TGCT: Trauma and Grief Component Therapy for Adolescents

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."**

Each time this program has been implemented in either domestic or international settings, the program materials (including the treatment manual, training materials, and trainings) have been adapted for the specific populations served.

- The program was initially tailored for Armenian youth living in the aftermath of the devastating 1988 Armenian earthquake.
- The program was then adapted for use with ethnic Serb, Muslim, and Croatian adolescents and families, many of whom were internally displaced or refugees following the 1992-1995 Bosnian Civil War.
- The program was also adapted for use with African American, Hispanic, Asian and Pacific Island youth in public schools in the Los Angeles area.
- The program was also adapted for use with a similarly diverse group of children, adolescents and families across the boroughs of New York following the September 11th 2001 attack on the World Trade Center.
- The program was adapted over the past seven years for use with hurricane-exposed youth and families living in rural and urban settings in various Southern states.
- The program is currently being adapted for use with Native American youths in collaboration with the University of Montana Category II site.

Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.

During training, clinicians are guided in how to adapt engagement and assessment strategies for different cultural groups. Specific strategies include:

- Methods for engaging prospective clients and creating an effective therapeutic alliance.
- Pacing treatment appropriately for the clients' developmental stage and cultural background.
- Deciding which nuclear family members, extended family members, and community members may be appropriate to include in specific components of the intervention.
- Framing and prioritizing therapeutic goals in ways that are appropriate for the developmental stage and cultural background of clients.
- Identifying the most helpful practitioner roles (e.g., "one down" vs. expert vs. collaborative helper vs. coach) that may be most helpful in facilitating engagement.

Are there culture-specific engagement strategies *(e.g., addressing trust)* **that are included in the intervention?** (see above)

TGCT: Trauma and Grief Component Therapy for Adolescents

Language Issues	**How does the treatment address children and families of different language groups?** The program has been translated into Bosnian and a large number of bi-lingual therapists have been trained in the protocol to extend services to children and families who only speak Spanish, Armenian, and Chinese. **If interpreters are used, what is their training in child trauma?** It is recommended that interpreters receive foundational training in child and adolescent trauma. **Any other special considerations regarding language and interpreters?** Trainings have been conducted through interpreters in Bosnia and Armenia.
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?** Research is currently being conducted to address these questions with Native American youths. **If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?** If they are found, the treatment will be adapted to address these differences. Areas of particular interest include: • Developmentally- and culturally-linked differences in how bereaved adolescents grieve and mourn. • Ways in which distress is manifest. • Ways in which dysfunction is manifest.
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?** In addition to our standard set of measures that assess trauma and loss exposure, post-traumatic distress, traumatic grief, depression and anxiety, a number of specialized measures have been used for various cultural groups. • For example, in our implementation in a post-war setting with Bosnian youth, we developed, field-tested, and used a Post-War Adversity Scale, a Trauma Reminder Scale, a Loss Reminder Scale, a Maladaptive Grief Scale, and a specialized Social Support Scale (the Multi-Sector Social Support Inventory, or MSSI). • Descriptive statistics are available pertaining to all of these measures. • The psychometric properties of the MSSI social support scale have been carefully evaluated in Bosnian youths, the results of which are published in a 2008 book chapter.

TGCT: Trauma and Grief Component Therapy for Adolescents

Assessment continued	**If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** The measures described above are used in risk screening (to be used in conjunction with clinical judgment) and as talking points to facilitate the pre-treatment clinical interview. Test results are used to guide: • Which treatment components are implemented. For example, Module III is used if there is a history of bereavement and grief reactions are present. This module provides specialized psychoeducation and interventions to promote adaptive grief reactions, and to remediate maladaptive grief reactions (including traumatic grief and existential grief) in bereaved adolescents. • How much time is allocated for the development of specific coping skills and activities. For example, depending on the extent of trauma exposure and current reactivity to reminders, a greater or lesser degree of exposure work from Module II is employed along with specialized training to identify and deal with trauma and loss reminders. **What, if any, culturally specific issues arise when utilizing these assessment measures?** Different cultures may vary in marked ways in, for example, the ways in which grief rituals are carried out (e.g., the period of time one formally mourns a deceased close person; formal and informal mourning rituals to memorialize the deceased; ways in which maladaptive grief reactions are manifest, such as delaying or precociously accelerating developmental progression).
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** The process by which TGCT was developed to enhance "cultural fit," ecological validity, adoption, and sustainability has been described in a number of publications. This process included: • Ongoing consultation with local cultural experts, including mental health experts, indigenous adolescents and family members, educators, and community stake holders. Modalities of gathering data included personal interviews and focus groups. • Creating multiple iterations of the program following initial implementation to refine and further adapt the intervention. • Facilitating the development of local professional networks comprised of mental health experts (affiliated with local clinics and universities) who served as program supervisors, school counselors who implemented the program, and government administrators who coordinated and advocated for the program at the Federal and Cantonal (regional) levels. • Identifying and addressing barriers to successful implementation (including barriers to access, and cultural values and meanings attached to help-seeking and disclosure).

TGCT: Trauma and Grief Component Therapy for Adolescents

Cultural Adaptations continued	**Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)*. The program contains four modules that may be flexibly employed for the adolescent or family. Examples of specific cultural adaptations include: • Coping skills contained in Module I are modified to be appropriate for different cultural settings, including recruiting and giving social support (e.g., ways in which support is sought and provided; available sources of support, such as school professionals, clergy members, athletic coaches, etc.). • Module III, which focuses on promoting adaptive grieving, is tailored in substantial ways to enhance cultural appropriateness. Adaptations include addressing ways in which death is understood at different developmental stages and cultural settings; and identifying appropriate grieving rituals and ways of commemorating the deceased. • Module IV, which focuses on promoting adaptive developmental progression, involves identifying culturally-appropriate developmental expectations and milestones, rites of passage, and culturally appropriate ways of expressing adolescent identity (e.g., individualism vs. communal identity) across cultures. **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 rates have not been specifically investigated. However, relatively low drop out rates have been found for participants in TGCT.
Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** This program has been adapted for use in urban, low SES settings that pose substantial risks for adolescent exposure to community violence and various forms of violence in the home. Key aspects of psychoeducation and coping skills address these risks. Guidance is also provided for conducting narrative exposure and developing coping skills for adolescents who have on-going exposure to danger and must maintain appropriate degrees of vigilance and defensive coping. **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 program has been implemented in community mental health settings, in schools, and has been used for in-home services as well. The randomized controlled study found evidence of program effectiveness in a variety of school settings, and a pre-post open-trial evaluation found evidence of effectiveness in community mental health settings. **Are there cultural barriers to accessing this treatment** *(i.e., treatment length, family involvement, stigma, etc.)***?** A primary aim of all program implementations has been to offer services in convenient and accessible settings, including schools and local community centers.

Intervention Delivery Method/ Transportability & Outreach continued	In addition, TGCT strongly emphasizes psychoeducation and skills-building to reduce possible barriers to receiving "therapy" for psychological disorders. Some cultural variations in program accessibility have nevertheless been anecdotally noted. • For example, when implemented with a very culturally diverse set of clients in post-September 11th New York City, reports indicated that certain groups, including Asian teens and families, had lower rates of utilization. This finding was attributed to a hesitancy among these teens to discuss personal or family issues or to seek out mental health related services. **Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** (see above) **Are these barriers addressed in the intervention and how?** During the initial sessions, common barriers for participation are explored, normalized, and addressed. Barriers at the level of the individual, family, school, and community are discussed with the teens during the first group session. Specific tools for addressing culturally-linked barriers include normalizing, using cultural metaphors, psychoeducation, problem-solving, and accommodating differences. **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)***?** The program is very flexible in its structure and implementation and encourages the inclusion of schools, religious and spiritual leaders, and community-based sources of support in the assessment, planning, and intervention phases.
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** A significant portion of training and preparation for implementation is dedicated to adapting the program for use in specific cultures. Specific issues include: • Enhancing accessibility • Case conceptualization and treatment planning (e.g., identifying how dysfunction appears; defining what developmental derailment looks like, in the cultural and developmental group) • Engaging adolescents • Engaging and collaborating with family members and important others • Goal setting • Selecting coping skills and appropriate modalities for conducting narrative exposure • Dealing with grief and loss • Adapting the program to the developmental level of the client • Termination

Training Issues continued	Special emphasis is also given towards working with the family in an appropriate fashion to maximize family support and understanding of the program goals and process. Transference and counter-transference issues related to culture are also highlighted in supervision. **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** Implementation typically involves intensive training of direct service providers and supervisors, followed by consultation in adaptation and implementation for some months (up to one year) post-training. In this way, cultural issues can be addressed on a case-by-case basis. • Ongoing consultation (and supervision by local supervisors) should focus on possible conflicts or threats to the therapeutic relationship that may be linked to cultural differences or lack of cultural knowledge. • As appropriate, cultural informants are contacted to insure the implementation is suited to the specific family and culture. **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** (see above) **Has this guidance been provided in the writings on this treatment?** This guidance is noted in one of the articles on the ecological validity of the program.