NCTSN The National Child Traumatic Stress Network

TST-R: Trauma Systems Therapy for Refugees

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."**

This intervention is tailored for refugee and immigrant youth. We have adaptations of the intervention for Somali refugees and for Bhutanese refugees. We are working on an adaptation for mixed ethnicities.

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

Clinicians work with cultural brokers at all stages of the intervention to engage community members in services and tailor interventions to the specific cultural group. Cultural brokers are professionals who combine intimate community-level cultural knowledge and experience with an understanding of mental health services and supports in order to facilitate access for cultural minority communities and improve care. The bottom two tiers of the intervention (Community engagement/Tier 1 and Skills-based groups/Tier 2) are both designed to overcome the barriers that refugee communities in general experience when accessing care. The Bhutanese and Somali adaptations of the model involve culture-specific changes to the curriculum for Tier 2.

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

TST-R is specifically designed to reduce barriers to mental health services commonly faced by refugee youth and families through the following mechanisms:

1. Reduce **distrust** of authorities by engaging the community
2. Reduce the **stigma** of mental health services by embedding services in existing service systems
3. Reduce **linguistic and cultural barriers** by creating a partnership between providers and cultural experts
4. Reduce the primacy of **resettlement stressors** by integrating services

The intervention uses gateway providers to engage key community members (family, community leaders, and school personnel) in identifying and referring youth for care, build trust and relationships between families and clinical staff prior to the initiation of treatment, and destigmatize treatment by connecting it with broad-reaching services for the general population.

Language Issues

How does the treatment address children and families of different language groups?

The cultural broker who is involved in all four Tiers of the program is usually from the same cultural background as the children and families involved in the intervention. We use cultural brokers because translation alone can be limiting in mental health settings, since the context of the experience can be lost. The cultural broker can translate both the words that are used and the cultural context of the experience, thus providing a richer picture to the clinical team.

Language Issues continued	**If interpreters are used, what is their training in child trauma?** The aforementioned cultural broker can have a variety of training but at a minimum has gone through a four-day TST-R training that includes child trauma, and receives continuing education and skill-building through regular consultation with our team. In addition, the job description of cultural broker requires experience in both care systems and the culture. **Any other special considerations regarding language and interpreters?** It is important that any interpreting comes from the cultural broker, since he/she is a member of the intervention team and can provide continuity of care as well a richer explanation of the issues for the clinical team.
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 evidence suggests that these populations do experience trauma symptoms consistent with other populations; however, clinical evidence also suggests that there may be some variability in symptom expression. For example, somatic complaints may be more likely in Somali and Bhutanese refugees. Furthermore, in Somali culture an individual is seen as being either severely mentally ill or well, with nothing in between. People who are experiencing mental health distress, therefore, may not seek help unless they exhibit psychotic behaviors (Guerin, B., Guerin, P., Diiriye, R., & Yates, S., 2004). Similarly, cultural forces including concepts of self, attributions of distress, the stigma of mental illness, and linguistics influence the ways that mental health symptoms are understood and expressed within Bhutanese refugee populations (Acharya, 2008). For example, elevated rates of medically unexplained pain among Bhutanese adult refugees may be indicative of trauma exposure and/or accepted idioms of distress (Van Ommeren et al., 2001). We use the PTSD-RI and the DSRS to assess symptoms, both of which have been used with diverse populations and have shown good validity. If needed, these measures are interpreted by the cultural broker. We also use trauma exposure measures that have been adapted for the Bhutanese and Somali populations in order to more accurately capture information on trauma exposure. **If there are differences in symptom expression, in what ways does the theoretical/ conceptual framework of this treatment address culturally specific symptoms?** Cultural brokers are integrated into the program as liaisons between the family/ culture and clinicians. In this role they can help identify culturally specific or culturally acceptable forms of symptom expression. Treatment is then framed within this context with the help of the cultural broker working in collaboration with treating providers.

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?** There is no normative data available for these populations, especially those populations in the diaspora.There are a few differences in the assessment measures we use with the Bhutanese and Somali populations. **If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** N/A **What, if any, culturally specific issues arise when utilizing these assessment measures?** Decisions around inclusion of assessment measures and, at times, particular items (e.g., asking about sexual abuse) should be reviewed with a cultural broker. Similarly, we often administer assessment measures in interview format with the availability of an interpreter or cultural broker who is familiar with the interview questions available as needed.
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** There are a number of writings that discuss the cultural issues: Miller, A., Ellis, B.H., Baldwin, H., & Abdi, S. (2011). New directions in refugee youth mental health services: Overcoming barriers to engagement. J Child Adolesc Trauma 4:69-85. DOI:10.1080/19361521.2011.545047 Refugee Trauma and Resilience Center (in development). Trauma Systems Therapy for Refugees (TST-R): A Cultural Brokering Program Supplemental Manual. *Boston Children's Hospital*, Boston, MA. Abdi, S.,M., & Nisewaner, A. (2009). *Group Work with Somali Youth Manual.* Unpublished manuscript. Center for Refugee Trauma and Resilience, Children's Hospital Boston, Boston, MA. Nisewaner, A., & Abdi, S. M. (2010, June). Challenges, strategies and rewards of an adaptation of trauma systems therapy for newly arriving refugee youth: School-based group work with Somali adolescent boys. In V. Roy, G. Berteau, & S. Genest-Dufault (Eds.), Strengthening Social Solidarity through Group Work: Research and Creative Practice. Paper presented at the Proceeding of the XXXII International Symposium on Social Work with Groups, Montreal, June 3-6, (pp. 129-147). Forest Hill, London: Whiting & Birch. Ellis, B. H., Miller, A. B., Abdi, S., Barrett, C., Blood, E. A., & Betancourt, T. S. (2012). Multi-tier mental health program for refugee youth. *Journal Of Consulting And Clinical Psychology, 81*,129-140. DOI:10.1037/a0029844

Cultural Adaptations continued	**Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)***.** Specific cultural adaptations have been made to the skills-based group (Tier 2) curriculum for Bhutanese and Somali refugees. In addition, a multi-cultural version of the group curriculum is being piloted. **Has differential dropout been examined for this treatment? Is there any evidence to suggest differential dropout across cultural groups? If so, what are the findings?** Differential dropout has been examined and there is no differential dropout across cultural groups.
Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** The treatment components of the intervention (Tiers 3 and 4) focus on the importance of addressing environmental factors and post-resettlement stressors in order to prevent susceptibility to worse symptoms of PTSD. The skills-based groups (Tier 2) focus on decreasing acculturative stress and increasing social support, factors known to be associated with better mental health among refugee youth. **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 community-based; both the individual and the home-based treatment can be provided in the school, in the home, or in a location of the participants' choosing. **Are there cultural barriers to accessing this treatment** *(i.e., treatment length, family involvement, stigma, etc.)***?** As stated above, TST-R is specifically designed to reduce barriers to accessing mental health services commonly faced by refugee youth and families through the following mechanisms: 1. Reduce distrust of authorities by engaging the community 2. Reduce the stigma of mental health services by embedding services in existing service systems 3. Reduce linguistic and cultural barriers by creating a partnership between providers and cultural experts 4. Reduce the primacy of resettlement stressors by integrating services **Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** The intervention was designed to minimize logistical barriers. Services are provided in schools (where refugee youth already attend) or in homes/community locations convenient to the family. Families do not pay for the groups and the clinical services are often billable through insurance.

Intervention Delivery Method/ Transportability & Outreach continued	**Are these barriers addressed in the intervention and how?** Yes (see above). **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)***?** Schools are involved, as are community-based mental health organizations and community agencies.
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** Clinicians and cultural brokers receive training in cultural humility and cultural competence. These aspects of practice are integrated throughout ongoing supervision and consultation to TST-R teams. Cultural humility and confidence in working cross-culturally with children, families, and coworkers are fundamental and essential aspects of a TST-R program that must be cultivated and will evolve over time. Some of the key issues that come up for cultural brokers in supervision/ training include self-disclosure, boundaries and dual roles, cultural expectations and norms, and balancing clinical and cultural expectations. Cultural brokers also provide training in specific cultural and community issues to clinical staff. **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** The issues are addressed in training and then identified by the program team on the ground or during weekly consultation calls with TST-R trainers. **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** The issues are discussed in weekly supervisory consultation calls with the TST-R trainers. Cultural/clinical integration and looking at problems through a clinical-cultural lenses are major components of both training and consultation. **Has this guidance been provided in the writings on this treatment?** Yes, in the Cultural Brokering Program Supplemental Manual that is in progress. **Any other special considerations regarding training?** Our training and consultation use case examples and scenarios to teach clinicians and cultural brokers to develop skills that are integral to enhance engagement and ensure that treatment is culturally and clinically sound.