to providing general psychoeducation about bullying, the therapist provided psychoeducation about different types of racial trauma, examples of microaggression and the historical context of calling Black people certain names, and also maintained a supportive and neutral stance. This allowed the youth to acknowledge that it felt bad to be called mean names at home and in school that were related to her racial identity.

The psychoeducation component also involves educating Black youth on the common cognitive, behavioral, and emotional reactions of youth exposed to racial stress and trauma. For instance, therapists should share that exposure to racial stressors may cause youth to develop psychiatric concerns such as PTSD, depression and anxiety; unhelpful thought patterns (e.g. "It's my fault" or "My skin color is ugly"); feelings of low self-esteem; decreased motivation to complete academic assignments; and an increase in risk taking behaviors such as substance abuse, aggression and unsafe sex practices. The therapist can educate Black youth on the negative implications associated with racial stress and trauma by introducing the following handouts in session: Coping with Racial Trauma; How is Racial Trauma Similar to PTSD Handout?; and What are the Common Reactions to Microaggressions? After educating youth on the common reactions of Black youth exposed to trauma, the therapist should ask the youth whether they have experienced any of these symptoms. As with general TF-CBT psychoeducational information, therapists should tailor racial trauma psychoeducational information to the individual youth's presentation. For example, the gay Black youth above presented with significant PTSD and depressive symptoms related to his father's colorism that denied his Black identity. Identifying the nature of colorism, and racial trauma aspects of his father's behavior as well as the homophobia was extremely helpful, as was enlisting parental support from his mother (who had not until this session known about father saying these things to her son). When children share such traumatic experiences openly within the context of a caring, therapeutic environment, the child is likely to feel less alone in making sense of these traumatic experiences and will have support later in treatment to explore such experiences further as well as help in challenging dysfunctional developing beliefs that might stem from such

experiences. Therapists should reassure youth and caregivers that TF-CBT will provide strategies for addressing these difficulties, including Racial Socialization.

Specifically, therapists can explain that Racial Socialization is a set of strategies to manage racial stress and trauma and prepare for it in the future. For instance, racial socialization involves therapists and caregivers having open and honest conversations about race and racism (Metzger, et al, 2021). Therapists and caregivers should normalize and highlight that although racism is prevalent it does not make it okay. People of color should not have to endure these experiences. Racial socialization also involves encouraging positive interactions between Black youth and their caregivers to promote resiliency, strength, positive self-worth surrounding the youth's racial identity and to assist the youth with coping with future racial stressors. Examples of these positive interactions may include: introducing youth to books, movies, and television shows discussing race; educating youth on Black history; introducing racial pride messages; or discussing how to manage potential racial encounters with police officers or sales associates. Helpful resources to introduce the concept of racial socialization to Black youth include the following handouts: What is Racial Socialization?; What Are The Types Of Racial Socialization Messages?; How is Racial Socialization Communicated?; How Does Racial Socialization Impact Our Identity? and What Are The Benefits Of Racial Socialization? Therapists should review the suggested handouts with the youth in session and explore which of these activities the youth may want to engage in with the caregiver.

Caregiver Considerations: In addition to the above information related to general trauma and racial socialization, the following considerations are important with regard to providing psychoeducation with caregivers of Black youth. Therapists need to explore the nature of prior experiences with mental health and other service systems. For instance, black families may exhibit a sense of distrust for mental health providers due to previous negative encounters in the healthcare system. Therefore, it is important for therapists to ask about these experiences, validate, and offer psychoeducation as needed. Therapists should also explore the family's cultural beliefs about participating in mental health treatment. Black families may possess cultural beliefs and values that might cause apprehension or reluctance to participate in treatment services. For example, black families may believe that "family matters should remain in the family", "Black boys should remain strong and not express their emotions", or "Black girls should be prepared to be superwoman." Encouraging these discussions with families, provides therapists with the opportunity to learn about the family's values and expectations and provides clarifying information. Once these issues have been addressed, the therapist can proceed to provide psychoeducation as described above related to trauma and racial socialization. In the psychoeducation component, TF-CBT is structured, time limited and very transparent in terms of the goals and therapy methods utilized. Moreover, what is being reviewed with the child in each session will be shared with the caregiver. Such clear communication with caregivers may help to address the distrust some caregivers may feel as a result of negative experiences with therapy or other service providers in the past. More information in this regard is included in the Parenting Skills component below.

Links to Handouts:

What is Racial Stress and Trauma Handout: https://www.drishametzger.com/care-package-for-racial-healing

The Four Levels of Racism Handout: https://www.drishametzger.com/care-package-for-racial-healing

What are Microaggressions Handout : https://www.drishametzger.com/care-package-for-racial-healing

What are Common Reactions to Microaggressions Handout: https://www.drishametzger.com/care-package-for-racial-healing

How is Racial Trauma Similar to PTSD Handout: https://www.drishametzger.com/care-package-for-racial-healing

What is Racial Socialization?: https://www.drishametzger.com/care-package-for-racial-healing

What are the Types of Racial Socialization Messages? https://www.drishametzger.com/care-package-for-racial-healing

How is Racial Socialization Communicated? https://www.drishametzger.com/care-package-for-racial-healing

How does Racial Socialization Impact our Identity: https://www.drishametzger.com/care-package-for-racial-healing

What are the Benefits of Racial Socialization?: https://www.drishametzger.com/care-package-for-racial-healing

PARENTING SKILLS

Goals: The goals of the TF-CBT parenting component are to enhance support of the non-offending (non- perpetrator) parent for the youth, and optimize parental skills with regard to recognizing and responding to the youth's trauma-related difficulties including trauma reminders.

Typical Implementation: Typical TF-CBT provides specific training in effective parenting skills (e.g., the use of praise, selective attention, functional analysis of behavior problems, use of behavioral plans, negotiating, etc.) to address the youth's trauma-related behavioral problems and tweaks these as needed throughout therapy. The therapist provides each TF-CBT PRACTICE component to the parent and practices these so that the parent is best able to support the youth in implementing TF-CBT skills both in daily scenarios as well as in response to trauma reminders (gradual exposure, GE), while also serving as a role model for effective coping. Resources include TF-CBT for youth with co-occurring trauma and behavior problems (Cohen, Berliner & Mannarino, 2010), and the National Center on the Sexual Behavior of Youth website for managing sexual behavior problems, available at http://www.ncsby.org/ (resources available for therapists, parents and youth).

Racial Socialization Considerations: When talking about parenting, positive family routines and rituals, behavioral expectations and discipline, it is essential to understand the family's cultural identity and values, the meaning of different behaviors, and parental hopes, dreams and fears for their children if behaviors occur or do not occur, and the cultural and historical context of these. It is also important to explore how the caregivers themselves were raised (including discipline practices they experienced), what was or wasn't helpful about this, including abuse or trauma experiences the caregiver had. Thus, during the parenting component, the therapist should always inquire about the family's cultural background; specifically, their cultural or ethnic identity, religious/spirituality beliefs, and racial identity. It is important to communicate with families that their therapist is there to partner and collaborate with them and wants to learn how to further understand and support the family. Some helpful questions to aide in this discussion might include: " Tell me about your family?; "What culture, ethnic, religious or spiritual community does your family belong to? What comfort and sense of belonging does this bring to your family?" "What challenges, if any, come with this identity?" To further assist therapists with having conversations with caregivers about their cultural background -therapists should utilize the "Learning About You: Race, Culture and Identity (Therapist Guide)"

The therapist should have conversations with the caregivers about the ways in which they nurture and encourage positive behaviors in their children. This is sometimes challenging when children are presenting with significant behavior problems, but there are inevitably areas in which children continue to show strengths whether it is in their family or peer relationships, sports activities or particular clasess in school. Inquiring about positive routines and rituals that create some predictability in the children's lives may also be important to idenitify and/or encourage or re-instate if the recent traumas have disrupted such family routines as these are often important for supporting children's feelings of security and positive adjustment. Caregivers often have their own ways of conveying pride, affection and approval that may be culturally influenced. Discussing the impact of positive, negative and predictable attention and the value of expressing appreciation and

praise when their children engage in productive, prosocial behaviors warrants considerable discussion and time in the early stages of treatment (Deblinger, et al., 2015).

It is also important for the therapist to discuss with the caregiver the discipline practices used in the home environment. It is helpful to start this conversation by exploring the types of behavioral issues the youth may be having (if any), and understanding the antecedents and consequences that may be contributing to traumatic behavioral problems (discussed in detail elsewhere, e.g., Berliner et al, 2010; Cohen et al, 2017). In situations in which these are related to racial traumas (e.g., youth was pulled out of car, pushed and threatened by police), it is important for the therapist to help the caregiver recognize connections among trauma reminders (e.g., seeing media depictions of police brutality; being yelled at in school), affective dysregulation (e.g. fear and anger), and traumatic behavioral problems (e.g., fighting at school). Helping the caregiver to understand that the consequences (e.g., spanking for misbehavior in school) they implement, although well meaning, may be serving as a trauma reminder, is important for helping the youth to regain a sense of control, justice and behavioral regulation. A discipline strategy that is frequently used in Black families is corporal punishment or "spanking." It is important for therapists to remember that although corporal punishment is a common discipline strategy used in Black families – it should not be assumed that it is used in all Black families. Families of different races and cultural backgrounds use corporal punishment. It is also important to understand and acknowledge that most families in the US use spanking at some point, and that Child Protective Services (CPS) is significantly more likely to remove Black children than children of other races from parental care due to having experienced physical abuse. If corporal punishment is used in the family, it is important to explore how this strategy has worked for the family, the child's response to corporal punishment and inquire about the caregiver's interest in implementing alternative strategies such as positive reinforcement. It is important to focus on positive aspects of the caregiver's relationship with the child and how the therapist might help to enhance their connection through helping the caregiver to understand the connection between the youth's trauma experiences (including racial traumas) and behavioral problems. Using engaging language is especially useful with Black families (e.g., "Kudos" rather than ""praise", "wanting connection" or "what needs is your child trying to get met" rather than "seeking attention", etc.) It is also important to humbly encourage caregivers to reflect on how their children are experiencing their discipline practices through the perspective of having gone through racial and other traumas (and thus being outside the norm of what their usual discipline practices might call for), and how to help them not unintentionally remind their child of these past traumas. When having this conversation with caregivers, therapist must remind caregivers about the limits of confidentiality and their mandated reporter status when it comes to suspected physical abuse.

Next, therapists should inquire about whether caregivers are having conversations with the youth about race and racism. Some questions to assist in this discussion might include: "Are you having conversations with your youth about race and racism? If so, tell me more about those discussions. What topics are being covered during these conversations? And how does your youth typically respond to discussions about race and racism?" If caregivers are not having these discussions with their youth, it is important for therapists to inquire about the reasons why they are not having these discussions and educate them on the potential benefits of having discussions about race and racism with Black youth. For instance, conversations surrounding race and racism provide Black youth with education about their Black identity, boosts self-esteem, helps Black youth feel more

comfortable with having difficult conversations with caregivers; and assists them with preparing for potential racial stressors. Some caregivers may be reluctant to have these conversations with youth because they don't see the purpose or perceive these discussions as being irrelevant to the youth's presenting problem. Psychoeducation is key to helping caregivers understand the relevance of discussing race and racism with black youth. Therapists should provide parents with psychoeducation on the prevalence of racial trauma; the definition of racial stress and trauma; the common behavioral, emotional, and cognitive reactions of youth exposed to racial stressors; the definition of racial socialization and the benefits of implementing racial socialization with youth. Therapists can utilize the same resources introduced in the psychoeducation component to educate caregivers on the above concepts.

Therapists should discuss with caregivers the benefits and the importance of racial socialization for Black youth. Racial socialization can be described to caregivers as, "the process of encouraging conversations and interactions between Black youth and families to help Black youth to identify and develop coping strategies to manage racial stressors" (Metzger, et al, 2021). Caregivers should be informed that racial socialization is designed to help build the self-esteem of Black youth; highlight their strengths and resilience; and increase communication between youth and caregivers. Therapists should introduce helpful ways for caregivers to implement racial socialization in the daily lives of Black youth. Some helpful strategies might include: encourage parents to talk about their personal experiences with racism and how they managed the stressors; teach youth about the family's cultural or ethnic identity and special traditions; provide youth with books about Black history; have discussions about current events surrounding race; and visit museums focused on Black history. A resource to help caregivers with implementing racial socialization with their youth is the Racial Socialization Caregiver Handout.

It is often helpful and important for the caregiver (and/or the therapist) to provide psychoeducation and advocacy about racism, racial trauma and Racial Socialization to educators, athletic coaches, and other adults with whom the youth interacts, particularly if the youth is encountering racial stress or trauma in those settings (e.g. at school). When caregivers become stronger advocates in this regard, the youth will feel more supported and have a better model for positive coping with future racial stress or trauma.

In encouraging the caregiver to share with the youth the caregiver's personal encounters with racism, it is particularly helpful for the therapist to first explore some of these encounters, and to elicit 1) what types of responses the caregiver had; 2) what potential other responses the caregiver could have had that the caregiver might have wished to model more helpful coping to the youth; and 3) whether there are other episodes that illustrate more effective type of coping. For example, a parent described to a therapist that he was stopped when leaving a store and asked for a receipt when no other families were stopped. He was angry at being singled out but just showed the receipt because he was in a hurry and "didn't want a hassle". He described another time when he was asked for a receipt and this time he showed the receipt and also said that he saw several white families leaving without being asked to show their receipts, and was he being asked to do this because he was Black? The clerk said no, and apologized. The therapist praised the father for modeling positive racial socialization and self-advocacy for the child, and encouraged father to discuss this with his son. Father agreed to do this and reported that it was a very positive discussion.

Caregivers of younger Black children may be reluctant to allude to racism directly with these children due to wanting to protect them from the pain of this experience. Therapists can be helpful in coaching caregivers in how to start these discussions (e.g., focusing on the positive aspects of Black identity, introducing books that help to strengthen young children's sense of and comfort with their Black identity, etc.). Caregivers may be hesitant to address racism or to engage in Racial Socialization discussions for a variety of other reasons, e.g., they do not perceive that racial identity is related to the reason for the child coming to trauma-focused therapy or to the child's primary behavioral issues, the caregiver is overwhelmed with other issues and does not want to deal with race now; the caregiver does not perceive race to be relevant to their current circumstances, etc. If after the therapist has provided information about Racial Socialization the caregiver continues to maintain that they are not interested in pursuing this, the therapist should not insist on doing so.

Therapists should also take into consideration that Black youth may reside with caregivers from different racial backgrounds. For instance, a Black youth in the foster care system may be placed with a white family or a bi-racial child may reside with his or her non-Black parent. Non-Black caregivers may lack understanding on how to support Black youth with positive identity development and how to help Black youth navigate through experiences of racial stress and trauma. Therapists should educate caregivers from different racial backgrounds on why it is important to have conservations with Black youth about race and racism; discuss the negative implications associated with racial stress and trauma; and educate caregivers on racial socialization and helpful ways to implement racial socialization in the home environment. Therapists can use the "Being a Better Ally" resource located in the first author's racial trauma guide to educate non-Black caregivers on ways to implement racial socialization. The "Being a Better Ally" resource educates non-Back caregivers on the importance of having conservations about race and racism with Black youth; discusses the concept of White Privilege and introduces helpful ways that caregivers from more privileged backgrounds could utilize their privilege to combat racism. For instance, non-Black caregivers can support Black youth through racial stress and trauma by speaking up and advocating against racial discrimination and educating themselves on Black culture by reading books, watching movies, or visiting Black history museums (Metzgher Racial Trauma Guide).

Next, therapists may need to educate non-Black caregivers on helpful ways to promote positive identity development in Black youth. For instance, some Black youth who reside in non-Black households may feel insecure surrounding having a darker skin complexion or more textured hair. Therapists can introduce non-Black caregivers to strategies that could help boost the self-esteem of black youth and assist them with feeling pride in their appearance. For instance, non-Black caregivers can educate themselves on Black hair care and helping their child recognize the beauty of having Black hair. Below are a list of you-tube videos and books for parents to view on their own and collaboratively with the Black youth. For instance, the video "A white mom's tool kit for caring for Black curly hair" demonstrates how a white mom learned to care for her bi-racial daughter's hair. When a youth feels good about his or her appearance, it is likely to help boost their self-esteem. Therapists should also recommend that non-Black caregivers identify beauty shops or barbershops that specialize in Black hair care.

Lastly, another helpful racial socialization strategy for non-Black caregivers is to offer Black youth the opportunity to connect with individuals in the Black community. Black youth with non-Black caregivers do not always have the opportunity to interact with individuals from the Black community. Some helpful ways that non-Black caregivers can assist Black youth with connecting with the Black community areby connecting them with and envouraging the youth's ongoing participation with youth groups, church organizations, Black sororities, and/or mentoring programs.

Links to Resources:

Learning About You: Race, Culture and Identity (Therapist Guide):
https://www.seattlechildrens.org/globalassets/documents/healthcare-professionals/pal/fast/learning-about-you-brief-provider-version.pdf

Racial Socialization Caregiver Handout:
https://www.seattlechildrens.org/globalassets/documents/healthcare-professionals/pal/fast/fast-t-caregiver-racism-handout.pdf

Being a Better Ally Resource: https://www.drishametzger.com/racial-trauma-guide

You-tube video links on black hair care:

Kids Curly Hair Wash Day Routine: Tips for Foster Care + Adoptive Parents – Christy Gior
https://www.youtube.com/watch?v=LtWgO_-72P4

How to care for black children's hair properly/ Transracial Adoption, Black Hair Guide:
https://www.youtube.com/watch?v=1QS3qyQZsKs

A white mom's toolkit for Caring for Black, Curly Hair: https://www.youtube.com/watch?v=9-MaQVbcudA

How a white mom tackles black hair care: https://www.youtube.com/watch?v=riDKdZ_0rG0

Books on black hair care:

Hair Love by Matthew A Cherry: https://www.amazon.com/Hair-Love-Matthew-Cherry/dp/0525553363/ref=asc_df_0525553363/?tag=hyprod-20&linkCode=df0&hvadid=343252337225&hvpos=&hvnetw=g&hvrand=5723432446560071058&hvpone=&hvptwo=&hvqmt=&hvdev=c&hvdvcmdl=&hvlocint=&hvlocphy=9005926&hvtargid=pla-751409076857&psc=1&tag=&ref=&adgrpid=66484626942&hvpone=&hvptwo=&hvadid=343252337225&hvpos=&hvnetw=g&hvrand=5723432446560071058&hvqmt=&hvdev=c&hvdvcmdl=&hvlocint=&hvlocphy=9005926&hvtargid=pla-751409076857

Hair Like Mine by LaTashia M. Perry: https://www.amazon.com/Hair-Like-Mine-Kids/dp/0986237973/ref=asc_df_0986237973/?tag=hyprod-20&linkCode=df0&hvadid=247586506947&hvpos=&hvnetw=g&hvrand=5723432446560071058&hvpone=&hvptwo=&hvqmt=&hvdev=c&hvdvcmdl=&hvlocint=&hvlocphy=9005926&hvtargid=pla-565418761918&psc=1

Cool Cuts by Mechal Renee Roe: https://www.amazon.com/Cool-Cuts-Mechal-Renee-Roe/dp/1984895575/ref=asc_df_1984895575/?tag=hyprod-20&linkCode=df0&hvadid=459726190744&hvpos=&hvnetw=g&hvrand=3720658807645087492&hvpone=&hvptwo=&hvqmt=&hvdev=c&hvdvcmdl=&hvlocint=&hvlocphy=9005926&hvtargid=pla-1078932454712&psc=1

Resmaa Manakem Breaks Down Deep Rooted Trauma Linked to Racism, Healing Practices and More video: https://www.youtube.com/watch?v=omyzEvVvjog

RELAXATION SKILLS

Goals: The goals of TF-CBT relaxation skills are to develop and practice individualized relaxation : strategies that the youth can use and parent can reinforce the youth using in a variety of settings to reverse physiological and psychological trauma-related hyperarousal.

Typical Implementation: The TF-CBT therapist typically asks the youth to describe activities the youth finds enjoyable and/or relaxing (e.g., sports, reading, crafts, games, music, etc.), and uses these as a basis for developing a "toolkit" of individualized relaxation strategies the youth can use in a variety of settings (e.g., going to sleep; at school; with friends; with trauma reminders). The therapist usually demonstrates and asks the youth to try some empirically proven relaxation strategies such as focused ("belly") breathing; progressive muscle relaxation; visualization; guided imagery; yoga. The therapist meets individually with the parent, shares the youth's preferred relaxation strategies with the parent, and instructs the parent to encourage the youth to practice these in a structured way for at least 20 minutes each day, and to encourage the youth to use these strategies when trauma reminders occur (gradual exposure, GE). Resources for implementing relaxation strategies with teens include Rays of Calm (Kerr, 2007).

Considerations for Racial Socialization: In the Relaxation component, therapists should explore the youth and family's cultural beliefs and values surrounding rest and relaxation. For instance, therapists should ask, "what are your family's beliefs surrounding rest and relaxation?" Some common messages in many Black families are related to "John Henryism", (a strategy for coping with prolonged exposure to stresses such as racism by expending high levels of effort which results :in accumulating emotional and physiological costs); the cultural expectation of the "Strong Black Woman" which includes an expectation of not asking for help and overworking as an adaptation to overcome chronic racial stress and trauma; and/or that "you must work twice as hard to get half as much" which may cause many Black youth to devote less time and attention to rest and relaxation. Therefore, it is pertinent that therapists educate Black youth and their families on the benefits of implementing relaxation strategies into their daily routine to cope with racial stress and trauma. Relaxation provides Black youth with the opportunity to rest and recharge so that they are able to navigate through their daily life. A resource to educate Black youth on the benefits of relaxation is the "Relaxation and Restoration" Handout.

In session, therapists should assist Black youth with identifying a list of relaxation strategies that are engaging, helpful and appealing to the individual youth and that might be effective in response to trauma reminders. To start this process, therapists should ask youth, what types of activities help you relax after a long and stressful day? The goal is to assist youth with building a relaxation skills tool kit to help them navigate future racial stressors. Relaxation strategies that therapists can introduce to Black youth include: playing a sport; participating in a hobby, listening to gospel or other praise and worship music, prayer, meditation, watching a comedy clip on youtube, writing poetry, spoken word, deep breathing, and progressive muscle relaxation. Resources that can assist therapists with educating Black youth on helpful relaxation strategies to cope with racial stress and trauma include the Relaxation Handout (Appendix 2); Progressive Muscle Relaxation Handout; Coping with Stress and Racism: Helpful Information For Teens Handout; and Coping with Stress and Racism: Helpful Information for Kids and Teens Handout. These are available at

https://ishametzger.com/research. It is important to also assist youth in using these relaxation strategies with racial stress and trauma reminders, as well as with other trauma reminders as they occur during the youth's daily life. As with other traumas, it is important for the therapist to assist the youth in learning to self-monitor how the relaxation strategies are working to reduce stress and physiological tension by self-rating (e.g., on a Subjective Units of Distress Scale, SUDS of 1-10, with 1=no stress or tension and 10=maximal stress or tension) at least daily and when racial and other trauma reminders occur. More information about self-monitoring is available elsewhere (Cohen, et al, 2017, page 178). The youth should then record how the relaxation strategies are working, both for daily practice to reduce physical stress and in response to racial stress and trauma and/or other trauma reminders; and bring this daily record in to subsequent sessions so that the therapist can help the youth to tweak these relaxation strategies as needed.

Caregiver considerations: When integrating Racial Socialization with TF-CBT, therapists should similarly inquire of caregivers about their attitudes about using relaxation, exploring parallel family and cultural attitudes to those described above (e.g., John Henryism, Strong Black Woman, need to work harder than others to get less, etc.). The therapist should also provide information to the caregivers about the value of implementing relaxation into the routine of Black youth as well as to the caregivers themselves, for coping with trauma and racial stress. With the permission of the youth, therapists should share with caregivers some of the relaxation strategies discussed in session so that the caregiver can model and assist the youth with practicing these skills in the home environment. Encouraging relaxation activities that the youth and caregiver can jointly participate in can also provide opportunitites for enhancing connection and communication between the youth and caregiver, as well as sharing these fun and relaxing times. For example, joining a gym together, attending a program to learn about creating Black hair and skin care products, and going to a Black African Art class together are some relaxation strategies that enhance family Racial Socialization for youth during TF-CBT. The therapist should also encourage the caregiver to help the youth to use these strategies when racial stressor or trauma reminders occur, and to help the youth use self-monitoring to record how relaxation strategies are working to reduce physical stress. If necessary the caregiver can remind the youth to record and bring the record of the relaxation strategies in to weekly sessions so that the therapist can tweak the relaxation strategies to enhance their efficacy in response to racial and other trauma reminders.

Links to Handouts:

Relaxation and Restoration Handout: https://www.drishametzger.com/care-package-for-racial-healing

PMR Handout: https://www.drishametzger.com/care-package-for-racial-healing

AFFECTIVE MODULATION SKILLS

Goals: The goals of affect expression and modulation are to provide the youth with vocabulary to describe the full range of affective states, and to provide individualized skills to the youth and parent to modulate and manage negative affective states.

Typical Implementation: The therapist typically provides the youth with affective expression skills through games or activities such as Emotional Bingo (for Children or Teens), feelings brainstorm or other games and activities. The therapist also demonstrates and practices with the youth a variety of affective modulation skills tailored for the youth's developmental level and preferences. These may include positive imagery, visualization, mindfulness for teens, ongoing self-monitoring of feelings (rating on thermometer), distraction skills (e.g., activities, social, reading/puzzles, intentionally changing mood via humor, watching a funny movie, etc., positive sensations, social support, improving the youth's ability to read/understand others' affective states (e.g., accurately reading facial expressions), and others. The therapist also encourages youth to use these skills in response to trauma reminders (gradual exposure, GE) and also to describe the feelings elicited by these trauma reminders. The latter can help the youth to respond to trauma reminders in a more modulated and balanced manner. The therapist meets individually with the parent to teach the parent these skills and encourage the parent to support the youth in practicing these skills daily, including in response to trauma reminders. Resources for implementing these skills include Emotional Bingo for Teens, feeling thermometer, emotional color wheel, and a variety of videos for youth of different ages and interests.

Considerations for Racial Socialization: In starting the Affective Modulation component, therapists typically begin with feeling expression games and exercises (e.g., Emotional Bingo, Color Your World, Emotional Color Wheel, etc.) As part of these strategies, therapists can include questions that focus on racial pride, for example, if a youth drew the feeling "Excited" in Emotional Bingo, the therapist could ask, "Is there a time you felt (or a child felt) excited about something race-related? If the youth drew the feeling "Ashamed", the therapist could ask, "Has there ever been a time you felt ashamed of your race?" If a youth said "yes", the therapist should then explore the situation in which the youth felt this way, and use appropriate psychoeducation and Racial Socialization strategies to explore these feelings (in some situations, Cognitive Processing strategies may also be helpful) . For example, after one youth described feeling ashamed of being Black, he described an episode when, after his father beat his mother, he heard one of the responding police officers say "all those guys are like that". The youth believed the police officer meant "all Black men are violent to their wives" and this made him feel ashamed of being Black. The therapist reviewed Racial Socialization psychoeducation to help the youth to identify the statement "all those [Black]guys are like that [perpetrators of domestic violence]" as an example of individual racism as well as microaggression (and possibly also institutional police racism). The therapist also reminded the youth of the psychoeducation they had discussed about domestic violence, which had emphasized that this occurred in all types of families regardless of race, ethnicity, sexual orientation, religion, etc. Through this discussion, the youth was able to recognize that the police officer who said this was showing his own ignorance about domestic violence, and his own prejudice and racism about Black men, very few of whom perpetrate domestic violence.

Through this process the youth was able to say that he was ashamed of his father for hitting his mom, but it didn't have to do with his race. He was subsequently able to identify positive feelings related to being Black later in the game and throughout the session. In addition to general feeling expression, therapists should encourage Black youth to specifically express their feelings related to encountering racial trauma and discrimination. For instance, therapists may ask youth, "What recent experiences have you had with racial discrimination? How did those experiences make you feel?" It is important for therapists to not only focus on negative emotions related to race, but also highlight positive feelings related to being Black (e.g, "Is there a time you felt pride in your race?") Many youth will identify with pride the accomplishments of famous people in sports, music, politics, etc., but also may be proud of their parents or other relatives who have overcome challenges. The Emotion Regulation Handout (Appendix 3) can be helpful to facilitate this process.

It is important for therapists to be aware that some Black caregivers have socialized their children to suppress or minimize overt affective expression out of concern that negative affective expression by Black youth is more likely to be interpreted as aggression by the majority culture and may lead to discrimination, racism or even violent responses. (Kang & Chasteen, 2009; Metzger et al, 2022). Thus, if therapists find that youth are reluctant to express negative emotions, say they do not feel anything, etc., they may want to consider discussing this with the caregiver and finding ways to encourage youth to express feelings in ways that the family believes to be safe.

In addition to feeling expression, the Affective Modulation component focuses on developing effective strategies for managing negative emotions related to trauma, including racial stress and trauma. Black youth exposed to racial stressors are likely to experience many different emotions such as sadness, anger, hopelessness, irritability, embarrassment, and shame, but often lack skills for how to cope with these negative emotions. Once youth are able to identify and communicate their feelings about the racial trauma, it is the role of the therapist to help them develop strategies to better tolerate the distressing emotions. Therapists should inquire about how youth currently cope with uncomfortable emotions and then assist them with identifying additional strategies to continue building their coping skills tool kit. Examples of affect regulation strategies include: seeking social support from family and friends, journaling, listening to music, prayer, listening to podcasts or youtube videos, and engaging in a hobby.

Although racism is a reality in the lives of Black American youth, it is wrong. Thus, there is value in Black youth being angry about racism, and the injustice and unfairness of having to live with this additional burden. It is important for therapists to validate and encourage the righteous anger arising from oppression, injustice and helplessness, when it is expressed appropriately. Providing youth with tools to manage this anger and to express it effectively are important aspects of affective modulation. For example, using dialectic (i.e. two seemingly opposite or different things can both be true simultaneously) can lead youth to balancing anger with other important feelings such as love, compassion and sadness, seeing the good in others, etc. and thus not being overwhelmed with uncontrollable anger. Many Black youth receive messages that they "cannot embarrass our race", and/or expectations that they must be "tough", have "grit" and "determination" and this may be difficult for youth whose temperaments are not consistent with that presentation. Therapists must be aware of these types of messages from caregivers and the specific subculture in which the youth is living, when implementing TF-CBT Affective Modulation skills for Black youth. Helping these youth to develop effective affective expression and modulation skills within the strictures of

these expectations may be challenging but it is even more important for youth who are likely to encounter ongoing experiences of racism and racial stress.

Caregiver considerations: Therapists should also educate caregivers on the importance of implementing affective modulation skills into the daily routine of Black youth. Similar to relaxation strategies, affective modulation skills are not only beneficial for helping Black youth cope with racial stressors but they can assist caregivers with coping with racism as well. With the permission of the youth, therapists should share with caregivers some of the affective modulation strategies discussed in session so that they can model and assist Black youth with practicing these skills in the home environment. A helpful affective modulation strategy is encouraging caregivers to talk with Black youth about how the caregiver themselves felt and coped with an experience of racial discrimination. An example might be a Black caregiver talking to a youth about a time when the caregiver was mistreated by a white store clerk. To cope with the situation, the caregiver utilized a deep breathing exercise and then addressed the situation by speaking with a store manager. Through sharing this example with the youth, the caregiver both informed the youth that the caregiver had also experienced very affectively distressing racial discrimination, and also provided the youth with concrete modeling of effective strategies for modulating the negative feelings and advocating for oneself in that racial discrimination situation. For caregivers who are uncertain about how to do this with their youth or whether the youth will receive it positively, it may be helpful to role play the scenario of the caregiver sharing and modeling coping strategies with the youth, for the caregiver to practice what and how they would want to communicate with the youth in this regard.

Another example that most caregivers of Black youth are familiar with is having "The Talk" with their youth (e.g. about how to handle being stopped by the police). This is a perfect example of the caregiver modeling for the youth how to integrate Racial Socialization with TF-CBT Affective Modulation (and Enhancing Safety) for the youth, e.g., "You may be unfairly stopped by the police because you are Black, but for your safety and possibly your very survival, you must contain your righteous negative emotions and act calm, cool, collected and polite no matter how angry you are inside. This is how to do that." The therapist can discuss with the caregiver whether and when they have had "The Talk" with their youth (and if not, when they plan to do so in the future), and the content and tone of that discussion. The therapist can then use this as a springboard for reinforcing this discussion with the youth as an example of using affective modulation skills for racial stress/trauma situations, and how to extend these same skills for other situations. If the caregiver had suggested specific strategies to the youth for the police stop situation, the therapist should try to incorporate these strategies into the youth's affective modulation tool kit, since the caregiver will be likely to support and reinforce their use.

COGNITIVE COPING SKILLS

Goals: The goals of TF-CBT cognitive coping skills are to help youth and parents gain mastery in understanding connections among their thoughts, feelings and behaviors; and to gain mastery in replacing inaccurate or unhelpful cognitions related to everyday (i.e., non-traumatic) situations.

Typical Implementation: In typical TF-CBT, the therapist assists the youth and parent in considering whether their everyday thoughts are accurate, helpful, or balanced, and if not, in developing skills to replace these thoughts with more accurate, helpful or balanced thoughts, in order to feel and act more positively. The therapist typically introduces the cognitive triangle (connections among thoughts, feelings, and behaviors) in relation to common scenarios from the youth's daily life that generate negative emotions (e.g., " a friend walks past you in school without saying hello—what do you think, how do you feel, how do you act?"), and through this process, helps the youth to explore whether their thoughts are accurate, helpful or balanced (e.g., "I think my friend is mad at me"; "I feel sad and mad—I didn't do anything for her to get mad at me"; "I don't talk to her the rest of the day"). The therapist then assists the youth to develop more helpful, balanced and/or accurate thoughts (e.g., "Maybe something upsetting happened to her at home last night; maybe she's worried about her family today") thereby developing more positive feelings ("concerned about my friend; not mad at her") and behaviors ("I'd try to find her and ask if she's okay") in the situation. The therapist encourages the youth to practice this skill regularly and to track how it works. The therapist also introduces and practices these cognitive coping strategies with the parent. Gradual Exposure (GE) is used only with the parent in this component, by starting to explore the parent's maladaptive cognitions related to the youth's trauma experiences. GE is NOT used with the youth in this component, because it is beneficial for youth to engage in trauma narration before attempting to cognitively process trauma-specific maladaptive cognitions. The process of trauma narration facilitates youth in correcting their maladaptive trauma-related cognitions by helping the youth to better clarify and organize their traumatic experiences. Resources for typical implementation for younger children include using the TF-CBT Triangle of Life app (available at Apple Store or Google Play); teen resources include the Thinking Mistakes for Kids (Kliethermes, 2009, available at https://tfcbt.org/the-what-are-you-thinking-team-kliethermes-2009/)

It is worth adding that the relationship between thoughts, feelings, and behaviors is bi-directional. Thus, in some instances, inaccurate or unhelpful thoughts may be so entrenched that it may be easier for the youth to start with changing their behavior. For example, if a youth has been listening to sad or depressing music, it might help to listen to more upbeat music which could help the youth feel better which may result in more positive thoughts.

Considerations for Racial Socialization: As noted earlier, most Black youth experience multiple experiences of racism, and most Black youth and caregivers recognize these experiences for what they are. Many Black youth develop maladaptive cognitions related to racial stress and trauma. As discussed previously, some Black youth may be reluctant to attribute negative experiences to racism even if the therapist and/or caregiver believe that this is clearly the case. This may be due to trauma avoidance, lack of understanding or knowledge about racism, and/or a survival strategy to lessen the negative emotional impact of ongoing racial stress and trauma. Integrating racial

socialization with TF-CBT may more effectively help youth to address these situations. Strategies for addressing this are described in Psychoeducation, above.

The therapist should take the following steps when implementing TF-CBT Cognitive Coping component with Black youth and their caregivers.: 1) identify whether the youth has maladaptive cognitions related to racial stress and trauma 2) provide the youth with helpful cognitive coping skills; and 3) address the caregiver's maladaptive cognitions related to racial stress and trauma. Some examples of maladaptive cognitions that Black youth exposed to racial discrimination might encounter are -"I'll never be good enough" , "I'll never be accepted on my own merits"; " There's no point trying hard, I'll be shot or killed before I make it to adulthood anyway"; "I'll never be a normal teen", or "My skin is ugly".

As described earlier, factors such as the intersection of racism and sexism (e.g., early sexualization of Black girls); racial trauma sometimes perpetrated by family members (and sometimes combined with colorism, e.g., a young gay Black male rejected by his father's religious family and told "there are no Black faggots, you're not really Black"); and racism perpetrated by police, within the school system, child protection and other child serving systems (e.g., Black youth beaten by police told he was "lucky" it wasn't worse), may cause Black youth to develop racism-related cognitions that are actually accurate, but that are so dissonant to the messages that they receive from others in their family or those in authority, the media or general society, that they question their own perceptions, reality, or even sanity (the definition of gaslighting). In these situations, it may be easier to accommodate to a maladaptive cognition (e.g., self-blame, shame, etc.) than to hold on to one's own inner truth. For example, the Black gay teen whose father told him he wasn't Black and rejected him, blamed himself for the physical abuse by his father because, he said "I deserve to be beaten for my sins."

Therapists will begin to help Black youth to address maladaptive cognitions surrounding their racial identity and develop a more balanced way of thinking by introducing the cognitive triangle exercise and incorporating racial socialization messages. Much of the description and processing of actual racial traumas will likely occur during the next component (Trauma Narration and Processing); however, youth will start to address maladaptive cognitions generally during this component, and it is likely that some themes related to racial stress will emerge at this time. Therapists can introduce the cognitive triangle exercise by asking the following questions: "Tell me about a recent experience when you had a distressing thought that led to a negative emotion? What was the scenario? What did you think? How did it make you feel?". can be very helpful in this regard. The therapist should then follow this with helping the youth or caregiver to develop more helpful, accurate, and/or balanced beliefs about the situation. Below is an example scenario that therapists can use to demonstrate the cognitive triangle exercise.

Scenario:
The situation involves - a youth walking into a classroom and everyone begins to laugh. The youth may develop the following negative cognition – "I'm ugly and must look funny, that's why everyone is laughing at me. As a result of the unhelpful thought pattern, the youth experienced the following emotions: embarrassment, anger and hurt and engaged in the following unhelpful behaviors: walked up to the table and started a fight.

The therapist then helps the youth develop a more helpful and accurate thought by incorporating racial socialization. A more helpful thought might include "My Black is beautiful, so I wonder if someone just told a joke. The new thought may lead the youth to feel proud about their identity and then engage in more helpful behaviors such as walking up to the table and inquiring about why everyone was laughing.

Helpful resources for introducing the cognitive triangle incorporating racial socialization include the "Cognitive Restructuring", "How Can Racial Socialization Help in Response to Everyday Stressors?" (Appendix 4), and "How Can Racial Socialization Help in Response to Racial Stressors in the Community" handouts (available from https://ishametzger.com/research). Some therapists may find it useful to use the metaphor of M&Ms, which are different colors on the outside, but all the same color inside; yet despite this, some folks insist on sorting M&Ms by their outside colors, and only eating those of specific colors, and leaving others. Therapists can discuss with youth why some people treat some people differently based on outward characteristics or appearances, and what the consequences are for the people who act this way, and the recipients of these actions. Therapists can also discuss explanation vs. excuse, i.e. understanding a behavior does not excuse it.

Caregiver Considerations: In the caregiver session, clinicians should also educate caregivers on the connection between thoughts, feelings, and actions. Therapists should introduce caregivers to examples of unhelpful thought patterns that black youth exposed to racial trauma may develop and discuss ways to challenge the unhelpful thought patterns by introducing parents to the cognitive triangle exercise and assist them with helping the youth identify more helpful thought patterns. Clinicians should encourage parents to practice using the cognitive triangle exercise at home with the youth as a homework exercise. It is not uncommon for caregivers to also disclose unhelpful thoughts patterns related to not being able to protect their children from experiencing racial discrimination. Clinicians can normalize that this is an unhelpful thought that many caregivers possess and utilize the Socratic questioning skill to help caregivers challenge this thought and develop a more positive one. Although gradual exposure is not incorporated into the Cognitive Processing component with youth, it is typically helpful to do so with the caregiver. Thus, the therapist can address any inaccurate and/or unhelpful thoughts that the caregiver may have about the youth's trauma experiences and assist the caregiver in processing those thoughts through Socratic questioning and other strategies. The goal is help the caregiver to develop more accurate and/or helpful cognitions to help them to feel better and also so that they can be a more positive role model for the youth.

Additionally, given how racism can function in systems that maintain and exacerbate white supremacy in schools and other institutions, it is particularly important for clinicians to empower caregivers to partner with schools to check in, advocate for their youth and work to mitigate at the parent-systems level any racial traumas that may be occurring at school (or in other institutions or organizations the youth attends).

Link to Handouts:

Cognitive Restructuring: https://www.drishametzger.com/care-package-for-racial-healing

How Can Racial Socialization Help in Response to Everyday Stressors Handout: https://ishametzger,com/care-package-for-racial-healing

How can Racial Socialization Help in Response to Racial Stressors in the Community Handout: https://www.drishametzger.com/care-package-for-racial-healing

TRAUMA NARRATION AND PROCESSING

Goals: The goals of TF-CBT trauma narration and processing are to assist the youth in developing a narration about the youth's personal trauma experiences; cognitively process these experiences in order to address maladaptive cognitions; and to provide the caregiver the opportunity to hear and cognitively process the youth's trauma narration during individual sessions with the therapist, in preparation for subsequent conjoint child- parent sessions.

Typical Implementation: Typical TF-CBT trauma narration and processing involves the therapist collaborating with the youth in an interactive, trusting process of developing a detailed description of personal trauma experiences ("speaking the unspeakable"); cognitively processing these traumatic experiences (making new meaning); and sharing the narration and processing with the caregiver during individual sessions,in preparation for upcoming conjoint youth-parent sessions. This typically involves creating a timeline of the youth's life to include traumatic and other events the youth has experienced (e.g., changes in living circumstances, births of siblings, deaths or other losses of important relationships, moves to new homes, etc.) It is important to emphasize that the product the youth develops (e.g. written narrative, song, poem, etc.) represents only a small part of that process. Resources for trauma narration and processing include using timelines or life narratives to guide trauma narration. These may be especially helpful for youth with complex trauma.

Considerations for Racial Socialization:
The purpose of trauma narration and processing component is to describe details of trauma experiences that Black youth have, including racial stress and trauma experiences, and to cognitively process these to make new, more accurate, helpful and more balanced meaning of these experiences. Due to the fact that Black youth are likely to experience racial stressors, it is important for therapists to continually assess for encounters of racial discrimination or vicarious racial trauma experiences because they may be negatively hindering the youth's well-being. In order to identify the full range of traumas that Black youth have experienced, therapists may collaborate with the youth to develop a timeline, starting with the youth's birth, going to the present day, and include both typical traumas (e.g., child abuse, domestic violence, traumatic deaths, traumatic separations, episodes of community violence, etc.,) and racial stressors or traumas (e.g., those identified through the racial trauma assessment instruments) that have occurred throughout the youth's life. Since many of these traumas have occurred on an ongoing basis rather than being one-time incidents, the therapist should denote this on the timeline as a color line with a start point and end point (e.g., sexual abuse from ages 3-8 years in green line; racial-related school bullying from ages 8-present time in red line, etc.) Discrete episodes of racial trauma should also be denoted in the timeline (e.g., violent encounter with police at 13 years old). More information about completing a trauma timeline is available elsewhere (e.g., Cohen, Mannarino, Murray & Kleithermes, 2012). The timeline can provide the basis for developing an outline for the chapters or sections that the youth and therapist will include in the trauma narration . This typically starts with general information about the youth and their family and then progresses to specific traumatic experiences described in detail. For Black youth the trauma narration and processing component should typically incorporate one more more chapters or sections that describe current and past experiences of racial trauma and discrimination that have caused the youth distress. Incorporating these into the narration will assist the youth with addressing the

difficult racial trauma experiences and allow the therapist to identify and correct associated, unhelpful or inaccurate thoughts such as "Racism is a normal part of life." When completing the trauma narration and processing component with Black youth, therapists should encourage a section in the narration that discusses the Black youth's thoughts and feelings surrounding their racial and ethnic identity, spiritual and religious beliefs and family traditions. Incorporating this section into the narration, will provide therapists with the opportunity to gain more information about the youth's thoughts and feelings surrounding their Black identity and learn about the youth's cultural beliefs and values which can be further utilized as strengths and coping mechanisms during the treatment process. As with all TF-CBT trauma narration, a final chapter typically includes information about how the youth has changed since the start of therapy, what they have learned in therapy including about racial trauma and racial socialization, what they would tell other Black youth who have experienced trauma including racial trauma, and/or what their hopes and dreams are for the future.

Although trauma narration is commonly developed in a book format that may include a series of chapters, it can be completed in many different ways. Therapists should have a conversation with Black youth about their preferred method for completing the narration. Some of the suggested narration formats might include short stories, a chapter book, comic strips, picture collage, drawings, fables with morals, writing songs or raps and poetry. Importantly, trauma narration is an interactive process during which the youth verbally describes increasing details about their most difficult, often avoided and heretofore "unspeakable" trauma experiences, including racial traumas, including thoughts and feelings the youth had at the time of these traumas, and with the therapist's guidance, the youth processes these experiences using their newly obtained understanding and knowledge about racial socialization, in order to gain a better perspective about these experiences and to move forward in a more positive developmental trajectory.

Caregiver Considerations: During Trauma Narration and Processing, clinicians should share the youth's trauma narrative individually with the caregiver either as the youth is developing it or when the youth is almost finished processing the narrative, with the eventual goal of the youth sharing the narrative with the caregiver during conjoint sessions. Since this narrative will, in most cases, include both non-racial traumas and racial stress and trauma experiences, it is important for the caregiver to have an opportunity to both hear the full details about the youth's trauma experiences and have the opportunity to fully cognitively process these with the therapist prior to the conjoint sessions. Often the caregiver will be hearing about these very painful traumatic and racial trauma experiences through the youth's perspective and voice for the first time. This can be very difficult for the caregiver, and bring up painful memories, feelings and cognitions (e.g., the caregiver's personal racial and/or interpersonal traumas, anger about injustice and racism towards their child; guilt about not having protected their child, etc.) that may require multiple sessions to process. In some cases the caregiver may want to prepare a plan for how to use TF-CBT + Racial Socialization skills to advocate for the youth in the future.

As with general traumatic experiences, there may be some instances in which a Black youth may prefer (or the therapist's clinical judgement may indicate) that the caregiver not hear the youth's trauma narration in part or at all. This is most commonly because the youth wants to protect the caregiver from hearing the details about the youth's racial (or other) trauma experiences. In some cases, the youth fears retribution or punishment from the caregiver if they were to hear that the

youth did not follow the family's rules and this may have contributed to the trauma occurring. The therapist should process with the youth the costs vs. benefits of sharing some or all of the narration with the caregiver, taking into consideration the youth's developmental stage, confidentiality and trust issues, the likelihood that the caregiver will be able to support the youth, etc. If there are legitimate concerns about sharing details of the narration (e.g., the caregiver will not be supportive, will be overly punitive, is overly dysregulated emotionally, etc.), perhaps the youth could share the first chapter (e.g., about me and my family) and the last chapter (e.g., how I've changed, what I want for my future) without sharing the details of their trauma experiences.

IN VIVO MASTERY

Goals: The goals of the In vivo Mastery component are to overcome avoidance in real life situations for those youth who have developed overgeneralized fear and avoidance of innocuous trauma reminders. This component is only implemented if the situation is innocuous, i.e., safe. If the situation is not safe, the therapist does not implement this component, but rather focuses on the Enhancing Safety component. Of course, In Vivo Mastery would not be implemented if there are no generalized trauma reminders that the youth is avoidant of.

Typical Implementation: In vivo Mastery is the only TF-CBT component that is optional, i.e., this component is only implemented for those youth who develop overgeneralized fear and avoidance of real life situations that serve as trauma reminders that are innocuous, and the avoidance results in significant functional impairment (e.g., avoiding the use of public bathrooms; not attending school; or not sleeping in one's bedroom). The therapist implements this component by educating the youth and parent about the value of overcoming overgeneralized avoidance of innocuous situations; collaboratively developing a fear hierarchy ("ladder") from the least feared to the most feared situations, and through graduated real life ("In vivo") exposure paired with relaxation or other coping strategies, helping the youth to master and overcome avoidance of the feared situations. Parental involvement and buy-in is essential to overcoming this type of avoidance, since parents have often been allowing the youth to avoid the feared situation. Importantly, since this component typically takes several weeks to successfully complete, the therapist may begin this component during the stabilization phase (e.g., as soon as the youth has learned relaxation strategies). This will assure that most youth will complete the In vivo Mastery Component soon after completing the Trauma Narration and Processing treatment component. Resources for implementing this component include an avoidance hierarchy (fear ladder) for developing the youth's individualized In vivo Mastery plan.

Considerations for Racial Socialization: After exposure to racial trauma, it is not uncommon for many Black youth to develop overgeneralized fears and avoid specific situations because they are trauma reminders for the race-related traumatic event. For instance, a Black youth accused of stealing by a salesclerk at a grocery store because of the color of their skin might develop a fear of going to grocery stores. Another example might include a Black teenager who developed a fear of driving after being pulled over, searched and harassed by a police officer because of the color of their skin. Avoidance of these situations is problematic for Black youth because it prevents them from participating in activities that are crucial to daily living. A youth will need to go to the grocery store to obtain food and to drive to navigate from place to place. Also, these situations are mostly innocuous and not life threatening to the youth. However, in terms of the police officer example - it is important for therapists to consider that there have been many media reports of Black youth and adults experiencing brutal and often fatal encounters with police officers while driving. It is important to normalize and validate this concern and provide the youth with helpful tools to navigate future encounters with police officers. The focus is on movement toward engaging in the tasks that have been avoided rather than reducing the risks inherent in being profiled while shopping or driving while Black. Since there is a decent chance those situations will happen for Black youth in the future, it is critical to combine enhancing safety skills as an opportunity to normalize those experiences.

To help Black youth overcome these feared situations, it is important for clinicians to develop an in-vivo plan with the youth and caregiver. An in-vivo plan is designed to help the youth identify and challenge maladaptive cognitions that are maintaining the overgeneralized fear and assist the youth with gradually approaching the feared situation so that they no longer need to avoid it. Caregiver support and participation is necessary when creating an in-vivo plan because often times caregivers unknowingly reinforce the avoidant behaviors. For instance, a Black youth with the fear of going to grocery stores will continue to avoid the grocery store as long as the caregiver is going to the grocery store in place of the youth.

The first step in the in-vivo plan is for clinicians to educate Black youth and their caregivers on how these avoidant behaviors are problematic and impairing the daily functioning of the youth. The second step involves the therapist assisting the youth with identifying and challenging maladaptive thought patterns related to the feared situation. For instance, the Black youth who avoids the grocery store might possess the following maladaptive cognitions: "Every time I go to the grocery store I will be accused of stealing"; I will be racially profiled by every sales clerk in the grocery store; If I go to the grocery store, I will always experience racial discrimination"; and "Avoiding the grocery store, will keep me safe from racial discrimination." In addition, the Black youth with the fear of driving might possess the following maladaptive cognitions: "All police officers are dangerous"; Every time I drive, I will be stopped by a police officer; "If I drive again, I will be killed by a police officer; and "Not driving keeps me safe." To assist the youth with examining and challenging these maladaptive thought patterns, the therapist can re-introduce the cognitive triangle exercise. In session, the therapist and youth can insert each of the maladaptive thought patterns into the cognitive triangle to assist with challenging the unhelpful thoughts and identifying more accurate and helpful thought patterns. Adding in effective safety skills to cope with these situation is also critical so that youth have a practical plan to practice and follow should they encounter a similar situation in the future.

For example, the therapist can insert the following maladaptive cognition into the cognitive triangle – "Every time I go into the grocery store, I will be accused of stealing." The therapist can ask the youth, "how does this thought make you feel?" which might include sad, anxious, angry and/or embarrassed. Next, the therapist may ask, "how does this particular thought and feeling make you want to respond?" The youth may say. "it causes me to avoid going to the grocery store." With this particular maladaptive thought pattern, the therapist may have to utilize Socratic Dialogue which involves asking specific questions to help the youth begin to recognize that this thought is not helpful or accurate. For instance, here are some sample questions that a therapist might ask a youth to assist them with challenging the unhelpful thought: "prior to this encounter at the grocery store, what was your experience like at grocery stores with sales clerks and other staff? Has there ever been a time when you visited the grocery store and you were not accused of stealing?" Hopefully, these questions will begin to assist the youth with recognizing that although this was a bad experience that occurred it does not mean that each and every time they visit the grocery store they will be accused of stealing.

The next step in the in vivo plan is to assist the youth with building a gradual fear hierarchy to help the youth with overcoming the feared situation gradually. Below is an example of a fear hierarchy for a youth with a fear of driving after experiencing a racial encounter with a police officer. While

the youth is navigating through each of the steps of the fear hierarchy, it is important to pair the exposure with relaxation strategies. For example, when completing step one of standing by the car door for 10 minutes, the clinician may encourage the youth to complete this step while engaging in a deep breathing exercise to help minimize feelings of anxiety.

1. Have the youth stand by the car door for 10 minutes
2. Have the youth open the car door
3. Have the youth sit in the car with a caregiver
4. Have the youth sit in the car alone
5. Have the youth turn on the ignition of the car
6. Have the youth drive for 5 minutes with the caregiver present
7. Have the youth drive for 5 minutes alone
8. Have the youth drive for 10 minutes alone

For each step, the youth should also have a practical safety plan for "what will I do if I have a racial encounter with a police officer?" This should be a step-by-step plan (e.g., what to say, what tone of voice to use, how to move, where to put hands, etc,), that the youth can practice until they feel confident that they can do it without feeling angry, frightened or out of control. Should such an encounter occur, they will be more likely to follow the plan than to do something out of fear or anger. This of course does not guarantee safety, but is it more likely to decrease the youth's anticipatory anxiety and fear of negative consequences, and avoidance of these situations.

Caregiver considerations: Caregiver support is necessary during the in vivo mastery process because caregivers will need to offer encouragement, remind youth to utilize their relaxation strategies during the exposure process and offer praise to the youth for completing each step of the fear hierarchy. Having racial socialization discussions with the youth are also important because, as described above, these discussions provide a realistic balance of the risks inherent in living in America as a Black youth, with the joy and richness of Black life, and the many accomplishments that Black individuals have and continue to make.

CONJOINT CHILD-PARENT SESSIONS

Goals: The goals of conjoint youth-parent sessions are to: a) enhance direct, supportive trauma-focused communication between the youth and parent, including (in most cases) facilitating the youth to directly share the trauma narration and processing with the parent; b) address other trauma- related issues collaboratively with youth and parent (e.g., trauma-related behavior problems; sexual health; safety concerns); and c) transfer direct, supportive trauma-related communication with youth from therapist to parent.

Typical Implementation: During the conjoint youth-parent sessions, the therapist typically facilitates the youth in directly sharing the trauma narration and processing with the parent. Of critical importance is that the therapist has already shared and the parent has processed the narration during individual parent sessions, while the youth was developing it (or shortly thereafter) during the trauma narration and processing treatment phase. The therapist should never share the trauma narration in a conjoint session, until the therapist has prepared the youth and parent for this session. At a minimum, this requires that: a) the youth knows that the conjoint session will occur; b) the therapist has previously shared the trauma narration with the parent who has had the opportunity to process it; and c) the therapist has prepared the parent for the upcoming conjoint session. This preparation includes preparing the parent for how to respond to the youth's sharing the narration, including practicing appropriately supportive parental responses. If the parent is unable or unwilling to provide sufficiently supportive responses to the youth's trauma narration, the therapist should not proceed with sharing the youth's narrative with this parent during the conjoint sessions.

Alternative strategies for a conjoint youth-parent session are to: 1) identify an alternative adult with whom to share the trauma narration and processing (this requires the youth's assent) and, depending on age, the parent's consent; as well as several sessions of preparatory work to learn about TF-CBT treatment as well as to complete the steps described above to prepare specifically for the conjoint sessions); or 2) include the parent in conjoint sessions but not share the entire trauma narration during these sessions.Alternative activities for these conjoint sessions might include: a) enhancing trauma-related communication such as discussing sexual health principles; b) developing a family safety plan; c) addressing ongoing behavioral issues; and d) providing praise for each other related to work accomplished. The youth may also choose to only share the final chapter of the trauma narration, allowing a sense of mastery and meaningful representation to be shared with the parent

Considerations for Racial Socialization: During the conjoint youth-parent sessions, the therapist should assist Black youth with directly sharing their trauma narration with the caregiver. The therapist and caregiver should provide the youth with praise, support, and encouragement throughout the process. The conjoint youth-parent meeting should also include the therapist exploring the impact of racial socialization activities on the youth and caregiver's well-being. The therapist might also inquire about how the youth's thoughts and feelings have changed regarding racial trauma and discrimination since participating in treatment. Therapists should encourage Black youth and their parents to continue having discussions about racial discrimination and to

incorporate racial socialization strategies into their daily routine. For instance, therapists may encourage Black youth to share with their caregiver cultural activities that are rewarding to them such as visiting an African American Museum, cooking a traditional African dish together, watching a movie or tv show focused on Black heritage or having a conversation about an identified Black role model. These cultural activities will continue to promote racial pride and bonding between the youth and caregiver.

ENHANCING SAFETY AND FUTURE DEVELOPMENT

Goals: The goals of enhancing safety are to identify threats to the child's and family's safety and develop individualized and family safety strategies to minimize these in the present and future.

Typical Implementation: In typical TF-CBT, Enhancing Safety is the final treatment component. Youth and parents develop an individualized safety plan that is responsive to the youth's developmental level and personal situation. They may include strategies to address self-destructive behaviors (e.g., running away, suicidal behaviors, self-injury, etc.); body safety education (for younger children) or education about sexual health principles (for older youth); problem solving skills; drug refusal skills; bullying prevention/management skills; and/or other skills as needed. The youth and (and as appropriate) parent actively participate in developing and practicing the safety strategies to assure that these are feasible for the youth to use. However, as noted earlier, for youth with complex trauma, this component is provided first and throughout TF-CBT treatment, in recognition that these youth often have significant unsafe behaviors that are a priority to address early in treatment. Despite their resiliency and personal strength, many Black youth continue to face ongoing and severe traumas. Sadly, this often times results in the development of a complex trauma presentation and often these youth have acute safety issues early in treatment. In these situations (or whenever it is clinically indicated), the therapist should implement the Enhancing Safety component first and throughout TF-CBT treatment. Youth with complex trauma presentations are often involved with other child serving systems, e.g., medical, child welfare and/or juvenile justice systems. It is critical that all professionals working with the youth collaborate with these systems to effectively communicate and enhance safety across providers and systems.

Considerations for Racial Socialization:
The goal of Enhancing Safety is to reduce the youth's ongoing risk for revictimization by creating a safety plan to use in future situations that may be potentially stressful or traumatic. Developing a safety plan that is tailored to the individual Black youth's developmental level, family circumstances and past and ongoing traumas including racial stressors and traumas will help the youth to identify potentially risky situations and alert them to warning signs of danger. When youth recognize signs of potential danger, they can use PRAC coping skills to stay calm, think clearly, and make the best possible decisions to stay as safe as possible in the moment, while also realizing that complete safety may be out of their control. The safety plan will also teach Black youth appropriate ways to respond to future experiences of racism and discrimination. For instance, there have been frequent reports of racial discrimination for Black youth in the school and criminal justice system. Therapists should discuss and role play with Black youth and their caregivers about how to respond when stopped by police officers, confronted with racial microaggression at school or in other community settings, and a variety of other common scenarios that the youth and caregiver provide as situations that the youth has or is likely to encounter as potential safety threats.

For example, most Black youth and their caregiver(s) have (or will have) had "The Talk" about how to respond if they are pulled over in a car by the police. As described earlier, this is an example of racial socialization integrated with affective modulation (how to maintain external affective regulation regardless of internal fear, anger or other strong emotions) and enhancing safety (what

the youth should do and say, and not do or say, in order to stay as safe as possible). In TF-CBT the therapist and youth, in collaboration with the caregiver, should extend "The Talk" into action through role play and practice, that is, first discuss with the youth what the content of The Talk entailed, i.e., what should the youth do and not do in this circumstance? The therapist can then delineate the steps for the safety plan if the youth is stopped by the police, following the points described in The Talk. If necessary (i.e., if the youth's description seems confusing or unclear), the therapist can suggest inviting the caregiver in to clarify points in this regard. Once the safety plan for responding to a police stop has been written down in a step-by-step fashion, the therapist should practice this through a series of role plays. First, the youth can take the role of the police with the therapist being the youth, and then they can reverse roles. After this, the therapist should ask whether the youth has concerns or questions about this, e.g., "Do you wonder about what to do if something doesn't go right with this plan? Like what are you worried about might happen?" The youth might say, "What if the police gets violent even if I do what we said in the plan?" This is a common fear, based on the high profile, incidents of police violence towards Black individuals during traffic stops that have turned deadly, and it is important for the therapist to validate the youth's fear while also providing information about the rarity of these occurrences. The therapist should role play optimal safety responses in this situation (e.g., maintaining affective regulation, not physically resisting or raising one's voice in the moment, etc.) while simultaneously encouraging the youth to continue repeating calming and self-affirming statements to oneself (e.g., "I am a law abiding person who does not deserve to be treated this way. I will seek justice when this is over, but to stay safe I need to keep calm and get through this now.") The therapist should develop similar safety plans and role play and practice these for other racist experiences that the youth may potentially encounter in the future, until the youth feels confident that they will be able to enact the plan calmly and competently.

Caregiver Considerations: During the caregiver sessions therapists should discuss with the caregiver the types of racial stress and trauma experiences that the youth is likely to encounter in the future, and coordinate with the caregiver the safety plans that the youth and therapist are developing as described above. It is essential that the caregiver be in agreement with the safety strategies that the youth is planning to use, so that the caregiver can practice these with the youth and advocate for the youth in the respective situations (e.g., school, community, justice system, etc.) if and when the youth needs to use these strategies in the future. The therapist should involve the caregiver in planning the respective safety plans, or agreeing to them after the youth has developed them (depending on the age and developmental level of the youth), so that the caregiver can support the youth in practicing them and in using them if and when this becomes necessary in real life.

If appropriate, therapists can explore with the caregivers ways to advocate for Black youth in the school system. For instance, advocacy in the school system may involve caregiver's speaking with school staff about the youth's experience of racial discrimination, writing letters to school officials, or following-up to make sure the youth is receiving the required educational accommodations. Also, with the appropriate consent from the youth and caregiver, the therapist can advocate for the youth and family by communicating and educating the school staff on racial discrimination and its impact on the well-being of Black youth. In similar fashion, therapists can support caregivers in providing advocacy in other systems (e.g., with police, juvenile justice, child welfare, etc.) when and if racial discrimination occurs.

TREATMENT COMPLETION

At the end of TF-CBT, the therapist should repeat the trauma assessment instrument(s) , i.e., UCLA PTSD RI, CPSS, TSCC, that was used at the start of treatment, to ascertain the degree to which this instrument indicates that clinical improvement has occurred (while understanding potential limitations of such instruments in detecting such improvement). It is important that the therapist discuss the results of the post-TF-CBT assessment with the youth and caregiver in order to emphasize the youth's progress during treatment and why TF-CBT treatment is now ending. For youth whose self-report instruments do not reflect improvement but who may have shown other gains (e.g., improvement in adaptive functioning such as decreased self-injury, increased therapy or school attendance, etc.), the therapist should help the youth and parent reflect on these positive changes that have occurred since the start of therapy, and the therapist's observations about how well the youth is using TF-CBT skills (if this is the case) to manage negative emotions, behaviors, and/or cognitions even if this is not reflected in the self-report instrument. For many youth who complete TF-CBT, a final session in which progress is reviewed and celebrated may be very important. Many youth have never completed a given intervention, even though they may have seen several therapists. A final "graduation" session can recognize the hard work that both the youth and parent have engaged in and how far they have come in their therapeutic journey.

The therapist may also find it helpful to review the impact of chronic trauma and to reiterate that, just as traumatic impact can continue after the traumatic experiences themselves are over, the positive impact of treatment can be long-lasting, if the youth and parent continue to practice and implement the skills that they learned. Since trauma-focused treatment may be only one aspect of the youth's needs, appropriate referrals should be made for additional services, as clinically indicated.

CONCLUSION

As noted in the Foreword, developing initial iterations of integrating TF-CBT with Racial Socialization strategies followed the ADAPT-ITT model. ADAPT-ITT consists of answering eight sequential questions across phases: 1) **A**ssessment, 2) **D**ecision, 3) **A**dministration, 4) **P**roduction, 5) **T**opical Experts, 6) **I**ntegration, 7) **T**raining, and 8) **T**esting.

The answer to Phase 1: *Assessment* which asks "who is the target population and what are their risk and protective factors?" indicates that Black youth are at particular risk for experiencing both interpersonal and racial trauma and that they can utilize cultural strengths (e.g., racial socialization) to encourage resilience despite ongoing stressors (Andrews, Metzger et al., 2015; Metzger et al., 2017; 2018; 2020). Phase 2: *Decision*, asks, "what evidence-based program exists and does it need to be adopted or adapted?" TF-CBT has been identified s the gold-standard treatment for children and families exposed to traumatic life events e.g., DeArellano et al, 2016; Thielemann et al, 2022). Thus, it was decided that it would be applied to focus on the integration of racial socialization to help Black youth heal from interpersonal and racial trauma. Phase 3: *Administration*, asks "What in the original evidence-based program needs to be adapted, and how should it be done?" allowed

for the creation of the initial manuscript and fidelity checklist published by Metzger and colleagues (Metzger et al., 2021).

In Phase 4 of the ADAPT-ITT Model: *Production*, the question is asked "How do you produce draft 1 and document adaptations/applications?" This was completed through concurrent National Institute of Health (NIH) funded postdoctoral fellowships at the Medical University of South Carolina and at Yale University that allowed for the initial draft of the application detailing racial socialization psychoeducational materials and in-vivo assignments concerning racial socialization messages, means of transmission, and psychological and behavioral benefits for Black youth who experience trauma. These materials were refined by Isha Metzger, Ph.D. in close collaboration with TF-CBT developers (e.g., Cohen) and TF-CBT master trainers (e.g., Kmett Danielson, de Arellano) to ensure that materials did not compromise fidelity to the original TF-CBT treatment model. Phase 5: *Topical Experts*, asks "who can help adapt the evidence-based program? With funding from the National Institute of Mental Health, the lead author conducted a qualitative study to gain feedback via key informant interviews with therapists (e.g., Thomas) and trauma exposed Black youth and their caregivers receiving TF-CBT at The Georgia Center for Child Advocacy, a community based mental health organization engaged in the Learning Community described below, to help refine the application.

Together with a graphic designer, the feedback gained was utilized to complete Phase 6: *Integration*, which asks "What will be included in the pilot application?" that leads to the training that was designed for TF-CBT practitioners. Phase 7: *Training*, asks the question "Who needs to be trained?", and Phase 8: *Testing*, asks "was the application successful, and did it enhance short- and long- term outcomes? The *training* and *testing* phases were completed through the NCTSN Learning Community grant from SAMHSA to the AGH Center for Traumatic Stress in Children and Adolescents described in the forward and throughout this implementation manual.

This implementation manual describes strategies for integrating Racial Socialization with TF-CBT for trauma-impacted Black youth and their parents or primary caregivers to improve youth mental health and functioning. The results of the year-long learning community indicated several positive outcomes from integrating these interventions, including that:

1) The majority of Black youth who participated in treatment completed TF-CBT;
2) Black youth who completed TF-CBT experienced highly significant improvement in PTSD symptoms;
3) Black youth reported highly positive subjective experiences related to receiving these integrated interventions (e.g., feeling validated in being asked about and understood in relation to racial trauma experiences); and
4) Clinicians who participated in the learning community reported that they experienced significant increases in their self-perceptions of racial trauma efficacy, as assessed by the Therapist Racial Trauma Efficacy Scale.

Based on these findings, we encourage clinicians to learn and use the strategies and resources included in this manual for Black youth who are impacted by trauma.

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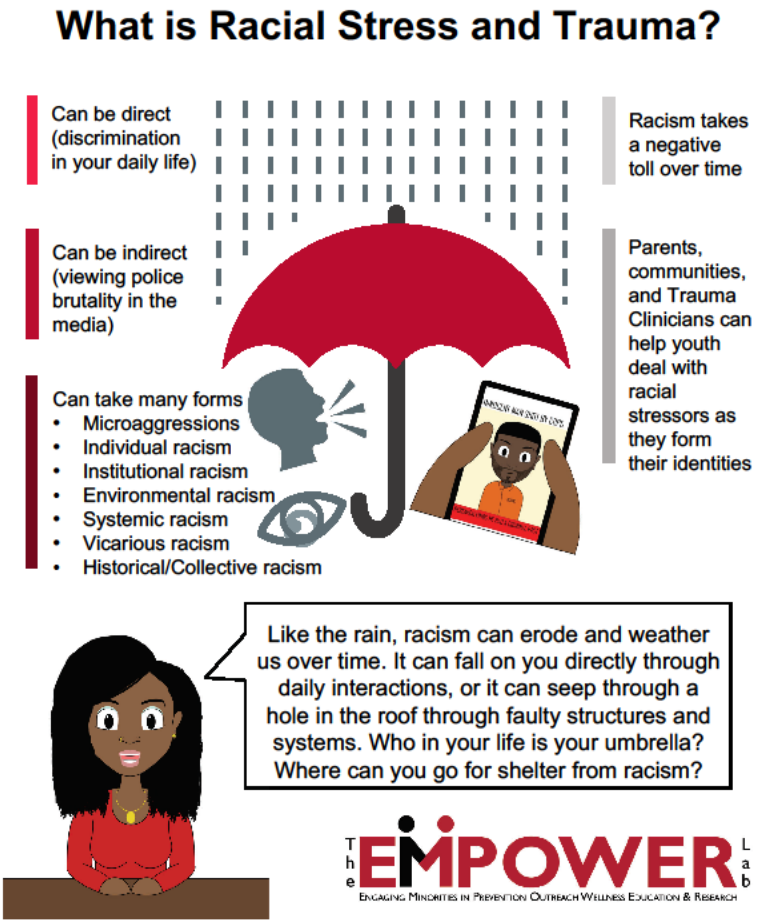
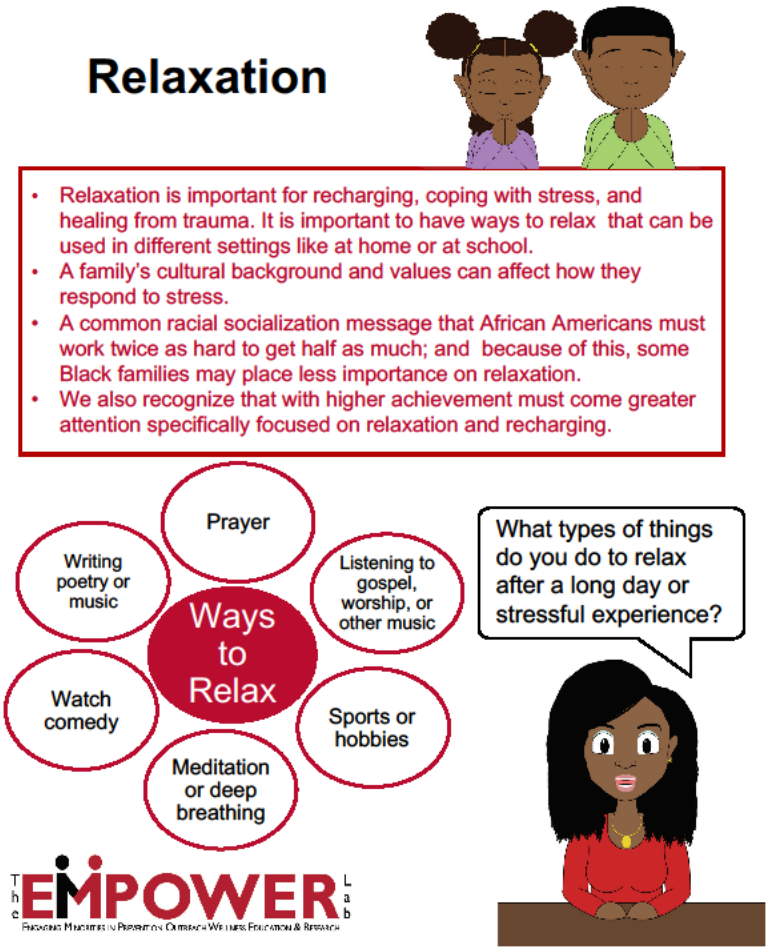
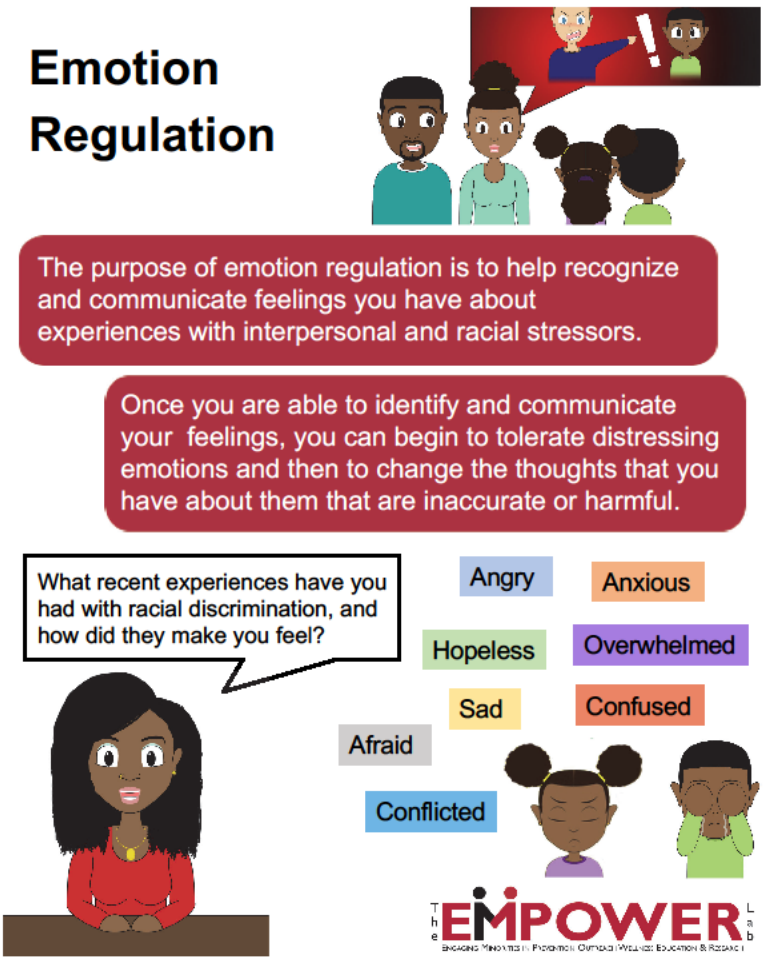
Appendix 1: Psychoeducation



Appendix 2: Relaxation Skills



Appendix 3: Affective Modultation Skills



Appendix 4: Cognitive Coping Skills