NCTSN The National Child Traumatic Stress Network

CULTURE-SPECIFIC INFORMATION

SPARCS: Structured Psychotherapy for Adolescents Responding to Chronic Stress

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.** It is expected that SPARCS clinicians will balance fidelity to the core components of the intervention while simultaneously adapting and applying elements in a way that will be meaningful and culturally relevant to their specific group. Ways in which to do this are specifically discussed at the training and during consultation calls. Developers and trainers work with agencies to support them in their implementation of the model with ethnically and culturally diverse groups. To date, SPARCS has been used with African American, Latino, Native American, and LGBTQ adolescents, as well as refugee/immigrant populations and adolescents in gangs and in rural settings. SPARCS has also been implemented with adolescents in foster care and in shelters with runaway/homeless youth. In each of these settings, clinicians have reached out to families and youth in a manner that best fits with their cultural norms and expectations. For example, clinicians in rural communities and Native American reservations have conducted outreach through home visits and community meetings with tribal leaders that families trust in order to foster engagement, rather than relying solely on referrals from schools and other professionals or services. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** These are discussed as part of the SPARCS Planning Worksheet and explored during extensive pre-training calls. As an example, clinicians working in an area with a large Latino immigrant population took special care to address issues related to cultural marginalization and trust when recruiting group members. Some of the groups were conducted in Spanish, and clinicians developed fliers written in Spanish in order to facilitate family involvement during the recruitment and engagement process. Bilingual clinicians were also available to meet and talk with caregivers. Clinicians think creatively about ways to continuously engage group members throughout the intervention. Activities, metaphors, and role plays are routinely modified in order to make them more relevant for specific cultural groups. In working with Native American adolescents, group leaders used a Medicine Wheel, a concept already familiar to the youth, in order to introduce one of the core components of SPARCS which had parallels to the Medicine Wheel.
Language Issues	**How does the treatment address children and families of different language groups?** SPARCS has piloted handouts in Spanish for youth and Spanish speaking caregivers. These handouts, coupled with family sessions, support and inform caregivers before joining any multi-family meetings. Some agencies provide multi-family groups for specific SPARCS sessions. **If interpreters are used, what is their training in child trauma?** This depends upon the agency. **Any other special considerations regarding language and interpreters?** No.

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?

There are published data which suggest that the manifestation of Complex PTSD/ Developmental Trauma Disorder among adults differ by culture. Further systematic study of alterations in functioning vary by culture (and across other variables), is greatly needed in the child trauma literature. While the recommended battery of assessments for SPARCS includes a comprehensive trauma history exposure screen and assessment of PTSD symptoms, in an effort to capture a range of responses, our focus includes a broader evaluation of current functioning and coping strategies across a number of domains particularly those associated with complex trauma..

If there are differences in symptom expression, in what ways does the theoretical/ conceptual framework of this treatment address culturally specific symptoms?

SPARCS addresses culturally specific symptoms in a variety of manners, most notably through the use of "meaning making," which is a central component of SPARCS. The ability to make meaning, out of trauma, and out of routine life events, is culturally-based, and integral to the developmental tasks of adolescence. Therapists routinely engage group members in discussions around the ways in which trauma has impacted their lives and what it means to them in the context of their culture. Members are encouraged to view both past and present life events in the context of what is really important to them, that is, those often intangible things from which meaning is derived (e.g., sense of belonging, fairness, trust, etc.). To this end, activities are structured so as to assist adolescents in identifying the core beliefs and values that drive their behavior. "Maladaptive", or "acting out" behaviors are examined in light of the adolescents' underlying principles and motivations. The ways in which meaning making affects trauma reminders, and coping strategies, is central to this treatment model. SPARCS therapists are trained to routinely assess and address the ways in which meaning making influences their group members' choices, coping strategies, and interpretations of life events in the wake of trauma. This flexibility is built into the intervention. In addition to the ways in which meaning making is applied, the SPARCS model encourages and expects that clinicians are flexible in addressing culturally based differences in symptom expression. As an example, clinicians in one agency reported differences in symptom expression among Latino and non-Latino groups with respect to activities tapping into affect regulation. Group leaders shared anecdotal observations of two SPARCS groups conducted simultaneously, one with primarily Latino members, and the other mixed. Given the flexibility of the model, the differences were not an issue and were handled within the context of the session material. The flexibility of the model also allows for group members to participate in material experientially, while sharing only the information they are comfortable disclosing. Both the content and amount of information that members disclose is often culturally driven. Members that are not comfortable sharing personal stories, whether traumatic or otherwise (e.g., conflict with peer), are still able to participate in and benefit from activities and role plays.

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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?** Most of the primary measures used as part of the SPARCS protocol are available in both English and Spanish. Refer to assessment manuals for any available culture-specific normative data. Evaluation of outcome differences across cultural groups is currently in progress.
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** General cultural issues are addressed in writing and the ways in which the treatment can flexibly address different needs based on culture. Further issues related to cultural differences are addressed in examples and activities within the intervention as well as in the training. Specific recommendations for specific groups have not been empirically evaluated. **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)*. See meaning making description and examples of activities outlined earlier. Additional activities and adaptations are provided at the training and shared on consultation calls. **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?** Differential drop out has been examined in comparison to a standard of care group (rather than in comparison to other cultural groups). In the Evidence Based Practices Pilot (EBPP) in Illinois, African-American adolescents receiving SPARCS (the primary group in the EBPP) were less likely to drop out of treatment than youth receiving treatment as usual. See "Outcomes" in the "General Information Intervention" fact sheet.
Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** SPARCS was specifically designed for youth living with ongoing stressors. A review of the trauma histories of adolescents who have received SPARCS, reveals chronic, multiple traumas. Many of these adolescents are at increased risk for further trauma exposure (e.g., continue to live in communities with high rates of community violence). SPARCS addresses these, and related cultural risk factors throughout the intervention. For example, safety planning occurs early in the intervention and is tailored to address the specific needs and life circumstances of each group member.

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?**

SPARCS has been piloted in a variety of settings including outpatient clinics, schools, group homes, boarding schools, residential treatment centers and facilities, Native American reservations, day treatment centers, and shelters (e.g., domestic violence and runaway/homeless shelters). Evaluations in these different settings are underway.

Pilot data indicate that treatment is effective in multiple settings. However, the group curriculum is not transportable into the home. In such circumstances, clinicians have applied components of the intervention for use in individual therapy in the home.

Are there cultural barriers to accessing this treatment *(i.e., treatment length, family involvement, stigma, etc.)***?**

The marketing of the group varies depending upon location and culture. In order to avoid the stigma of psychotherapy, some schools and cultures have successfully engaged youth in a "stress management" group. Others have introduced group as a "preventative" workshop/group to decrease the likelihood that youth will be displaced from their current foster home. When orienting youth and families to SPARCS treatment, clinicians conduct a needs assessment from the youth and caregiver's perspective first. They focus on what it is that the adolescent and his/her caregivers are seeking to change and why. This information "lives" in the context of their cultural norms and expectations. Then the ways in which SPARCS may be helpful to address their concerns is described in detail using their language and perspective.

Are there logistical barriers to accessing this treatment for specific cultural groups *(i.e., transportation issues, cost of treatment, etc.)***?**

Transportation is often an issue and agencies have pursued creative ways to raise funds to provide assistance with transportation, or to provide child care for younger siblings. Some agencies have successfully conducted simultaneous multi-family groups so that groups for caregivers run concurrently with the adolescent group. This was helpful in addressing late pick ups of adolescents in group. While there are issues related to transportation and retention of members for any cultural group, implementing SPARCS with homeless and runaway youth is particularly challenging given the transiency and guardedness of this particular group (e.g., reluctance to share their real names). SPARCS is a 16-session intervention, of which, each session builds upon earlier material. While some attrition is expected over the course of the intervention, the groups that have been most successful in retaining their core members, are those that engaged in extensive work during the planning/pre-training phase of the project.

Are these barriers addressed in the intervention and how?

They are addressed in the SPARCS Planning Worksheet which is accompanied by several consultation calls prior to the first training. It is critical that agencies engage in comprehensive planning (facilitated via worksheet and consultation calls) and carefully choose members that are most likely to participate in the full course of the intervention. For example, in group homes, choosing members that have been recently admitted; in schools, beginning groups early on in the semester and planning around school holidays and closures.

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)***?** SPARCS clinicians reach out to the community in which the treatment is being run in order to better orient additional stakeholders and interested parties. In order to help youth with increasing their network of social support, members are also encouraged, through handouts and specific activities, to reach out to specific members of their community, teachers, spiritual leaders, extended family, etc. for specific types of support. As an example, youth have shared group material (e.g., handouts), with friends and family. In one urban setting, youth in a gang asked group leaders for help in effectively communicating with law enforcement officials around a particular problem. In another setting, an adolescent in group role-played approaching her teacher and principal in order to negotiate a schedule change that would otherwise prevent her from continuing in group.
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** Culture-specific issues are frequently addressed during the training and during regularly scheduled consultation calls. These vary widely based upon the agency and the clientele served (e.g., foster care youth, vs. LGBTQ youth, vs. Native American adolescents, etc.). Cultural issues are also identified and addressed through the ways in which adolescents make meaning out of life events, and with respect to the values and beliefs that underlie what they hold to be important. (Please refer to earlier description of meaning making in "Symptom Expression" section.) **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** They are addressed during consultation calls. **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** They are addressed during consultation calls. **Has this guidance been provided in the writings on this treatment?** They are addressed during consultation calls. **Any other special considerations regarding training?** The training provides opportunities to discuss how SPARCS can best be applied to each setting in a way that is culturally relevant for that agency and most importantly, for the clientele served by the agency. For a complete description of the training process, please refer to the "Training Materials & Requirements" section of the SPARCS General Information Fact Sheet, preceding this one.