NCTSN The National Child Traumatic Stress Network

CULTURE-SPECIFIC INFORMATION

CM-TFT: Culturally Modified Trauma-Focused Treatment

Engagement	**For which specific cultural group(s)** *(i.e., SES, religion, race, ethnicity, gender, immigrants/refugees, disabled, homeless, LGBTQ, rural/urban areas)* **is this treatment tailored? If none, please respond "not specifically tailored."** The intervention was developed for use with Latino children. While early development focused primarily on children from Mexican immigrant families, further development and piloting has been conducted with a broad range of Latino children from various nationalities (e.g., Central and South American), geographic locations (e.g., Florida, Texas, California, New York), and socioeconomic backgrounds. **Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.** Yes, the intervention utilizes a flexible approach that can be adapted to Latinos with different belief systems and levels of acculturation. A number of cultural constructs (e.g., spirituality, traditional gender roles, *familismo*, *personalismo*) are assessed and integrated throughout treatment depending on their importance and relevance to the family's belief system. This approach permits tailoring of the intervention to a wide variety of belief systems across Latino populations. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** Therapists are trained to be respectful of and responsive to cultural beliefs including norms for interpersonal interactions (e.g., *personalismo*) which facilitate providing services within an appropriate cultural context. Therapists are also trained to assess and address potential challenges to the development of strong therapeutic relationships, including previous interactions that families have had with mental health treatment providers or "the system" in general, as well as racism and discrimination.
Language Issues	**How does the treatment address children and families of different language groups?** When available and/or preferred, treatment is provided in Spanish. Various handouts and other therapy materials are available in Spanish. At times, therapy is provided in English and Spanish to facilitate treatment for children who have learned English as a second language. Language issues, such as the language in which trauma-related memories, thoughts, and feelings are encoded are also considered. **If interpreters are used, what is their training in child trauma?** Interpreters should be certified to interpret. Additionally, interpreters should receive general training in trauma and trauma-related problems and specific training in the overall intervention. Consistency of interpreters working with each child and family can help facilitate the therapeutic process. **Any other special considerations regarding language and interpreters?** Interpreters should be certified. Family members should not be used as interpreters.
Symptom Expression	**Is there research or clinical evidence to suggest that the populations served manifest trauma symptoms in differential ways? If so, are there differences in the ways that symptoms are assessed for the various populations?** Some research suggests a greater tendency to express somatic symptoms (e.g., aches and pains, lethargy) among Latinos experiencing depression and/or anxiety.

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Symptom Expression continued	In cases in which significant levels of somatization exist, efforts should be made to assess somatic symptoms (e.g., Children's Somatization Inventory) throughout treatment to monitor progress. **If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?** It is believed that somatic symptoms are an expression of depression and/or anxiety and, as such, should also improve given that this intervention targets depressive and anxiety symptoms.
Assessment	**In addition to any differences noted above, are there any differences in assessment measures used across cultural groups? If so, please indicate which measures are used for which cultural groups. Are there normative data available for the populations for which they are being used?** The following measures have been used with children from various Latino backgrounds: • Acculturation Rating Scale for Mexican Americans-II (ARSMA: Cuellar, Arnold & Maldonado, 1995) • Multiphasic Assessment of Cultural Constructs–Short Form (Cuellar, Arnold & Gonzalez, 1995) **If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** Normative data is available for use with Latinos. The ARSMA was designed for Mexican Americans and in this form only has normative data for this population. **What, if any, culturally specific issues arise when utilizing these assessment measures?** These measures permit the efficient assessment of a number of cultural concepts, and can help facilitate discussion of cultural beliefs held by the child and caregivers.
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** Descriptions of the treatment outline the culture-specific assessment strategy of cultural constructs and the strategy for tailoring treatment based on this assessment. **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)*. Adaptations have been made for individual components across the treatment intervention. **Has differential drop out been examined for this treatment? Is there any evidence to suggest differential drop out across cultural groups? If so, what are the findings?** Anecdotal evidence suggests that the cultural modifications help enhance engagement and consequently leads to reduced premature termination.
Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** While not a "cultural risk factor," some communities have risk factors for different types of trauma (e.g., residing in a border community increasing risk for drug-related kidnappings). Such risks are addressed in treatment and attempts are made to reduce the risk of future exposure to such events.

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Intervention Delivery Method/ Transportability & Outreach continued	**Is this a clinic-based treatment or is the treatment transportable** *(e.g., into home, community)***? If the treatment is transportable, how is it adapted into the new setting? Is it still efficacious?** Treatment has been provided in office-based and community-based (e.g., church) settings. Preliminary pilot work suggests that the treatment is efficacious in community settings as well. **Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** Given that Latino families are over represented below the poverty line, many families can have difficulties accessing services due to lack of transportation, employment barriers (e.g., no time off), and being uninsured/underinsured. Undocumented immigrant families can often experience additional barriers, including concerns about arrest and deportation. **Are these barriers addressed in the intervention and how?** Potential barriers are assessed and addressed in treatment, including assisting families with basic needs financial assistance, and legal assistance. **What is the role of the community in treatment** *(e.g., local groups such as faith-based organizations, community groups, youth and/or parent organizations, first responders, schools)***?** Collaboration and coordination with faith-based organizations, schools, and other agencies within the community is essential to serving difficult-to-reach populations, such as some Latino communities. Developing such relationships also facilitates the provision of community-based services.
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** In addition to learning about the specific cultural group that will be served, therapists are encouraged to be aware of their own cultural background, beliefs, and biases, which can have an impact on working with families from that cultural group. **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** As needed, cultural issues are identified and discussed in supervision as they pertain to the provision of services or personally for the therapist. **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** Therapists are encouraged to include cultural beliefs and practices as an integral part of treatment. Strategies are discussed for tailoring treatment to be responsive to specific cultural beliefs important to the child and family. **Has this guidance been provided in the writings on this treatment?** Specific guidance has been provided to encourage therapists to integrate cultural constructs into treatment as needed for each family.
References	Cuellar, I., Arnold, B. & Gonzalez, G. (1995). Cognitive referents of acculturation: Assessment of cultural constructs in Mexican Americans. *Journal of Community Psychology, 23*(4), 339-356. Cuellar, I., Arnold, B. & Maldonado, R. (1995). Acculturation Rating Scale for Mexican Americans-II: A revision of the original ARSMA scale. *Hispanic Journal of Behavioral Sciences, 17*, 275-304.