LC: Let's Connect

CULTURE-SPECIFIC INFORMATION

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."** Not specifically tailored **Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.** Yes, clinicians trained in LC also receive training in evidence-based engagement strategies (e.g., based on the work of Mary McKay; McKay et al., 2004) that have been found to be effective for engaging minority and low-income families in child and family mental health treatment. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** The LC intervention includes parent/caregiver reflection on family of origin, emotional climate in the home, and the impact of culture on family communication patterns, which helps to shape the clinician's approach to teaching LC skills. This approach to culturally-specific engagement and treatment planning is consistent with existing recent recommendations for integrating cultural context into evidence-based care (Huey, Tilley, Jones, & Smith, 2014). The LC skills themselves (listening, emotion support/validation) are also effective for engaging families from diverse backgrounds.
Language Issues	**How does the treatment address children and families of different language groups?** LC intervention materials (handouts, videos) have been translated into Spanish. LC has been delivered in Spanish by Spanish-speaking clinicians with success. **If interpreters are used, what is their training in child trauma?** Interpreters have not been used in LC implementation thus far. Training in child trauma and some background in LC skills would be ideal for anyone participating in the treatment process. **Any other special considerations regarding language and interpreters?** Should interpreters be used, in-person interpretation would be preferred over phone interpretation services, given emphasis on body language and non-verbal communication as part of the LC intervention. Efforts should be made to deliver the intervention in the language that is most comfortable for the family.

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?** Attention is paid during LC implementation to individual differences in symptom expression across families. There is no evidence as of yet to suggest that the populations served respond to LC in differential ways; however there is evidence that Hispanic youth tend to report more somatic symptoms than non-Hispanic youth (Piña & Silverman, 2004). LC is well-suited to address this difference and identify trauma-related somatic issues because of attention paid to tuning into one's body sensations and internal cues as part of developing emotional self-awareness. **If there are differences in symptom expression, in what ways does the theoretical/ conceptual framework of this treatment address culturally specific symptoms?** LC incorporates mindfulness and mind-body connection in its theoretical framework for parents and children, therefore capturing awareness of both somatic and emotional reactions to trauma. LC also takes a strengths-focused approach to discussing family and cultural differences in emotional expression.
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?** Assessment measures are translated into Spanish for native Spanish-speaking families. As part of a trauma exposure screen, we incorporate an assessment of immigration experiences for anyone who has immigrated to the United States. Otherwise, the assessment measures used are the same across cultural groups. There are no normative data available for specific cultural groups for the assessment measures we have used. We incorporate guidelines related to culturally-sensitive assessment from the *Adaptation guidelines for serving Latino children and families affected by trauma* (2008) and the work of deArellano & Danielson (2008) on culturally-sensitive assessment into our training and supervision for using LC with Latino and culturally-diverse families. **If no normative data exist for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** Measures are used to assess parent beliefs about emotion, use of specific emotion-communication behaviors in the parent-child dyad, parent stress level, and child social-emotional skill development. **What, if any, culturally specific issues arise when utilizing these assessment measures?** Parent comments and behaviors during parent-child discussion of emotion are video recorded and coded for parent use of LC skills. Careful efforts were made to take cultural differences in expression of emotion and comfort discussing emotion into account during development of the coding system and while training coders.

Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** None at this time. **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)***.** None at this time. **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?** There is no evidence to suggest differential drop-out rates across cultural groups. There is preliminary evidence to suggest that when delivered as a strategic enhancement to Trauma-Focused CBT, LC enhances engagement and reduces drop-out rates across groups compared to Trauma-Focused CBT alone.
Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** For racial and ethnic minority children and youth, perceptions of ethnic and racial discrimination and perception of social status may be influential in terms of risk and vulnerability for mental health concerns (Alegría, Green, McLaughlin, & Loder, 2015). LC skills can be easily applied to family conversations about race, ethnicity, and contextual or societal implications that may strengthen child ability to benefit from caregiver support around their experiences of disparity or discrimination, thus promoting child and family resilience. **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?** The treatment is transportable and is currently being piloted in school settings. In-home implementation would also be possible with minimal adaptations required. The biggest adaptation would include live-coaching "in-the-room" rather than use of bug-in-ear technology or two-way mirrors/observation rooms. In-home delivery of LC would include increased emphasis on family management skills and environmental supports (e.g., family routines, rituals, transitions and creating space for stress-reduction and/or family sharing time). **Are there cultural barriers to accessing this treatment** *(i.e., treatment length, family involvement, stigma, etc.)***?** None identified **Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** None identified **Are these barriers addressed in the intervention and how?** For group-delivery of LC for low-income families, LC has been delivered in the community at a convenient location, with family meals provided to facilitate engagement (e.g., schools).

Intervention Delivery Method/ Transportability & Outreach continued	**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)***?** Information about LC for communities (e.g., schools, community youth centers, parent organizations, child welfare) is helpful in facilitating referrals and engaging families. Use of community facilities (e.g., schools, community youth centers) can be helpful to promote engagement and reduce transportation barriers as well.
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** Family of origin issues are identified and addressed as clinicians learn to assess emotional climate in family of origin among parents/clients. Discussion of how LC skills intersect with cultural values related to expression of emotion is part of supervision and training. We also attend to recent research highlighting differential access to services for maltreated minority children, compared to non-Hispanic White children (Martinez, Gudiño, & Lau, 2013). In particular, African American and Latino children and youth exhibiting internalizing symptoms are less likely to receive services following maltreatment, compared to their non-Hispanic White counterparts. We include this information in our training related to engaging families and other service providers, to build awareness of the possibility that services may not be sought as often on behalf of minority children experiencing internalizing symptoms. Clinicians also practice describing the connection between trauma, externalizing, and internalizing symptoms, and the benefit of Let's Connect to address both types of symptoms, to improve treatment engagement and access to care for minority youth. **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** Supervisors/trainers ask about and create safety for discussion of cultural issues and differences. **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** Clinicians are trained to listen and support families' views of the LC material and intervention components. Components can be flexibly delivered in a culturally-sensitive manner, depending on the needs of individual families. **Has this guidance been provided in the writings on this treatment?** Not specifically **Any other special considerations regarding training?** We incorporate psychoeducation about working with diverse families (e.g. low-income, specific cultural groups, kin/grandparents, etc.) into training for LC. The developers of LC are also trained in Culturally-Modified Trauma-Focused CBT (deArellano & Danielson, 2005) and familiar with cultural themes relevant to working with Latino families. These themes are incorporated into trainings for clinicians implementing LC for Latino families.

References

Alegría, M., Green, J. G., McLaughlin, K. A. & Loder, B. (2015). Disparities in child and adolescent mental health and mental health services in the U.S. *Intersecting Inequalities: Research to Reduce Inequality for Immigrant-Origin Children and Youth*. William T. Grant Foundation.

de Arellano M. A., & Danielson C. K. (2008). Assessment of trauma history and trauma-related problems in ethnic minority child populations: An INFORMED approach. *Cognitive and Behavioral Practice, 15*(1), 53-66.

de Arellano, M. A., & Danielson, C. K. (2005). Culturally-Modified Trauma Focused Treatment. Unpublished Manuscript, Medical University of South Carolina.

Huey, S. J., Tilley, J. L., Jones, E. O., & Smith, C. A. (2014) The contribution of cultural competence to evidence-based care for ethnically diverse populations. *Annual Review of Clinical Psychology, 10*, 305-38.

Martinez, J. I., Gudiño, O. G., & Lau, A. S. (2013). Problem-specific racial/ethnic disparities in pathways from maltreatment exposure to specialty mental health service use for youth in child welfare. *Child Maltreatment, 18*, 98-107.

McKay, M., Hibbert, R., Hoagwood, K., Rodriguez, J., Legerski, J., Fernandez, D., & Murray, L. (2004). Integrating evidence-based engagement interventions into 'real world' child mental health settings. *Journal of Brief Treatment and Crisis Intervention, 4*, 177-186.

Pina, A. A., & Silverman, W. K. (2004). Clinical phenomenology, somatic symptoms, and distress in Hispanic/Latino and European American youths with anxiety disorders. *Journal of Clinical Child and Adolescent Psychology, 33*(2), 227-236.

The Workgroup on Adapting Latino Services. (2008). *Adaptation guidelines for serving Latino children and families affected by trauma* (1st ed.). San Diego, CA: Chadwick Center for Children and Families.