NCTSN The National Child Traumatic Stress Network

CULTURE-SPECIFIC INFORMATION

MMTT: Multimodality Trauma Treatment (aka Trauma-Focused Coping in Schools)

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. MMTT has been used with diverse populations (i.e., race/ethnicity, gender, SES, & religion in both rural and urban settings). **Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.** This is a trauma-specific CBT "core components" treatment offered in schools, residential settings, or clinics that is facile enough to allow tailoring to different cultural group members; cultural awareness of and sensitivity to both individual and familial issues is key. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** Emphasis on the therapeutic alliance and group makeup are dealt with first thing in Session 1. Engagement strategies, such as those suggested by Mary McKay, are strongly recommended by the developers and trainers.
Language Issues	**How does the treatment address children and families of different language groups?** Manual has been translated into French and other languages (e.g., Spanish) to address cultural and linguistic differences. **If interpreters are used, what is their training in child trauma?** A background in trauma work or CBT would be very helpful. **Any other special considerations regarding language and interpreters?** Manuals are available from developers in Spanish and French. Adaptations are currently being made in several other languages and dialects. Providers are encouraged to use professional guidelines on cultural and linguistic competence.
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?** N/A **If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?** CBT has demonstrated robust results across various racial/ethnic groups, particularly with regard to symptom reduction.
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?** Suggested assessment measures have been normed on diverse racial/ethnic/cultural groups and are available in multiple languages. Alternative measures can be substituted readily as long as PTSD, depression, and anxiety are considered.

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Assessment continued	**What, if any, culturally specific issues arise when utilizing these assessment measures?** A grief module is available in the treatment and there are grief symptoms and rituals that are culturally specific that should be considered in assessment.
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** Adaptations are easily done given the basic nature of the CBT approach. Specific cultural adaptations are not included. **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)*. Components of CBT are being tested with diverse traumatized populations. **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?** No differential drop out rates across groups were noted in any of the previous or current studies.
Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** N/A **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?** This treatment is transportable as evidenced by previous trials in schools, clinics, residential treatment and community settings. **Are there cultural barriers to accessing this treatment** *(i.e., treatment length, family involvement, stigma, etc.)***?** No, and perhaps less than some CBT treatments that require intense family involvement. Stigma is often avoided by school based delivery availability. **Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** Considerable time has been invested to ensure that logistical barriers are kept to a minimum. MMTT, as with many other interventions, requires that clinicians assess and respond appropriately to the unique needs of the children and families served. **Are these barriers addressed in the intervention and how?** Providing services in the school is just one of many ways to reduce logistical barriers. **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)***?** Greater awareness of the impact of trauma on youth and their families can lead to better referrals and increased access to services. Moreover, community members are essential to increasing the level of safety and support available in multiple settings.

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Training Issues

What potential cultural issues are identified and addressed in supervision/training for the intervention?

Training with consultation offers tailoring to specific cultural scenarios often encountered in CBT treatments. Feelings identification, emotional expression, cognitive distortions, attitudes about the trauma mediators and sequelae, and facilitating trauma narratives require cultural sensitivity, not only for individual clients but also in group settings.

If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?

Providers should be aware of how their own experiences, beliefs, values, and biases impact treatment and adhere to professional standards for cultural and linguistic competence. Supervisors should encourage providers to consider how culture impacts treatment.

If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?

These can be done in anticipation of each session as session goals are listed and can be addressed with supervisor/consultant readily to ensure cultural sensitivity and competence.

Has this guidance been provided in the writings on this treatment?

This guidance is assumed as part of the model. Additional information will be added to subsequent revisions.

Any other special considerations regarding training?

The treatment utilizes individual “pull-out” sessions that allow trauma narratives and stimulus hierarchies to be generated for individual group members. This is also the time when cultural specificity can be brought into play and is addressed in training.