NCTSN The National Child Traumatic Stress Network

MUSC MEDICAL UNIVERSITY of SOUTH CAROLINA

Trauma-Informed Interventions:

Clinical and Research Evidence and Culture-Specific Information Project

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Saunders, B. E., Berliner, L. & Hanson, R. F. (Eds.). (2004). *Child physical and sexual abuse: Guidelines for treatment (Revised Report: April 26, 2004).* Charleston, SC: National Crime Victims Research and Treatment Center.

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For information about this project and report, contact:
Susan Ko, PhD
Director, Service Systems
National Center for Child Traumatic Stress
11150 W. Olympic Blvd, Suite 650
Los Angeles, CA 90064
sko@mednet.ucla.edu

This report may be accessed electronically at http://www.nctsn.org/cultureandtraumaresources, or downloaded directly at http://www.nctsn.org/nccts/asset.do?id=1392.

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Contents

4 **Introduction**
Goals of the Project

5 **Methodology**
Expert Panel
Expert Panel Meeting

9 **Conclusion**

11 **Future Directions**

12 **References**

13 **Appendix A**: General Information Intervention Template

16 **Appendix B**: Culture-Specific Information Intervention Template

18 **Appendix C**: Treatment Protocol Classification System

General and Culture-Specific Fact Sheets

23 **AF-CBT**: Abuse-Focused Cognitive Behavioral Therapy for Child Physical Abuse

35 **DBT-SP**: Adapted Dialectical Behavior Therapy for Special Populations

41 **TAP**: Assessment-Based Treatment for Traumatized Children: Trauma Assessment Pathway

51 **ARC**: Attachment, Self-Regulation, and Competency: A Comprehensive Framework for Intervention with Complexly Traumatized Youth

59 **CARE**: Child-Adult Relationship Enhancement

68 **CPP**: Child-Parent Psychotherapy

80 **CBITS**: Cognitive Behavioral Intervention for Trauma in Schools

93 **CPC-CBT**: Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse

103 **CM-TFT**: Culturally Modified Trauma-Focused Treatment

110 **IFACES**: International Family Adult and Child Enhancement Services, Heartland Health Outreach

118 **ITCT**: Integrative Treatment of Complex Trauma

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

137 **PCIT:** Parent-Child Interaction Therapy

147 **RLH**: Real Life Heroes

157 **Sanctuary Model**

167 **SPARCS**: Structured Psychotherapy for Adolescents Responding to Chronic Stress

178 **TGCT**: Trauma and Grief Component Therapy

193 **TARGET-A**: Trauma Affect Regulation: Guidelines for Education and Therapy for Adolescents and Pre-Adolescents

205 **TF-CBT**: Trauma-Focused Cognitive Behavioral Therapy

215 **TG-CBT**: Trauma-Focused Cognitive Behavioral Therapy for Child Traumatic Grief

221 **Trauma-Informed Organizational Self-Assessment**

227 **TST**: Trauma Systems Therapy

Introduction

The *Trauma-Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project* is a collaboration between the National Crime Victims Research and Treatment Center at the Medical University of South Carolina (MUSC) and the National Child Traumatic Stress Network (NCTSN). This project emerged in response to the heavy emphasis on evidence-based practices in the mental health community, a trend that may ultimately affect access to services, as well as policy and funding decisions.

The purpose of this project was to identify trauma-focused interventions that have been developed and utilized with trauma-affected youth populations of various cultural backgrounds and to describe their level of cultural competence. This project also aims to describe the level of clinical and research evidence surrounding the use of specific trauma-informed treatment interventions with diverse cultural groups. Included in the term "diverse cultural groups" are factors of race, ethnicity, sexual orientation, socioeconomic status, spirituality, geographic location, and any other distinguishing factors about a particular group or population.

Goals of the Project

The Project does not intend to provide a subjective value judgment about which interventions are the best. Instead, the primary goals of this project are as follows:

- To collect information on interventions that are currently being used for a broad array of diverse cultural groups of youth affected by trauma;
- To provide descriptions of existing clinical and/or research evidence for each of these interventions;
- To encourage practitioners and intervention developers to summarize practice-based and anecdotal evidence in written form so that treatments can be more widely disseminated and more thoroughly evaluated;
- To create a formal comprehensive report which documents our systematic process and describes the interventions that were identified and submitted by treatment developers. The report can then be used by practitioners when selecting treatments for the diverse communities they serve;
- To develop a web-based, searchable database describing the existing clinical and research evidence for the use of trauma-informed interventions with various cultural groups of youth exposed to trauma. The database will help to facilitate the identification and use of treatments for diverse communities affected by trauma.

Methodology

In 2005, the NCTSN began compiling a list of *Empirically Supported Treatments and Promising Practices*, including interventions being implemented by sites within the NCTSN for traumatized children and their families. Treatment developers were asked to complete an intervention template, which solicited specific information about their interventions (e.g., treatment description, target population, research evidence). Fact Sheets detailing each approach were developed from each completed intervention template, and then posted on the NCTSN website for public use. The interventions and treatments selected span a continuum of evidence-based interventions for use with trauma-affected youth, ranging from rigorously evaluated interventions to promising and newly emerging practices.

In June 2006, revised intervention templates were sent to all developers of the NCTSN's *Empirically Supported Treatments and Promising Practices*. Tailored for the *Trauma Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project*, the questions on these revised intervention templates were designed to elicit information about the cultural competence of an intervention as well as the level of research supporting the treatment. We placed special emphasis on providing this level of detail about the interventions to assist practitioners' selection of which treatment or practice to implement—based not only on their levels of evidence but also on their appropriateness for a given community and target population.

Therefore, the revised intervention templates sent to developers in 2006 included questions designed to evaluate the extent of both clinical and research evidence supporting the use of trauma-informed treatment interventions with trauma-affected youth from diverse cultural groups (as defined by race, ethnicity, sexual orientation, socioeconomic status, spirituality, disability, geographic location and other factors). These questions were intended to elicit information about each of the following categories (see Appendix A, General Information Intervention Template):

- Treatment Description
- Target Population
- Essential Components
- Clinical & Anecdotal Evidence
- Research Evidence
- Outcomes
- Implementation Requirements & Readiness
- Training Materials & Requirements
- Pros & Cons/Qualitative Impressions
- Contact Information
- References

Information gathered from the revised intervention templates replaced the previous Fact Sheets developed by the NCTSN in 2005.

In January 2007, these Fact Sheets on treatment interventions, based on revised intervention templates completed and returned by treatment developers, were sent to members of a nationally represented expert panel. The panel members were asked to meet to discuss the evidence base for the treatment interventions for use with various cultural groups and to determine future directions for this project.

Expert Panel

In February 2007, an expert panel was convened at the NCTSN's annual conference. The panel was asked to review evaluation criteria for treatment interventions, and to evaluate and categorize interventions according to the evidence for their efficacy and effectiveness with various cultural groups. The expert panel members were selected because of their acknowledged expertise and commitment to promoting and developing effective, culturally competent mental health treatments. This nationally represented group consisted of the following members:

Veronica Abney, PhD Private Practice & UCLA School of Medicine	**Larke Huang, PhD** Substance Abuse and Mental Health Services Administration (SAMHSA)
Dolores Subia Bigfoot, PhD Indian Country Child Trauma Center (ICCTC)	**Mareasa Isaacs, PhD** National Alliance of Multi-Ethnic Behavioral Health Associations (NAMBHA)
Ernestine Briggs-King, PhD National Center for Child Traumatic Stress (NCCTS)	**Russell Jones, PhD** Virginia Tech University (VT)
Elissa Brown, PhD Community PARTNERS at St. John's University	**Sheryl Kataoka, MD, MSHS** Department of Psychiatry and Biobehavioral Sciences at UCLA; Los Angeles Unified School District (LAUSD)
Carla Kmett Danielson, PhD Medical University of South Carolina (MUSC)	**Susan Ko, PhD** National Center for Child Traumatic Stress (NCCTS)
Michael de Arellano, PhD Medical University of South Carolina (MUSC)	**Sarah Maiter, PhD** American Professional Society on the Abuse of Children (APSAC)
Chandra Ghosh Ippen, PhD Child Trauma Research Project University of California, San Francisco (UCSF)	**Karen Wyche, MSW, PhD** University of Oklahoma Health Sciences Center (OUHSC)

Expert Panel Meeting

The rating system originally developed for this project was based very closely on the criteria used for *Child Physical and Sexual Abuse: Guidelines for Treatment* (2004). Those guidelines were developed by the Office for Victims of Crime, in collaboration with the National Crime Victims Research and Treatment Center at MUSC and the Center for Sexual Assault and Traumatic Stress at Harborview Medical Center. However, at the February, 2007 meeting, the expert panel concluded that the intervention Fact Sheets did not include enough information to provide a ranking for each treatment's level of cultural competence. Additionally, panel members raised concerns about the classification system, and expressed discomfort with categorizing interventions by assigning numerical ratings and citing inadequate information on specific ways in which the treatments address diverse cultural groups. The panel agreed that, rather than rating interventions based on the level of clinical and research evidence, it would be more helpful to solicit additional information about the degree to which cultural issues are addressed in the treatment intervention. The panel agreed that this would help more accurately capture the "cultural competence" of a given treatment.

As a result of these concerns, the panel decided to create a Culture-Specific Information Intervention Template. The panel spent the remainder of the meeting identifying additional culture-specific questions necessary to help determine the extent to which a particular treatment addresses the needs of diverse cultural groups. The panel decided that, once these Culture-Specific Information Intervention Templates were completed, the project would aim to present Culture-Specific Fact Sheets, alongside General Fact Sheets, in a comprehensive document.

Based on the culture-specific questions generated at the expert panel meeting, the Culture-Specific Information Intervention Template was developed and was sent to treatment developers to complete. This template included questions intended to address the following categories (see Appendix B, Culture-Specific Information Intervention Template):

- Engagement
- Language Issues
- Symptom Expression
- Assessment
- Cultural Adaptations
- Intervention Delivery Method/Transportability & Outreach
- Training Issues
- References

The information collected on the revised General Information Intervention Template as well as the Culture-Specific Intervention Template was used to create General and Culture-Specific Fact Sheets for each intervention. These Fact Sheets were then posted on the NCTSN website.

General and Culture-Specific Fact Sheets for Culturally-Competent, Evidence-Based, Trauma-Focused Interventions

Each General and Culture-Specific Fact Sheet includes all of the information provided by developers of the intervention and has not been substantively altered.[1] Only trauma-informed treatment interventions and practices that have both a General and Culture-Specific Fact Sheet are included in this report. Fact Sheets for each of the following interventions begin on page 23.

- **AF-CBT**: Abuse-Focused Cognitive Behavioral Therapy for Child Physical Abuse
- **DBT-SP**: Adapted Dialectical Behavior Therapy for Special Populations
- **TAP**: Assessment-Based Treatment for Traumatized Children: Trauma Assessment Pathway
- **ARC**: Attachment, Self-Regulation, and Competency: A Comprehensive Framework for Intervention with Complexly Traumatized Youth
- **CARE**: Child-Adult Relationship Enhancement
- **CPP**: Child-Parent Psychotherapy
- **CBITS**: Cognitive Behavioral Intervention for Trauma in Schools
- **CPC-CBT**: Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse
- **CM-TFT**: Culturally Modified Trauma-Focused Treatment
- **IFACES**: International Family Adult and Child Enhancement Services, Heartland Health Outreach
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- **MMTT**: Multimodality Trauma Treatment (aka Trauma-Focused Coping in Schools)
- **PCIT**: Parent-Child Interaction Therapy
- **RLH**: Real Life Heroes
- **Sanctuary Model**
- **SPARCS**: Structured Psychotherapy for Adolescents Responding to Chronic Stress
- **TGCT**: Trauma and Grief Component Therapy
- **TARGET-A**: Trauma Affect Regulation: Guidelines for Education and Therapy for Adolescents and Pre-Adolescents
- **TF-CBT**: Trauma-Focused Cognitive Behavioral Therapy
- **TG-CBT**: Trauma-Focused Cognitive Behavioral Therapy for Child Traumatic Grief
- **Trauma-Informed Organizational Self-Assessment**
- **TST**: Trauma Systems Therapy

[1] Please note: if a developer left any blanks in a template field, the question from the initial template was not included in the Fact Sheet for that particular intervention.

Conclusion

There is no one treatment intervention appropriate for all children who have experienced trauma. However, there are evidence-supported treatments and promising practices that share core principles of "culturally competent trauma-informed therapy," and that are appropriate for many children and families from diverse cultural groups.

Culturally competent trauma-informed therapies should include some, or all, of the following principles:

- **Engagement with the child, the family, and the community.** For many cultural groups, there may be cultural barriers to accessing treatment. Therefore, the start of treatment should begin with addressing strategies designed to engage children and families. These engagement strategies should be culture-specific. For example, addressing issues of trust may be important when working with refugees. Engagement strategies may also consider the role of other members of the family's immediate community, such as cultural or spiritual leaders, in reaching the child and family.
- **Sensitivity to the family's cultural background when building a strong therapeutic relationship.** Like most forms of therapy, trauma treatment requires the skillful development of a clinical relationship with the child and caregivers. During the process of building the therapeutic relationship, the practitioner must understand the importance of asking questions in order to learn about the child and/or family's cultural background.
- **Consideration of the impact of culture on symptom expression.** Most trauma-informed therapy includes a component that helps the child and caregivers identify and understand normal human reactions to trauma. When assessing reactions to trauma, it is important to consider the impact of culture, since cultural views may have an impact on symptom expression. If it is known that culture impacts symptom expression for a particular cultural group, assessment measures should reflect these differences.
- **Careful use of interpreters, when necessary.** Caregivers are typically powerful mediators of the child's treatment for and recovery from trauma. Involving the parent, resource parent, or other caregiver is a vital element of trauma treatment. Some trauma-informed interventions include a parenting component to give the parent greater mastery of child management skills. Language issues may sometimes arise if the clinician does not speak the parents' language. In such cases, it is very important to consider how the chosen treatment suggests use of interpreters in the absence of bilingual clinicians.
- **Understanding that differences in emotional expression exist among cultures.** To help with emotional regulation, it is typically necessary to teach the child (and sometimes the caregiver) practical skills and tools for gaining mastery of the overwhelming emotions often associated with trauma and its reminders. Again, it is important to assess cultural norms

regarding appropriate levels of emotional expression and with whom it is considered culturally appropriate to share emotions.

- **Assessment of the impact of cultural views on cognitive processing or reframing.** Child trauma can result in serious misunderstandings about personal responsibility. In the aftermath of a trauma, children may assume a great deal of self-blame for the events; or, they may blame someone else for not protecting them—even though protection may have been beyond that person's capacity. Traumatized children may associate the trauma with unrelated events and draw irrational causal relationships. Therapy often helps correct these misattributions. When treating trauma-affected youth from diverse backgrounds, clinicians must be aware that some misattributions may be related to cultural worldviews. A culturally-informed assessment can help to examine how culture affects the child's and family's comprehension of traumatic events. In such cases, cognitive processing and reframing will have to include an understanding of the impact of cultural views on attitudes and behavior.
- **Construction of a coherent trauma narrative using culturally congruent methods.** Successful trauma treatment often includes building the child's capacity to talk about what happened in ways that make sense of the experience without producing overwhelming emotions. Many non-trauma-informed therapists are uncomfortable with this aspect of treatment, which sometimes involves gradual exposure to traumatic reminders while using newly acquired anxiety management skills. Clinicians should consider how trauma narratives can be constructed so that they are congruent with the ways in which specific cultural groups feel comfortable sharing personal or private information (e.g., storytelling).
- **Highlighting ways in which culture may be a source of resiliency and strength.** Trauma treatment often includes strategies that build upon children's strengths. These strategies are designed to give them a sense of control over events and risks. Treatments then often end on a positive, empowering note, giving the child a sense of satisfaction and closure as well as increased competency and hope for the future. It is important to highlight the strengths inherent in children's and families' cultures as part of this process.

The *Trauma Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project* aims to promote cultural competence using each of these core principles of culturally competent trauma-informed therapy and to recognize practices that are effectively utilizing these principles. This report provides guidelines for evaluation of the treatments and promising practices that are appropriate for the cultural groups being served. Ultimately, it is the responsibility of clinicians, agencies and consumers to recognize how the needs of the specific cultural group being treated will be addressed by a chosen evidence-based treatment or promising practice.

Future Directions

The purpose of the *Trauma-Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project* was to identify trauma-focused interventions that have been developed and applied to trauma-affected youth populations of various cultural backgrounds and to describe their level of cultural competence and the level of clinical and research evidence supporting the treatment. Work on this project has revealed that significant groundwork has been established in this area by clinicians and researchers working directly with trauma-affected culturally diverse populations. However, more work will be required to improve the state of the science for the identification and application of evidence-based interventions with such populations. Advancing the science could be accomplished in a number of ways, as listed below.

First, developers of the interventions described in the Fact Sheets included in this report should seek to bring their respective interventions to the next level of evaluation. This may involve more rigorous collection of pre- and post-treatment outcome data with standardized, culturally appropriate measures. In some cases, assessment approaches may require modification in order to capture this data for a particular population. (See de Arellano & Danielson, 2008, for suggestions on culturally-informed trauma assessment.) For other interventions, developers may consider conducting a more rigorous open pilot trial or a randomized controlled trial. For the limited number of trauma-informed interventions that have been conducted with culturally diverse populations, treatment developers are encouraged to pursue ways in which to measure "real world" effectiveness—perhaps by designing and conducting community-based trials. Appendix C lists criteria for evaluating levels of evidence for interventions' use with specific cultural groups based on those used in previous treatment guidelines projects (Saunders, Berliner & Hanson, 2004) and can help provide suggested next steps for increasing the evidence base for interventions.

Another important future direction for this project may involve collaborations between community-based clinicians and researchers in order to develop a feasible "gold standard" for evaluation of trauma-informed interventions with culturally diverse populations. This pairing of science and practice could help address findings from previous reports that ethnic minority individuals and other culturally diverse youth are less likely to receive empirically-supported, gold-standard mental health interventions (U.S. Department of Health and Human Services, 2001).

Finally, it is hoped that this project will represent a first step in the continually evolving goal of developing a stronger clinical and research base for interventions used with culturally diverse populations. The Fact Sheets provided in this report are a resource that can be used to assist practitioners in the identification of interventions that have demonstrated efficacy in their application with culturally diverse populations. As clinicians continue to use interventions with diverse populations and document their clinical and research outcomes, the information on the effectiveness and efficacy of interventions for specific populations will grow and strengthen. A more formal evaluation of the state of the science, perhaps using the criteria listed in Appendix C, could then be pursued.

References[2]

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 & Behavioral Practice, 15,* 53-67.

Saunders, B. E., Berliner, L. & Hanson, R. F. (Eds.). (2004). *Child physical and sexual abuse: Guidelines for treatment (Revised Report: April 26, 2004)*. Charleston, SC: National Crime Victims Research and Treatment Center.

U.S. Department of Health and Human Services (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General.

[2] The reference list does not include references included in each of the Fact Sheets which follow.

Appendix A: General Information Intervention Template

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ACRONYM: Name of Intervention

GENERAL INFORMATION

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** **Average length/number of sessions:** **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** **Trauma type** *(primary)*: **Trauma type** *(secondary)*: **Additional descriptors** *(not included above)***:**
Target Population	**Age range:** *(lower limit)* _____ **to** *(upper limit)* _____ **Gender:** ❒ **Males** ❒ **Females** ❒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** **Other cultural characteristics** *(e.g., SES, religion)***:** **Language***(s)***:** **Region** *(e.g., rural, urban)***:** **Other characteristics** *(not included above)***:**
Essential Components	**Theoretical basis:** **Key components:**
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** ❒ **Yes** ❒ **No** ❒ **Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)***.** _____ **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** ❒ **Yes** ❒ **No** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***?** ❒ **Yes** ❒ **No** **If YES, please include citation:** **Has this intervention been presented at scientific meetings?** ❒ **Yes** ❒ **No** **If YES, please include citation***(s)* **from last five presentations:** **Are there any general writings which describe the components of the intervention or how to administer it?** ❒ **Yes** ❒ **No**

Appendix A: General Information Intervention Template

NCTSN The National Child Traumatic Stress Network

ACRONYM: Name of Intervention

GENERAL INFORMATION

Clinical & Anecdotal Evidence continued	**If YES, please include citation:** **Has the intervention been replicated anywhere?** ❒ **Yes** ❒ **No** **Other countries?** *(please list)* **Other clinical and/or anecdotal evidence** *(not included above)*:	
Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Published Case Studies		
Pilot Trials/Feasibility Trials *(w/o control groups)*		
Clinical Trials *(w/control groups)*		
Randomized Controlled Trials		
Studies Describing Modifications		
Other Research Evidence		
Outcomes	**What assessments or measures are used as part of the intervention or for research purposes, if any?** **If research studies have been conducted, what were the outcomes?**	
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** **Supervision requirements** *(e.g., review of taped sessions)***?** **To ensure successful implementation, support should be obtained from:**	

Appendix A: General Information Intervention Template

NCTSN The National Child Traumatic Stress Network

ACRONYM: Name of Intervention

GENERAL INFORMATION

Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** **How/where is training obtained?** **What is the cost of training?** **Are intervention materials** *(handouts)* **available in other languages?** ❒ **Yes** ❒ **No** **If YES, what languages?** **Other training materials &/or requirements** *(not included above)***:**
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** **Other qualitative impressions:**
Contact Information	**Name:** **Address:** **Phone number:** **Email:** **Website:**
References	

Appendix B: Culture-Specific Information Intervention Template

NCTSN The National Child Traumatic Stress Network CULTURE-SPECIFIC INFORMATION	**ACRONYM:** Name of Intervention
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."** **Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.** **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?**
Language Issues	**How does the treatment address children and families of different language groups?** **If interpreters are used, what is their training in child trauma?** **Any other special considerations regarding language and interpreters?**
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?** **If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?**
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?** **If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** **What, if any, culturally specific issues arise when utilizing these assessment measures?**
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)***.** **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?**

Appendix B: Culture-Specific Information Intervention Template

NCTSN The National Child Traumatic Stress Network

ACRONYM: Name of Intervention

CULTURE-SPECIFIC INFORMATION

Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** **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?** **Are there cultural barriers to accessing this treatment** *(i.e., treatment length, family involvement, stigma, etc.)***?** **Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** **Are these barriers addressed in the intervention and how?** **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)***?**
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** **Has this guidance been provided in the writings on this treatment?** **Any other special considerations regarding training?**
References	

Appendix C: Treatment Protocol Classification System

A primary goal of this project was to establish a clear, criteria-based system for classifying interventions and treatments according to their theoretical, clinical, and empirical support. This system can be applied not only to the interventions presented in this report, but also can be used to judge the utility of other current treatments, as well as treatments to be developed in the future. Therefore, the classification system is a tool that can be used by practitioners and others to make decisions about the appropriateness of certain treatments that are not included in this report. It is helpful to keep in mind that this report reflects the state of knowledge at the time of writing. Hopefully, more research will be conducted testing the efficacy of existing interventions and protocols. As more research is completed, the classifications of treatments will likely change over time. Therefore, this treatment classification system should be viewed as a tool that can be applied to a dynamic area where the body of scientific information is constantly increasing.

The classification system uses criteria regarding a treatment's theoretical soundness, clinical support, professional acceptance, potential for harm, documentation, and empirical support to assign a summary classification score. A lower score indicates a greater level of support for the treatment protocol. The summary categories are:

1 = Well-supported, efficacious treatment for specific cultural groups

2 = Supported and probably efficacious treatment for specific cultural groups

3 = Supported and acceptable treatment for specific cultural groups

4 = Promising and acceptable treatment for specific cultural groups

5 = Innovative or novel treatment for specific cultural groups

6 = Concerning or worrisome treatment for specific cultural groups

Specific criteria for each classification system category are presented below:

1. Well-supported, Efficacious Treatment for Specific Cultural Groups

a. The treatment has a sound theoretical basis in generally accepted psychological principles applicable to specific cultural groups.

b. A substantial clinical-anecdotal literature exists indicating the treatment's value with child trauma victims and/or their families from specific cultural groups.

c. The treatment is generally accepted in clinical practice as appropriate for use with child trauma victims and/or their families from specific cultural groups.

Appendix C: Treatment Protocol Classification System

d. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

e. The treatment has a book, manual, or other available writings that specify the components of the treatment protocol and describe how to administer it.

f. At least two randomized, controlled treatment outcome studies (RCTs) have found the treatment protocol to be superior to an appropriate comparison treatment, or no different nor better than an already established treatment when used with child trauma victims and/or their families from specific cultural groups. The RCTs must have focused on the specific cultural group or must have enrolled a sufficiently large number of the target cultural group within their sample to evaluate differential efficacy for that cultural group.

g. If multiple treatment outcome studies have been conducted, the overall weight of evidence supports the efficacy of the treatment.

2. Supported and Probably Efficacious Treatment for Specific Cultural Groups

a. The treatment has a sound theoretical basis in generally accepted psychological principles applicable to specific cultural groups.

b. A substantial clinical-anecdotal literature exists indicating the treatment's value with child trauma victims and/or their families from specific cultural groups.

c. The treatment is generally accepted in clinical practice as appropriate for use with child trauma victims and/or their families from specific cultural groups.

d. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

e. The treatment has a book, manual, or other available writings that specify the components of the treatment protocol and describe how to administer it.

f. At least two studies utilizing some form of control without randomization (e.g., matched wait list, untreated group, placebo group) have established the treatment's efficacy over the passage of time; efficacy over placebo; or, found it to be comparable to or better than an already established treatment when used with child trauma victims and/or their families from specific cultural groups. The studies must have focused on the specific cultural group or must have enrolled a sufficiently large number of the target cultural group within their sample to evaluate differential efficacy for that cultural group.

g. If multiple treatment outcome studies have been conducted, the overall weight of evidence supports the efficacy of the treatment.

Appendix C: Treatment Protocol Classification System

3. Supported and Acceptable Treatment for Specific Cultural Groups

a. The treatment has a sound theoretical basis in generally accepted psychological principles applicable to specific cultural groups.

b. A substantial clinical-anecdotal literature exists indicating the treatment's value with child trauma victims and/or their families from specific cultural groups.

c. The treatment is generally accepted in clinical practice as appropriate for use with child trauma victims and/or their families from specific cultural groups.

d. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

e. The treatment has a book, manual, or other available writings that specify the components of the treatment protocol and describe how to administer it.

f1. At least one group study (controlled or uncontrolled), or a series of single subject studies suggest the efficacy of the treatment with child trauma victims and/or their families from specific cultural groups, OR

f2. A treatment has demonstrated efficacy with non-trauma-related disorders, has a sound theoretical basis for its use with child trauma victims and/or their families from specific cultural groups, but has not been tested or used extensively with child trauma victims and/or their families from specific cultural groups.

g. If multiple outcome studies have been conducted, the overall weight of evidence supports the efficacy of the treatment.

4. Promising and Acceptable Treatment for Specific Cultural Groups

a. The treatment has a sound theoretical basis in generally accepted psychological principles applicable to specific cultural groups.

b. A substantial clinical-anecdotal literature exists indicating the treatment's value with child trauma victims and/or their families from specific cultural groups.

c. The treatment is generally accepted in clinical practice as appropriate for use with child trauma victims and/or their families from specific cultural groups.

d. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

Appendix C: Treatment Protocol Classification System

e. The treatment has a book, manual, or other available writings that specify the components of the treatment protocol and describe how to administer it.

5. Innovative or Novel Treatment for Specific Cultural Groups

a. The treatment may have a theoretical basis that involves innovative or novel, but reasonable, application of generally accepted psychological principles applicable to specific cultural groups.

b. A relatively small clinical literature exists to suggest the value of the treatment with child trauma victims and/or their families from specific cultural groups.

c. The treatment is not widely used or generally accepted by practitioners working with abused children with child trauma victims and/or their families from specific cultural groups.

d. There is no clinical or empirical evidence or theoretical basis suggesting that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

e. The treatment has a book, manual, or other available writings that specify the components of the treatment protocol and describe how to administer it.

6. Concerning or Worrisome Treatment for Specific Cultural Groups

a. The theoretical basis for the treatment is unknown; or the treatment represents a misapplication of psychological principles, or a novel, unique, and concerning or worrisome application of psychological principles as applied to child trauma victims and/or their families from specific cultural groups.

b. Only a very small and limited clinical literature exists suggesting the value of the treatment with child trauma victims and/or their families from specific cultural groups.

c. There is a reasonable theoretical, clinical, or empirical basis suggesting that compared to its likely benefits, the treatment constitutes a risk of harm to those receiving it.

d. The treatment has a manual or other writings that specify the components and administration characteristics of the treatment that allow for implementation.

AF-CBT: Abuse-Focused Cognitive Behavioral Therapy for Child Physical Abuse

Treatment Description

Acronym *(abbreviation)* **for intervention:** AF-CBT

Average length/number of sessions:
The delivery of treatment is organized into three phases:

- Phase 1: Psychoeducation and Engagement
- Phase 2: Individual and Family Skills Training
- Phase 3: Family Applications

Treatment generally involves 12 to 24 hours of service over a period of 12 to 24 weeks and is applied in the clinic or home. Modalities of treatment have included parallel individual and family therapy sessions. Group treatment is also an option.

Aspects of culture or group experiences that are addressed *(e.g., faith/spiritual component, transportation barriers)***:**
Parental history of being disciplined as a child and of disciplining one's own children; perspectives on the appropriate use of violence and the role of violence in media and family relationships; stressful life experiences from the perspective of each family member; community support and resources. Additional components related to cultural awareness and respect for cultural differences are in process. A research project completed in 2007 surveyed African-American stakeholders in the child welfare system and community at-large to determine their perspectives on clinical skills that contribute to professional competency with regard to culture and race. Their feedback will be incorporated into the engagement and behavioral management sections of the AF-CBT model.

Trauma type *(primary)*: Physical abuse and exposure to harsh/excessive physical punishment (use of coercion/physical force)

Trauma type *(secondary)*: Ongoing family conflict

Additional descriptors *(not included above)***:**
AF-CBT represents an approach to working with physically abused children and their offending caregivers that incorporates therapeutic principles/procedures from several areas, including learning/behavioral theory, family-systems, cognitive therapy, and developmental victimology. It was developed in an urban setting with primarily low-income families. AF-CBT integrates several behavior therapy and CBT procedures that target individual child and parent characteristics related to the abusive experience and the larger family context in which coercion or physical force/aggression occurs. Thus, this approach can be used to address parent and family risks for/correlates of physical abuse and/or common sequelae exhibited by children following the abuse. Treatment emphasizes instruction in specific intrapersonal (e.g., cognitive, affective) and interpersonal (e.g., behavioral) skills designed to promote the expression of prosocial behavior and discourage the use of coercive/abusive behavior at both the individual and family levels. For a detailed description, see Kolko & Swenson, 2002.

AF-CBT: Abuse-Focused Cognitive Behavioral Therapy for Child Physical Abuse

Target Population	**Age range:** School-age children **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)*: Treatment is not specifically designed for any one ethnic/racial group, but has been used extensively with urban African-American families and reviewed with several African-American stakeholders in a systematic series of studies that evaluated the relevance and utility of its content/process. **Other cultural characteristics** *(e.g., SES, religion)*: Primarily, but not exclusively, modest to low-income families **Language***(s)*: Mostly English-speaking **Region** *(e.g., rural, urban)*: Rural and urban populations **Other characteristics** *(not included above)*: AF-CBT is appropriate for use with physically coercive/abusive parents and their school-age children. Although it has been primarily used in outpatient settings, the treatment can be delivered on an individual basis in alternative residential settings, especially if there is some ongoing contact between caregiver and child. This approach is designed for caregivers who exhibit, for example, negative child perceptions, heightened anger or hostility, and/or harsh/punitive/ineffective parenting practices, or for families involved in verbally or physically coercive interactions. Related methods are designed for use with physically abused children who present with externalizing behavior problems, notably aggressive behavior, coping skills/adjustment problems, poor social competence, internalizing symptoms, and developmental deficits in relationship skills. Parents with serious psychiatric or personality impairments (e.g., substance use disorders, major depression) may benefit from adjunctive and/or alternative interventions. In addition, children or parents with limited intellectual functioning, or very young children may benefit from more simplified services or translations of key concepts. Children with psychiatric disorders (e.g., Attention Deficit Hyperactivity Disorder, Major Depressive Disorder) may benefit from additional interventions, and traumatized children, especially sexually abused children, may be more appropriate candidates for Trauma-Focused CBT.
Essential Components	**Theoretical basis:** Learning/behavioral theory, family-systems, cognitive therapy, and developmental victimology **Key components:** Child-directed components • Disclosure of incidents involving hostility and physical force/abuse (causes, characteristics and consequences) to help child understand the context in which they occurred

Essential Components continued

- Cognitive processing of key experiences to address potential consequences (i.e., views supportive of aggression, attributions of self-blame, etc.) that could maintain use of physical force/abuse
- Training in affect identification, expression, and management skills (e.g., relaxation training, anger control)
- Coping skills discussion and training (healthy vs. unhealthy coping) to address everyday problems (e.g., home, school)
- Social/interpersonal skills training to enhance social competence and development of social support plans

Caregiver/Parent-directed components

- Engagement/rapport-building that includes discussion of family of origin issues and current family circumstances
- Discussion of current referral reasons/child's disclosure, and family contributors to coercive behaviors
- Cognitive processing of caregiver's views on hostility/violence (attributions/beliefs) and child-related developmental expectations that may promote coercive interactions
- Training in affect-regulation skills to manage reactions to abuse-specific triggers (e.g., escalating anger, anxiety, or depression)
- Training in behavior management principles and practices/strategies (e.g., reinforcement and punishment) that serve as alternatives to using physical discipline

Parent-Child or Family-System directed components

- Treatment orientation and socialization to the role of stress and CBT model (A-B-C's)
- Psychoeducation about child abuse laws, child safety/welfare, and common abuse-related reactions/attributions to address potential consequences (i.e., views supportive of aggression, attributions of self-blame, etc.) that could maintain use of physical force/abuse
- Development of agreement for family to refrain from or limit use of physical force ("no-force" or "low/less" force) and to discuss any such incidents in the family
- Clarification sessions to establish responsibility for the abuse, focus treatment on the needs of the victims/family, and develop safety and relapse prevention plans, as needed
- Communication skills training to encourage constructive and supportive interactions
- Prosocial (nonaggressive) problem-solving skills training to minimize coercion, with home practice applications to help family incorporate them in everyday routines

Clinical & Anecdotal Evidence

Are you aware of any suggestion/evidence that this treatment may be harmful?
❒ **Yes** ☒ **No** ❒ **Uncertain**

Extent to which cultural issues have been described in writings about this intervention *(scale of 1-5 where 1=not at all to 5=all the time)***.** 2

This intervention is being used on the basis of anecdotes and personal communications only *(no writings)* **that suggest its value with this group.**
❒ **Yes** ☒ **No**

Are there any anecdotes describing satisfaction with treatment, drop-out rates *(e.g., quarterly/annual reports)***?** ☒ **Yes** ❒ **No**

If YES, please include citation: see articles below

Has this intervention been presented at scientific meetings? ☒ **Yes** ❒ **No**

If YES, please include citation*(s)* **from last five presentations:**
APSAC, ABCT, San Diego Conference, others.

Are there any general writings which describe the components of the intervention or how to administer it? ☒ **Yes** ❒ **No**

If YES, please include citation: AF-CBT Implementation Guide, v.2.2; Kolko, 1996a; Kolko, 1996b; Kolko, 2002; Kolko & Swenson, 2002

Has the intervention been replicated anywhere? ☒ **Yes** ❒ **No**
AF-CBT has been applied in several other clinical and academic settings. Reports from trained practitioners generally indicate positive results in terms of clinical improvements (e.g., reductions in parental use of force/abusive behavior, improved parent-child relationships), and successful case closures within the CPS system.

Other countries? *(please list)* Canada, Germany, Holland, Israel

Other clinical and/or anecdotal evidence *(not included above)***:**
Descriptions of the materials included in the book provide examples of their general application on an outpatient basis in addition to specific suggestions for cases that may require adaptations or special circumstances. Overall, the outcomes of these and related interventions have been fairly robust across different child and caregiver demographic background variables (e.g., age, gender, ethnicity, intellectual functioning and family constellation.) However, specific applications to specific cultural groups or settings have not been formally reported.

AF-CBT: Abuse-Focused Cognitive Behavioral Therapy for Child Physical Abuse

Research Evidence	Sample Size (N) and Breakdown *(by gender, ethnicity, other cultural factors)*	Citation
Pilot Trials/Feasibility Trials *(w/o control groups)*	**N=**150	SAMHSA pilot study conducted with Safe and Healthy Families Program, Intermountain Care, Salt Lake City, UT (manuscript in preparation)
Randomized Controlled Trials	**N=**55 children **By gender:** 72% male **By ethnicity:** 53% African-American or biracial	NCCAN Grant, 1990-1996; Kolko, 1996a; Kolko, 1996b
Studies Describing Modifications	1) Practictioners **N=**129 2) Children **N=**31 **By gender:** 1) 74% female 2) 77% male **By ethnicity:** 1) 70% Caucasian, 25% African-American, 2% Hispanic; 3% unknown 2) 57% Caucasian, 33% African-American, <1% Hispanic, 9% unknown	Ongoing treatment effectiveness trial (NIMH; 2006-2011)

Outcomes

What assessments or measures are used as part of the intervention or for research purposes, if any?

Several instruments may be used to evaluate factors in each of the following domains that may contribute to the risks for and/or consequences of child physical abuse (see Kolko & Swenson, 2002). An individualized assessment of this nature is encouraged to help the clinician better identify clinical targets for intervention:

Caregiver parenting practices, including the use of coercive, aggressive, or violent behaviors (e.g., harsh physical discipline) and positive management practice:

- Weekly Report of Abuse Indicators (WRAI; Kolko, 1996a)
- Conflict Tactics Scales—Parent to Child version (CTSPC; Straus et al., 1998)
- Alabama Parenting Questionnaire (APQ; Shelton et al., 1996)

Child social skills, interpersonal effectiveness, social withdrawal:

- Child Behavior Checklist (CBCL; Achenbach, 1991)
- Social Skills Rating Scale (SSRS; Gresham and Elliot, 1990)

Parental psychological distress and clinical targets

- Brief Symptom Inventory (BSI; Derogatis et al., 1983)
- Parent Opinion Questionnaire (POQ; Azar, 1986)

Children's behavioral and emotional problems

- Child Behavior Checklist (CBCL; Achenbach, 1991)
- Strengths and Difficulties Questionnaire (Bourdon, Goodman, Rae, Simpson & Koretz, 2005)
- Trauma Symptom Checklist for Children (TSCC; Briere, 1996)

Family functioning, especially levels of conflict and cohesion

- Family Environment Scale (FES; Moos et al., 1974)
- Family Adaptability Scales-II (FACES-II; Olson et al., 1982)

If research studies have been conducted, what were the outcomes?

Outcome evaluation can include the use of any of the above listed measures for follow-up assessment across a variety of domains (caregiver practices, child emotional and behavioral problems, family cohesion/conflict, etc.). Other measures may be found in Kolko, 2002.

Some of the methods incorporated in AF-CBT have been found efficacious in outcome studies conducted with various populations of parents, children, and families over the past three decades (see Chalk & King, 1998; Kolko, 2002). The individual and family approaches in AF-CBT were evaluated relative to routine community services (RCS) in a clinical trial that evaluated key outcomes through a one-year follow-up assessment. In an initial analysis comparing the treatment course of the two randomized conditions (individual CBT vs. family therapy; see Kolko, 1996a), weekly ratings of parents' use of physical discipline/force and anger problems were found to decrease significantly faster among the individual child and parent CBT cases than those receiving family treatment, but both showed significant improvements over time.

AF-CBT: Abuse-Focused Cognitive Behavioral Therapy for Child Physical Abuse

Outcomes continued	In terms of overall clinical outcomes through follow-up (Kolko, 1996b), both the individual CBT and family therapy conditions reported significantly greater improvements than RCS on certain child (i.e., less child-to-parent aggression, child externalizing behavior), parent (i.e., child abuse potential, individual treatment targets reflecting abusive behavior, psychological distress, drug use), and family outcomes (i.e., less conflict, more cohesion.) The official recidivism rates for CBT and family were lower (5-6%) than the rate for RCS (30%). Both CBT and family therapy had high consumer satisfaction ratings.
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** Clinicians are encouraged to review the book and maintain copies of relevant materials for efficient use during sessions. It is also helpful to develop tapes for later review during supervision. Clinicians who reach integrity ratings of 75 percent with at least two cases should be adequately competent to administer the treatment. Having a confidential space for conducting sessions, access to clinical supervision, and a system for monitoring and responding to clinical emergencies are important aspects of a clinician's general readiness for this work. **Supervision requirements** *(e.g., review of taped sessions)***?** We encourage bi-weekly supervision for the first six-12 months to review case progress, issues, and obstacles **To ensure successful implementation, support should be obtained from:** Dr. Kolko, Western Psychiatric Institute and Clinic, University of Pittsburgh School of Medicine
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** AF-CBT Implementation Guide, AF-CBT Session at a Glance, AF-CBT Session Guide and Handouts; all available from Dr. Kolko. **How/where is training obtained?** Training is intended for mental health professionals with at least some advanced training in psychotherapy skills/methods and experience working with physically abusive caregivers and their children. Participants are encouraged to review a brief summary of the treatment approach beforehand; whenever possible, it is desirable to become familiar with the materials in the author's book, which provides more detail on assessment and treatment methods. In addition, a pretraining assessment survey is administered to gain an understanding of therapist's practices and knowledge. Training generally involves at least six hours of didactic instruction. We strongly advise additional training experiences, including follow-up consultation and supervision on the implementation of AF-CBT with a small caseload; the duration of this experience may vary by level of experience and case difficulty (typical range: six to 18 hours over three to six months). Contact Dr. Kolko to discuss training opportunities.

AF-CBT: Abuse-Focused Cognitive Behavioral Therapy for Child Physical Abuse

Training Materials & Requirements continued	**Are intervention materials** *(handouts)* **available in other languages?** ❒ **Yes** ☒ **No** Not yet; we are working on a Spanish version.
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** Comprehensive content for children, parents, and families; focus on general use of physical force including child physical abuse; structured session guide with handouts to facilitate implementation. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** Requires clinician decision-making about what content should be emphasized. **Other qualitative impressions:** Based on independent supervisor ratings from the author's original clinical trial (Kolko, 1996a), high levels of therapeutic integrity have been found among trained master's-level clinicians who have conducted individual CBT (81 percent) and family treatment (85 percent). A simplified version of this integrity checklist for community application is being developed by the author.
Contact Information	**Name:** David J. Kolko, PhD **Address:** University of Pittsburgh, School of Medicine **Phone number:** (412) 246-5888 **Email:** kolkodj@upmc.edu **Website:** www.pitt.edu/~kolko
References	Achenbach, T. M. (1991). *Integrative guide to the 1991 CBCL/4-18, YSR, and TRF profiles.* Burlington, VT: University of Vermont, Department of Psychology. Azar, S. T. & Rohrbeck, C. A. (1986). Child abuse and unrealistic expectations: Further validation of the Parent Opinion Questionnaire. *Journal of Consulting and Clinical Psychology, 54*, 867-868. Bourdon, K. H., Goodman R., Rae, D. S., Simpson, G. & Koretz, D. S. (2005). The Strengths and Difficulties Questionnaire: U.S. normative data and psychometric properties. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*, 557-564. Briere, J. (1996). *Trauma Symptom Checklist for Children (TSCC) professional manual.* Odessa, FL: Psychological Assessment Resources. Chalk, R. & King, P. A. (Eds.). (1998). *Violence in families: Assessing prevention and treatment programs.* Washington D.C.: National Academy Press. Derogatis, L. R. & Melisaratos, N. (1983). The Brief Symptom Inventory: An introductory report. *Psychological Medicine, 13*, 595-605.

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Kolko, D. J. & Swenson, C. C. (2002). *Assessing and treating physically abused children and their families: A cognitive behavioral approach.* Thousand Oaks, CA: Sage Publications.

Moos, R. H., Insel, P. M. & Humphrey, B. (1974). *Combined preliminary manual: Family, work and group environment scales.* Palo Alto, CA: Consulting Psychologists Press.

Olson, D. H., Portner, J. & Bell, R. Q. (1982). *FACES II: Family Adaptability and Cohesion Evaluation Scales.* Minneapolis, MN: Family Social Science, University of Minnesota.

Straus, M. A., Hamby, S. L., Finkelhor, D., Moore, D. W. & Runyan, D. (1998). Identification of child maltreatment with the Parent-Child Conflict Tactics Scales: Development and psychometric data for a national sample of American parents. *Child Abuse and Neglect, 22*, 249-270.

Shelton, K. K., Frick, P. J. & Wootton, J. (1996). Assessment of parenting practices in families of elementary school-age children. *Journal of Clinical Child Psychology, 25,* 317–329.

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."** No one group specifically. However, the materials have been reviewed systematically over the past four years in two funded projects designed to adapt the materials for use with African-American families/practitioners. In addition, the treatment generally has been used with families having modest to low SES levels. **Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.** No, not for any specific group, especially given that this intervention has been used with families from numerous cultural and ethnic backgrounds. Instead, our initial engagement phase includes references to learning about the family's history and cultural background, including attention to cultural views about children, physical discipline, and other issues related to management. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** There is a heavy emphasis upon trust and relationship development, learning about each family's unique history and language/terms, and parental family of origin issues.
Language Issues	**How does the treatment address children and families of different language groups?** The clinician should determine if the family is able to comprehend fully in the family's language system, and, if not, an effort should be made to seek an interpreter. **If interpreters are used, what is their training in child trauma?** We have used interpreters in several languages and they are introduced to the session guide and provided with an explanation of the overall purpose and methods of the treatment. **Any other special considerations regarding language and interpreters?** Therapists are encouraged to learn the family's perspective on discipline and their terms for referring to disciplinary methods.
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?** No. We did not find differences among the few subgroups in our original study.

AF-CBT: Abuse-Focused Cognitive Behavioral Therapy for Child Physical Abuse

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?** We have used similar measures across Caucasian and African-American groups, which yield no significant group differences, but the sizes of the samples do not yield adequate normative data. **If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** Individualized assessments are combined with interviews designed to identify specific treatment targets. **What, if any, culturally specific issues arise when utilizing these assessment measures?** Having minimal familiarity with English; being less familiar with North American customs/norms and having different values in terms of the role of parents, women, and children; perspectives that support the appropriateness of harsh physical discipline, including authoritarian parenting style.
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** We do include some references in our session guide to understanding the family's background, including cultural identity and parental family of origin issues. **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)***.** No, but the materials have been adapted based on feedback from several African-American stakeholder subgroups. **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?** It has been examined and there is no differential drop-out.
Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** It includes attention to exposure to family violence and psychological abuse in both the assessment and engagement phases. **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 appropriate for and commonly used in both clinic and community settings. The original outcome study was conducted in both settings.

Intervention Delivery Method/ Transportability & Outreach continued	**Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** Nothing specific. **Are these barriers addressed in the intervention and how?** N/A **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)***?** We encourage liaisoning with other community providers involved with the family and making outside referrals at termination.
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** The family's language, personal values, roles of children, use of discipline and punishment, family of origin history. **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** This is discussed in relationship to what the clinician sees as potential differences of opinion in their understanding of the nature of the case and the perceived quality of the clinician's relationship to the family. **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** This is discussed in the initial engagement phase devoted to enhancing trust/rapport and understanding family of origin/background issues. **Has this guidance been provided in the writings on this treatment?** Only briefly, in the session guide and background sourcebook. **Any other special considerations regarding training?** We provide consultation during the training phase with pilot cases to examine relationship and engagement issues. We have trained clinicians from varying ethnic backgrounds and found them to be extremely interested and skilled in this approach, which they seem to be able to fit to the circumstances of their families.

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GENERAL INFORMATION

DBT-SP: Adapted Dialectical Behavior Therapy for Special Populations

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** DBT-SP **Average length/number of sessions:** 18 sessions per skill group **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** Adapted to meet the needs of youth with impaired cognitive functioning **Trauma type** *(primary)*: Various **Trauma type** *(secondary)*: Various **Additional descriptors** *(not included above)***:** This treatment addresses general symptoms of trauma rather than being a method of processing a specific trauma.
Target Population	**Age range:** 8 **to** 12 **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** Persons with developmental disabilities **Other cultural characteristics** *(e.g., SES, religion)***:** Other groups that experience difficulty processing complex verbal and visual information **Language***(s)***:** English **Region** *(e.g., rural, urban)***:** Urban
Essential Components	**Theoretical basis:** Cognitive Behavioral **Key components:** Emotion Regulation, Distress Tolerance, Relationship Effectiveness and Mindfulness
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** ❒ **Yes** ☒ **No** ❒ **Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)***.** 3 **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** ❒ **Yes** ☒ **No** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***?** ☒ **Yes** ❒ **No** **If YES, please include citation:** Charlton, 2006a

DBT-SP: Adapted Dialectical Behavior Therapy for Special Populations

Clinical & Anecdotal Evidence continued	**Has this intervention been presented at scientific meetings?** ☒ Yes ❒ No **If YES, please include citation***(s)* **from last five presentations:** National Association for the Dually Diagnosed: Charlton, 2006b; Charlton, 2007 **Are there any general writings which describe the components of the intervention or how to administer it?** ☒ Yes ❒ No **If YES, please include citation:** Dykstra & Charlton, 2003 **Has the intervention been replicated anywhere?** ❒ Yes ☒ No **Other clinical and/or anecdotal evidence** *(not included above)***:** Pilot data collected at Intercept Center, Aurora Mental Health Center (MHC)	
Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Pilot Trials/Feasibility Trials *(w/o control groups)*	**N=**16 **By gender:** 3 females and 13 males	Intercept Center; Aurora MHC
Training Materials & Requirements	**How/where is training obtained?** Implementation requires initial training in the standard DBT model, before implementation of the adaptations is possible **What is the cost of training?** Standard DBT training is offered through Behavioral Technology **Are intervention materials** *(handouts)* **available in other languages?** ❒ Yes ☒ No	
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** Addresses intellectual and processing barriers that may limit usefulness of the original materials for this population **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** The modifications have not yet been fully tested to demonstrate their effectiveness	

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GENERAL INFORMATION

DBT-SP: Adapted Dialectical Behavior Therapy for Special Populations

Contact Information	**Name:** Margaret Charlton, PhD, ABPP **Address:** Aurora Mental Health Center, Intercept Center, 11023 E. 5th Avenue, Aurora, CO 80010 **Phone number:** (303) 326-3748 **Email:** MargaretCharlton@aumhc.org
	Name: Eric Dykstra, Psy.D. **Address:** Hope Network Institute for Neurodevelopmental Differences, Developmental Adolescent Treatment Program, 3333 36th St. SE, Grand Rapids, MI 49512
References	Charlton, M. (2006a). Dialectical behavior therapy for children with developmental disabilities. *NADD Bulletin, 9*(5), 90-93. Charlton, M. (2006b). *Dialectical Behavior Therapy for children with developmental disabilities.* Presented at the National Association for the Dually Diagnosed, 23rd Annual Conference, San Diego, CA. Charlton, M. (2007, January). *Dialectical Behavior Therapy adapted for people with developmental disabilities.* Presented at the 23rd Annual San Diego International Conference on Child and Family Maltreatment. Chadwick Center for Children and Families, San Diego, CA. Dykstra, E. & Charlton, M. (2003). *Dialectical Behavior Therapy Skills Training: Adapted for special populations.* Unpublished manuscript.

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."** Youth with intellectual disabilities (developmental disabilities) **Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.** At this point, we have attempted to adapt DBT for use with youth who have ID, but we have not yet started working to address the needs of youth with intellectual disabilities (ID) who belong to specific other cultural groups. This work is planned for after our current adaptations have been researched. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** The current engagement strategies are specific to working with youth who have ID. They include using simplified handouts for skills training, restructuring the balance between the individual and group therapy components of the model, providing more time for role play exercises and for repetition of material.
Language Issues	**How does the treatment address children and families of different language groups?** Not yet. Addressing different language groups is planned once our initial work on the English version is completed. **If interpreters are used, what is their training in child trauma?** We have not yet used interpreters with DBT-SP. **Any other special considerations regarding language and interpreters?** Not at this time.
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?** In our work, we have found that youth with ID tend to be more vulnerable to the effects of trauma. They are less likely to be resilient and to recover spontaneously. **If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?** Following trauma, youth with ID tend to display increased difficulty with emotion regulation, distress tolerance and interpersonal relationships, which are addressed in the skill building components of the DBT-SP model.

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?** No, we are using an adapted daily diary sheet to assess all groups. **If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** This measure is not used to make outcome judgments. **What, if any, culturally specific issues arise when utilizing these assessment measures?** The daily diary sheet has been simplified for use with youth who have limited reading and writing skills.
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** Issues related to the challenges experienced by youth with intellectual disabilities are addressed. **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)***.** Only the adaptation for youth with intellectual disabilities 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?** We have not examined this yet, due to the small size of our current sample.
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?** We have used it effectively in an outpatient clinic environment, but it would probably be difficult to transport into the home or community. However, homework assignments encourage youth to use the skills they learn at the clinic in other environments. **Are there cultural barriers to accessing this treatment** *(i.e., treatment length, family involvement, stigma, etc.)***?** We don't have data on this issue yet. **Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** The treatment is currently being provided primarily for clients who have Medicaid. There are some barriers to accessing treatment due to limitations on treatment placed by other insurance providers.

Intervention Delivery Method/ Transportability & Outreach continued	**Are these barriers addressed in the intervention and how?** Not at this time. **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)***?** We have not developed a community role.
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** We provide ongoing supervision for clinicians at our facility as they learn this model to ensure that they have the necessary skills for adapting their treatment interventions for use with youth who have intellectual disabilities in a way that is consistent with the DBT-SP model. **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** Cultural issues between supervisor and supervisee are addressed on an ongoing basis in training, but do not have a direct relationship to implementation of this adaptation, since the focus here is on adaptation for clients who have intellectual disabilities. **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** N/A **Has this guidance been provided in the writings on this treatment?** No **Any other special considerations regarding training?** No

NCTSN The National Child Traumatic Stress Network

GENERAL INFORMATION

TAP: Assessment-Based Treatment for Traumatized Children: Trauma Assessment Pathway

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** TAP **Average length/number of sessions:** Session length varies based upon the clinical intervention(s) selected. **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** Ethnicity/race factors are considered in terms of the client's role in the family and community as well as their own level of acculturation and special considerations for treatment and symptom presentation as it relates to culture. Considerations for assessing different cultural groups are included. **Trauma type** *(primary)*: Child maltreatment **Trauma type** *(secondary)*: Complex trauma **Additional descriptors** *(not included above)***:** All forms of childhood trauma are addressed within the model.
Target Population	**Age range:** 2 **to** 18 **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** TAP can be used with Latinos and other Spanish-speaking populations. The model can also be adapted for use with other ethnic and cultural groups. **Other cultural characteristics** *(e.g., SES, religion)***:** N/A **Language***(s)***:** English and Spanish **Region** *(e.g., rural, urban)***:** Any **Other characteristics** *(not included above)***:** N/A
Essential Components	**Theoretical basis:** Developmental, systems, and cognitive-behavioral theories **Key components:** Assessment, Triaging Clients, Forming Clinical Hypotheses, Evidence-Supported Clinical Interventions.
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** ❒ **Yes** ☒ **No** ❒ **Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)***.** 3 **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** ❒ **Yes** ☒ **No**

Clinical & Anecdotal Evidence continued

Are there any anecdotes describing satisfaction with treatment, drop-out rates *(e.g., quarterly/annual reports)***?** ☒ **Yes** ❒ **No**

If YES, please include citation: Every month satisfaction rates are reported in Chadwick Center reports to team leaders. The Chadwick Center, Satisfaction Report, August 2006, reported satisfaction results for 14 therapists utilizing assessment-based treatment as described in the TAP model. Over 90% of parents reported being mostly to very satisfied in these surveys. In addition, satisfaction rates for clients triaged to TF-CBT were reported in the Breakthrough Series Collaborative monthly metrics (BSC Improvement Metrics, April 2006). One hundred percent of the caretakers triaged using techniques of the TAP model reported being satisfied with the treatment they received.

Has this intervention been presented at scientific meetings? ☒ **Yes** ❒ **No**

If YES, please include citation*(s)* **from last five presentations:**
San Diego International Conference on Child and Family Maltreatment: Conradi & Hazen, 2008; Gilbert & Taylor, 2006

International Society for Traumatic Stress Studies (ISTSS): Gilbert & Killen-Harvey, 2007

Are there any general writings which describe the components of the intervention or how to administer it? ☒ **Yes** ❒ **No**

If YES, please include citation: Taylor, Gilbert, Mann & Ryan, 2006

Has the intervention been replicated anywhere? ☒ **Yes** ❒ **No**
The intervention has been tested within the Chadwick Center and is being replicated at three other sites across the United States (Laredo, Texas; Tulsa, Oklahoma, Albany, Georgia and Houston, TX).

Other countries? *(please list)* N/A

Other clinical and/or anecdotal evidence *(not included above)***:** None

Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Clinical Trials *(w/control groups)*	**N=**59 (quasi-experimental, non-randomized)	
Randomized Controlled Trials	**N=**55	Kolko, 1996a; Kolko, 1996b

Outcomes	**What assessments or measures are used as part of the intervention or for research purposes, if any?** Participants are administered a core set of measures based upon the specific site needs. Recommended measures include an adapted Core Clinical Characteristics Form which also serves as an intake form, the Trauma Symptom Checklist for Children, the Child Behavior Checklist for Children, and the UCLA PTSD Reaction Index. Additional measures are included within the model, depending upon the individual needs of the client. Family measures, cultural measures, measures of caretaker functioning, and measures of specific posttraumatic stress symptoms are among the domains assessed via the model. **If research studies have been conducted, what were the outcomes?** N/A
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** Access to a variety of assessment measures as well as the ability to score the measures (by hand or electronically) and a locked filing cabinet/storage space for the completed measures. **Supervision requirements** *(e.g., review of taped sessions)***?** The Clinical Supervisor at the site needs to be trained on the model and actively discuss the model within supervision sessions. As sites are implementing the TAP Model, it is recommended that they receive 3-6 months of consultation as needed on TAP after receiving training on each component (assessment, triage and treatment). Consultation includes case consultation as it pertains to each component of the model. **To ensure successful implementation, support should be obtained from:** Review of the TAP Manual as well as staff at the Chadwick Center.
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** www.chadwickcenter.org **How/where is training obtained?** The Chadwick Center staff provide training on the model. Contact Lisa Conradi, Psy.D. **What is the cost of training?** $1000 per day for up to 15 people. **Are intervention materials** *(handouts)* **available in other languages?** ❒ **Yes** ☒ **No** **Other training materials &/or requirements** *(not included above)***:** An electronic database that provides scoring information and feedback from assessment measures can be licensed. Also, a database that tracks clients throughout treatment is recommended, and can be obtained through the trainers.

TAP: Assessment-Based Treatment for Traumatized Children: Trauma Assessment Pathway

Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** This intervention allows the clinician to accurately assess the client's needs and select the best intervention for the individual client based upon the unique client picture. The model includes factors that are unique to the client's culture and factors that are unique to the individual apart from their culture. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** The model itself is complex and for sites to take full advantage of the model, clinicians should be trained in a variety of different evidence-based practices and be open to using assessment measures in their clinical practice. **Other qualitative impressions:** The Supervisor needs to be trained on the intervention and assessment measures to be able to help clinicians use the model effectively to either triage to an existing evidence-based practice or to utilize the treatment component of the model.
Contact Information	**Name:** Lisa Conradi, Psy.D. **Address:** 3020 Children's Way, MC 5131, San Diego, CA 92123 **Phone number:** (858) 576-1700 ext. 6008 **Email:** lconradi@rchsd.org **Website:** www.taptraining.net, www.chadwickcenter.org
References	Conradi, L. & Hazen, A. (2008, January). *Evaluating the Trauma Assessment Pathway (TAP) Model.* Presented at the 22nd Annual San Diego International Conference on Child and Family Maltreatment, San Diego, CA. Gilbert, A. & Killen-Harvey, A. (2007, November). *Assessment-based treatment for traumatized children: Using the Trauma Assessment Pathway (TAP) Model.* Presented at the 23rd Annual ISTSS Annual Meeting, Baltimore, MD. Gilbert, A. & Taylor, N. (2006, January). *Assessment-based treatment for traumatized children: A Trauma Assessment Pathway Model (TAP): Integrating standardized assessment and trauma-focused treatment.* Presented at the 20th Annual San Diego International Conference on Child and Family Maltreatment, San Diego, CA. Kolko, D.J. (1996a). Clinical monitoring of treatment course in child physical abuse: Psychometric characteristics and treatment comparisons. *Child Abuse & Neglect, 20,* 23-43. Kolko, D.J. (1996b). Individual cognitive-behavioral treatment and family therapy for physically abused children and their offending parents: A comparison of clinical outcomes. *Child Maltreatment, 1,* 322-342. Taylor, N., Gilbert, A., Mann, G., & Ryan B.E. (2006, July). *Assessment-based treatment for traumatized children: A trauma assessment pathway.* Chadwick Center for Children & Families, Children's Hospital-San Diego. Retrieved September 8, 2006 from www.chadwickcenter.org.

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."** Because the TAP model provides strategies to create a "Unique Client Picture" it is specifically tailored to accommodate all different cultural groups. Clinicians are provided with a framework for approaching client assessment, triage and treatment, emphasizing unique aspects of the client's history and personality, and the client's family and social environment and culture. The model provides resources and strategies for creating a Unique Client Picture. The most specific information and guidelines are provided for different races/ethnic groups, with an emphasis on language and validity/reliability issues surrounding assessment. Guidelines are also presented in terms of treatment and engagement into therapy. **Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.** Engagement is addressed through assessment and through initial rapport-building strategies. Culture is integrated into both of these processes. Assessment strategies are selected based upon the translations available and the reliability and validity of the different translations with different cultural groups. Strategies for administering assessment measures may be modified based upon the client's cultural group and the way that these groups interact with mental health professionals. Clinicians are provided with guidelines for adapting engagement strategies in working with different cultural groups. Specifically, they are encouraged to become educated concerning the values and experiences of different groups and to translate this by clinically conveying acceptance, respect, and understanding to the client. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** The therapeutic portion of the TAP manual includes a section on Relationship Building. This portion of the manual specifically addresses issues related to building trust and directs clinicians to develop cultural competence for all client populations served and to utilize the information gathered in relationship building activities. Clinicians modify their rapport-building strategies to meet the client's unique needs. TAP also considers assessment to be part of the engagement process, and clinicians are instructed in how to select appropriate measures for children of different ages and cultural groups, how to administer, score and interpret them for the specific population being served, and how to provide appropriate feedback, taking into consideration individual and cultural factors related to specific cases.

Language Issues	**How does the treatment address children and families of different language groups?** The first segment of the TAP model deals with assessment of traumatized children. Centers seek out measures that have been translated into different languages, and reviewed for translation quality. Issues related to reliability and validity of different language translations are considered within this process. In terms of treatment, the TAP model specifies that therapy should be conducted in the language that the child and his/her caregivers feel most comfortable using. **If interpreters are used, what is their training in child trauma?** The TAP model does not include guidelines concerning the use of interpreters. **Any other special considerations regarding language and interpreters?** It is recommended that whenever possible, therapy be conducted in the client's native language. When interpreters must be used, it is recommended that family members or others who are involved with the family are not placed into the role of translator.
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 suggests that many different cultural groups manifest trauma symptoms in different ways. The TAP model provides a strategy for approaching individuals from different cultural groups. TAP includes guidelines for identifying appropriate measures for use with different populations and resources for finding appropriate assessment measures/strategies. Measures are selected in the client's native language. The measures are reviewed to ensure that, whenever possible, they have been validated or normed on the populations served. Although the TAP model can be modified for use with a variety of cultural groups, the current manual provides more in-depth information related to the Hispanic population. Specifically, trauma-specific measures with research supporting their use with Hispanic populations have been identified and included as resources. **If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?** The TAP model includes a treatment component called a "trauma wheel." The wheel includes a variety of different components that are central to treating traumatized victims. Cultural influences are identified as one of these aspects. Conceptualized as the "rim" of the trauma wheel, culture provides a framework for the therapeutic techniques that will be utilized with a client. Therapists are guided to consider client values and spirituality needs, language, acculturation, and cultural identity. The clinician assesses the client's view of the therapeutic process, from the perspective of the client's culture. Communication is modified to meet client needs, and terminology is reviewed to ensure that the interpretation is accurate for specific cultural groups. The therapist also considers the client's view of therapy, relationships and roles, and the therapist assesses the intergenerational and cultural transmission of trauma.

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?** The TAP model includes guidelines for using assessment measures across a variety of different cultural groups. Specific information is provided for use with Hispanic populations. Some of the Spanish-language measures used include the Trauma Symptom Checklist for Children (TSCC), the Trauma Symptom Checklist for Young Children (TSCYC), the Child Behavior Checklist for Children (CBCL), the Youth Self Report (YSR). These measures have been translated into Spanish and data exists for using these measures with Spanish populations. These measures are also appropriate for use with a variety of other cultures. The CBCL, for instance, has been translated for use with 68 different languages. In addition to these measures targeting symptoms, measures assessing culture-specific factors are recommended within TAP. Some of these include the ARSMA-II (Acculturation Rating Scale for Mexican Americans) and the SAFE Scale (Societal, Attitudinal, Familial, and Environmental Acculturative Stress Scale). Although the ARSMA-II was created to assess acculturation for Mexican Americans, it has been adapted for use with African Americans, Asian Americans, Armenians, and other Latino groups. The SAFE Scale was specifically designed and primarily focused on measuring acculturative stress in Latino children. When specific measures are adopted, clinicians are strongly encouraged to review all of the existing research pertaining to use of the measure within the specific cultural group. Resources are provided to guide the clinicians and the center through this process. **If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** In most cases there is not normative data for assessment measures that are translated from the original language. There is often research that allows new cut-off scores to be created, or enables clinicians to gain insight into the different ways in which individuals from different cultures might respond to specific items. Depending upon the information available concerning different measures, it is recommended that clinicians use modified scores or use information from the item-level in interpreting the measure. **What, if any, culturally specific issues arise when utilizing these assessment measures?** Several challenges arise in terms of using assessment measures with different cultures. Lack of funding for conducting research on these cultural measures creates challenges for those searching for appropriate measures. Often times, measures have poor translations, lack of appropriate norms, or translations that are not specifically created for the population being served. In addition, sometimes different family members are in different stages of acculturation. For this reason, in some cases a measure or translation that is appropriate for one family member may not be appropriate for another family member. Another challenge deals with reading levels for these measures. Some family members may not have the appropriate level of reading fluency to allow them to complete the measures accurately.

Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** Culture is specifically addressed in the manual as it relates to assessment, creating a Unique Client Picture, engagement, and treatment. Specific measures are recommended for use with Hispanic populations, and resources are presented to assist clinicians in identifying measures that are appropriate for use with other cultures. Measures assessing acculturation are presented. These measurement choices are built into an assessment pathway that is reviewed with each client. Culture is emphasized as a factor to be taken into consideration in hypothesizing about the client and their problems and treatment goals. This information is used to help the clinician form a Unique Client Picture. In terms of engagement and treatment, the TAP model reviews issues related to cultural competency and awareness and presents suggested treatment tasks for cultural awareness and competency and for relationship building. **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)***.** TAP provides a framework to seek out culture-specific adaptations for treatment models that might be appropriate for a client, or to adapt existing treatment strategies when a specific model is not available or appropriate. Guidelines presented assist trauma treatment centers in adapting existing treatment and assessment strategies for use with different and unique populations using pathways and algorithms. **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 specific research has been conducted examining differential dropout for different cultures utilizing TAP.
Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** The TAP model addresses safety and risk factors related to treating individual clients, and emphasizes the importance of focusing on high-risk situations first. Culture is a central component of the assessment framework and informs the clinician in conducting the risk assessment and in identifying the most pressing clinical issues to target in treatment. Culture is also considered in terms of identifying community resources and additional needs for referrals. **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 TAP model can be utilized in any setting, whether outpatient, inpatient, or home-based. Using algorithms within the TAP model, strategies would be adapted to meet needs unique to the treatment setting and the client.

Intervention Delivery Method/ Transportability & Outreach continued	**Are there cultural barriers to accessing this treatment** *(i.e., treatment length, family involvement, stigma, etc.)***?** Because the model is adapted based upon unique client needs, TAP is particularly conducive to addressing cultural barriers to accessing treatment. Treatment length can be modified based upon cultural requirements, and family involvement and perceptions of therapy are modified based upon the client's and family's needs and cultural perspective. **Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** Logistical barriers would vary depending upon the triage and treatment choices identified for different clients. TAP does not specifically address these issues. **Are these barriers addressed in the intervention and how?** Logistical barriers are not addressed in the TAP model. **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 TAP model identifies the community as a central aspect of the client's functioning in terms of resources and/or challenges. It is identified as a part of the Unique Client Picture. Issues related to community resources and challenges are assessed as part of the standard protocol within TAP. Community is also included in the therapy component of the model. Within the trauma wheel, treatment strategies targeting the community and family/cultural system are addressed based upon the client's Unique Client Picture. Through this process, clinicians gain the support of appropriate community resources.
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** A great deal of training related to TAP deals with researching and selecting assessment strategies that are appropriate for different cultural groups. Training sessions are tailored to address needs that are unique for different centers adopting the TAP model. Attendees are provided with known resources that are appropriate for different cultural groups. For instance, centers treating predominantly Hispanic families are provided with lists of existing measures that are used with these populations. The attendees are trained concerning specific issues to review in measurement selection, such as reliability, validity and translation quality/strategies and norms. When existing measures are unknown, attendees are provided with resources to conduct independent research in terms of measurement selection. Such resources include the NCTSN Measures Review Database. Cultural issues are also integrated into trainings related to triage and treatment. Appropriateness of different treatment strategies for different cultural groups are reviewed and issues related to engaging and treating different cultural groups are explored in a group format in training sessions.

Training Issues continued	**If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** The TAP model does not specifically address potential cultural issues between the supervisor and clinician. **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** The TAP model discusses the use of supervision in processing counter-transference issues between the client and clinician. Although culture is not specifically addressed in this section, it is alluded to through discussion of the Unique Client Picture and different unique aspects of a client's history and system that might influence the relationship between the client and clinician. **Has this guidance been provided in the writings on this treatment?** The manual includes specific cultural guidelines related to assessment selection, administration of assessment measures, and providing feedback to clients. In addition, cultural guidance is provided regarding understanding the client and forming a Unique Client Picture, building a relationship with the client, and integrating aspects of the client's culture into therapy. **Any other special considerations regarding training?** No.

NCTSN The National Child Traumatic Stress Network

GENERAL INFORMATION

ARC: Attachment, Self-Regulation, and Competency: A Comprehensive Framework for Intervention with Complexly Traumatized Youth

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** ARC **Average length/number of sessions:** Varies depending on client needs **Trauma type** *(primary)*: Sexual abuse **Trauma type** *(secondary)*: Physical abuse **Additional descriptors** *(not included above)*: ARC is a guideline for individuals working with traumatized children in the community. Interventions focus on building secure attachments, enhancing self regulatory capabilities, and increasing competencies across multiple domains. ARC targets children who have experienced chronic trauma such as sexual abuse, physical abuse, neglect, domestic violence, and community violence. Presenting problems typically include anxiety symptoms, depression, PTSD symptoms, bereavement/traumatic grief, sexualized behaviors, and multiple functional impairments.
Target Population	**Age range:** 5 **to** 17 **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)*: All **Other cultural characteristics** *(e.g., SES, religion)*: All **Language***(s)*: English (to date) **Region** *(e.g., rural, urban)*: ARC can be used in clinic, school, or community settings (transitional housing for homeless clients who have experienced domestic violence). Appropriate for urban and rural settings. **Other characteristics** *(not included above)*: ARC targets both male and female participants ranging from early childhood through school age and late adolescence. Participants to date represent all categories of race/ethnicity, including American Indian and Alaskan Native.
Essential Components	**Theoretical basis:** ARC proposes systematic interventions that are based in phase-oriented treatment approaches. **Key components:** Each area of focus (attachment, regulation, and competency) is grounded in trauma-informed interventions, techniques, and auxiliary treatment methods. Based upon the child/adolescent's needs and strengths, the practitioner chooses appropriate interventions from a menu. Therapeutic procedures include psychoeducation, relationship strengthening, social skills, and parent-education training as well as psychodynamic, cognitive, behavioral, relaxation, art/expressive, and movement techniques.

ARC: Attachment, Self-Regulation, and Competency: A Comprehensive Framework for Intervention with Complexly Traumatized Youth

Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** ❒ **Yes** ☒ **No** ❒ **Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)*. 1 **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** ❒ **Yes** ☒ **No** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***?** ☒ **Yes** ❒ **No** **If YES, please include citation:** Subsite progress report, February 2006 **Has this intervention been presented at scientific meetings?** ☒ **Yes** ❒ **No** **If YES, please include citation***(s)* **from last five presentations:** APSAC 2004, Boston Trauma Conference 2005, NCTSN All-Network Meeting 2005 **Are there any general writings which describe the components of the intervention or how to administer it?** ☒ **Yes** ❒ **No** **If YES, please include citation:** Kinniburgh, Blaustein, Spinazzola & van der Kolk, 2005 **Has the intervention been replicated anywhere?** ☒ **Yes** ❒ **No** Bethany Christian Services, Grand Rapids, Michigan; Los Angeles Child Guidance Clinic, Los Angeles, California; Anchorage Community Mental Health Center, Anchorage, Alaska; La Rabida Children's Hospital, Chicago, Illinois. **Other clinical and/or anecdotal evidence** *(not included above)***:** pending	
Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Pilot Trials/Feasibility Trials *(w/o control groups)*	**N=**estimated 300 children **By gender:** estimated even distribution **By ethnicity:** estimated varied	In process at 8 locations as part of current SAMHSA NCTSI project cycle

NCTSN The National Child Traumatic Stress Network

GENERAL INFORMATION

ARC: Attachment, Self-Regulation, and Competency: A Comprehensive Framework for Intervention with Complexly Traumatized Youth

Research Evidence	Sample Size (N) and Breakdown *(by gender, ethnicity, other cultural factors)*	Citation
Studies Describing Modifications	**N=**estimated 300 children **By ethnicity:** Alaskan Native; foster/adoptee; mixed urban ethnic sample: African-American, Latino, Asian	In process at 6 of the above locations
Other Research Evidence	**N=**estimated 12 children	Case studies pending

Outcomes

What assessments or measures are used as part of the intervention or for research purposes, if any?
NCTSN Core Dataset; Program-specific youth behavioral outcomes and indices.

If research studies have been conducted, what were the outcomes?
Initial formal evaluation on one sample completed. Results revealed a 50% reduction in PTSD symptoms as measured by the Clinician Administered PTSD Scale–Child Version. In addition, findings revealed reductions on all subscales of the Trauma Symptom Checklist, except the Sexual Concerns subscale.

Training Materials & Requirements

List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.
Kinninburgh & Blaustein, 2006
The manual can be obtained by contacting Margaret Blaustein at mblaustein@jri.org or at (617) 232-1303 ext. 214.

How/where is training obtained?
Via contract. Initial 2-day training can be provided at the Trauma Center in Brookline, MA or on-location throughout U.S. Follow-up consultation conducted bi-weekly or monthly as needed by telephone and email, with 1-2 advanced follow-up trainings (1-2 days/each) conducted on site.

What is the cost of training?
Depends on number of clinicians trained. Base rate=$6,000 plus travel costs for initial 2-day training with up to 20 attendees, or $300/person for larger groups (includes manuals). Follow-up telephone consultation sessions at $200/hr.

ARC: Attachment, Self-Regulation, and Competency: A Comprehensive Framework for Intervention with Complexly Traumatized Youth

Training Materials & Requirements continued	**Are intervention materials** *(handouts)* **available in other languages?** ❒ **Yes** ☒ **No** **If YES, what languages?** Not yet. **Other training materials &/or requirements** *(not included above)*: This is an advanced training. Basic proficiency in trauma-oriented interventions with children and adolescents is strongly recommended for optimal application.
Contact Information	**Name:** Kristine M. Jentoft-Kinniburgh, LICSW **Address:** The Trauma Center at JRI, 1269 Beacon Street, Brookline, MA 02446 **Phone number:** (617) 232-1303, ext. 213 **Email:** kkinniburgh@traumacenter.org **Website:** www.traumacenter.org
References	Kinniburgh, K., Blaustein, M., Spinazzola, J. & van der Kolk, B. (2005). Attachment, self-regulation and competency. *Psychiatric Annals 35*(5), 424-430. Kinniburg, K. & Blaustein, M. (2006). A.R.C.: *Attachment, Self-Regulation & Competency, A comprehensive framework for intervention with complexly traumatized youth.* Unpublished manuscript.

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."** ARC is designed as an adaptable treatment framework; it identifies 10 core targets of intervention within three broad domains, and provides guidelines and examples of intervention. The goal of designing an adaptable framework was to allow for differences in implementation and application across settings and across populations. To date, ARC has been used with a range of populations (including pre-/post-adoptive, internationally adopted, urban high-risk, Native Alaskan, juvenile justice-involved, child welfare involved, and war refugee youth), in a range of settings (including outpatient, community mental health, residential treatment, secure facility, domestic violence shelter, and hospital settings) and age groups (age 5 through late adolescent, and their caregiving systems). **Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.** Intervention developers/trainers work with the specific implementing system to tailor implementation and familial engagement in a way that is consistent with their setting. Factors considered in various settings have included ways to integrate caregivers (i.e., parenting groups vs. individual/dyadic treatment), structural supports (i.e., childcare while caregivers attend meetings), web-based engagement of family systems (one site has created a family access page for caregiver-to-caregiver tips, information, and support, and for child-to-child "feelings toolbox" ideas); and integration of cultural values in discussion of the treatment process. In addition, access to treatment has been seriously considered from the point of initial framework development by the primary developers, and the framework was designed in a manner to be adaptable to both clinical and non-clinical settings, with the goal of increasing access to trauma-informed services in the array of settings that trauma-exposed populations access and engage. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** As an adaptable framework, training emphasizes the importance of the assessment process to understanding family norms, values, roles, belief systems, etc. in organizing treatment planning, caregiver involvement, and culturally-relevant goals. For instance, caregiver work may include a primary caregiver or a larger familial system, etc.
Language Issues	**How does the treatment address children and families of different language groups?** No specific adaptations at this time. Caregiver materials (educational and work-sheets) are in the process of being translated to Spanish. **If interpreters are used, what is their training in child trauma?** N/A **Any other special considerations regarding language and interpreters?** N/A

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?** Although this question has not yet been specifically examined in the available data, clinical evidence suggests that there is extensive diversity in history and presentation among the populations with which ARC is currently used. Core issues are often relatively similar across sites, but their relative expression, intensity, and specific manifestations may vary. A future research question will involve understanding the ways symptom expression may vary at different sites, and how this factor influences intervention outcomes. **If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?** ARC focuses on core underlying issues, rather than specific manifestations and/or techniques.
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?** Currently, sites implementing ARC are primarily using the NCTSN core data set, the Parenting Stress Index (PSI; Abidin); and an ARC-specific assessment measure, currently in development. Despite site/population differences, the goal is to obtain consistent data across implementing sites during this phase of treatment implementation. **If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** The only non-normed measure currently in use is an in-development ARC-specific measure. This measure is designed to integrate assessment results obtained through a variety of means, including objective measures but also including child and dyadic/familial observation, interview, collateral contact, previous reports, etc., due to the understanding that information important to treatment planning may not be captured by formal measures. The purpose of the measure is to identify specific areas of strength and vulnerability within core target areas, and to translate these into concrete goals and treatment methods. **What, if any, culturally specific issues arise when utilizing these assessment measures?** Not yet assessed.
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** Consultation has been completed with an expert in cultural competence; culture-specific adaptations and considerations are in the process of being integrated into the treatment manual (these are not specifically contained in the current edition).

Cultural Adaptations continued	**Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)***.** Yes; developers work with implementing sites to adapt framework methods in a manner that is applicable to their specific population and/or setting; although core concepts remain the same, implementation often varies. For instance, in a rural Alaskan setting, affect regulation techniques integrate native culture and belief systems; attachment-based work has been adapted to be largely non-verbal and parallel (i.e., rather than face-to-face) in line with cultural norms and typical interaction styles. **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?** Not yet examined.
Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** The goal in creating an adaptable framework is that implementers best know their populations and specific areas to target (i.e., treatment has emphasized different factors in an urban, high-risk setting serving primarily African-American and Latino youth than in a mid-western agency serving primarily internationally adopted 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?** As noted above, ARC was specifically designed to be adaptable to the range of clinical and non-clinical settings in which trauma-exposed youth and families present for services. The framework identifies key targets; implementation varies across setting and population. For instance, within an outpatient setting, the target "Caregiver Affect Management" frequently involves individual or group work with biological, adoptive, or foster parents/other primary caregivers; within milieu settings, the emphasis of that target may involve working directly with milieu staff to monitor, understand, and address their own emotional reactions to clients. Data is currently being collected across settings. **Are there cultural barriers to accessing this treatment** *(i.e., treatment length, family involvement, stigma, etc.)***?** Treatment length varies by setting and client. This framework does specifically highlight the role of familial/caregiver involvement, which may be difficult for some families; however, in recognition of that, it is designed to apply to the range of caregiving systems, including clinicians and other health care providers. **Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** These factors are site-specific. **Are these barriers addressed in the intervention and how?** No.

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)***?** The ARC framework highlights the importance of the client's community in the caregiving system, and the importance of building connections. Each manual section includes a sub-section entitled "Beyond the Therapy Room," specifically addressing integration of external resources into treatment planning. The developmental competency section specifically targets connection to community resources; extent to which these are integrated depends on the client and setting implementing the framework.
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** Identification of specific cultural issues in training is still a work in progress; role of culture in definition of the caregiving system, familial norms regarding parenting, and other caregiver-focused targets; as well as in self and identity development, are routinely integrated into training. Cultural issues are frequently addressed in ongoing consultation. Integration of cultural factors into other target areas is often informal. More formal inclusion of cultural issues into the framework is a work in progress. **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** Not addressed. **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** Not addressed within specific ARC training materials **Has this guidance been provided in the writings on this treatment?** Not yet available. **Any other special considerations regarding training?** No.

NCTSN The National Child Traumatic Stress Network

CARE: Child-Adult Relationship Enhancement

GENERAL INFORMATION

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** CARE **Average length/number of sessions:** CARE is an on-going milieu intervention. **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** Addresses transportation and economic barriers through delivery of intervention within homeless shelters, DV shelters and transitional housing settings **Trauma type** *(primary)*: Interpersonal complex trauma (i.e., physical, sexual, and emotional abuse and neglect) **Trauma type** *(secondary)*: Acute trauma **Additional descriptors** *(not included above)***:** Child-Adult Relationship Enhancement (CARE) is a trauma-informed modification of specific PCIT skills for general usage by non-clinical adults who interact with traumatized children and their caregivers within various milieu settings. CARE has been adapted during the 2006 NCTSN project year by the National Center on Family Homelessness and the Trauma Center at Justice Resource Institute for use in homeless serving systems (see below).
Target Population	**Age range:** **Children of all ages and their caregivers. **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** All **Other cultural characteristics** *(e.g., SES, religion)***:** All **Language***(s)***:** English, currently being adapted in Spanish **Region** *(e.g., rural, urban)***:** All **Other characteristics** *(not included above)***:** CARE can be generalized to a wide variety of settings. It is supported by pragmatic evidence of its effectiveness. CARE training is applicable to a wide range of provider populations that can include but are not limited to: • Non-clinical staff in residential treatment centers • Day care providers • Medical care students, residents, fellows, and providers • Graduate students in education, social work, and psychology • Foster parents • Foster care caseworkers and child protection workers

CARE: Child-Adult Relationship Enhancement

Target Population continued	• Social service case managers • Community support providers • Home visitation providers • Child victim advocates • Staff at battered women shelters • Staff at homeless shelters • Receptionists and other support staff who come in contact with children as part of their duties
Essential Components	**Theoretical basis:** CARE was adapted from Parent-Child Interaction Therapy (PCIT). PCIT is an intervention approach for children with behavioral problems aged 2-12 and their parents, caregivers, and/or teachers. It has been adapted for use with children and caregivers with histories of traumatic stress. PCIT sessions include live coaching of caretakers with their children in two major components: • Relationship enhancement or Child Directed Interaction (CDI) • Child behavior management or Parent Directed Interaction (PDI) PCIT has been shown to develop caretakers' competence in managing their child's problematic behavior, promote caretakers' reinforcement of child's positive behaviors, reduce conflict between caretakers and their child, and enhance positive interactions between the caretakers and their child. **Key components:** CARE utilizes the three P skills (Praise, Paraphrase and Point-out-Behavior) to connect with children and their caregivers, provide a set of techniques for giving children and their caregivers effective positive commands, and the use of selective ignoring techniques to redirect problematic behaviors. CARE also contains a trauma education component to contextualize the use of these skills with the kinds of behaviors and problems exhibited by many traumatized children and their caregivers.
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** ❒ **Yes** ☒ **No** ❒ **Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)***.** Cultural issues with CARE have not been described in writings; however, PCIT has been described in writings and would be rated at a 3. **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** ❒ **Yes** ☒ **No** Evidence base draws upon extensive PCIT literature (see below)

CARE: Child-Adult Relationship Enhancement

Clinical & Anecdotal Evidence continued	**Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***?** ❒ **Yes** ☒ **No** **If YES, please include citation:** In process, unpublished training evaluations **Has this intervention been presented at scientific meetings?** ❒ **Yes** ☒ **No** **If YES, please include citation***(s)* **from last five presentations:** Submitted as part of NCTSN 2007 ANM workshop **Are there any general writings which describe the components of the intervention or how to administer it?** ☒ **Yes** ❒ **No** **If YES, please include citation:** Child Adult Relationship Enhancement Manual, Trauma Treatment Training Center, Cincinnati Children's Hospital **Has the intervention been replicated anywhere?** ☒ **Yes** ❒ **No** **Other clinical and/or anecdotal evidence** *(not included above)***:** See Other Research Evidence below

Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Other Research Evidence		While there has not been research directly conducted on CARE to date, the intervention from which it was derived and adapted has a strong evidence base supported in over 30 publications. Recent PCIT Publications: Bagner, Fernandez & Eyberg, 2004 Borrego, Urquiza, Rasmussen & Zebell, 1999 Brestan, Jacobs, Rayfield & Eyberg, 1999 Chaffin, Silovsky, Funderburk, Valle, Brestan, Balachova et al., 2004 Eyberg, Boggs & Algina, 1995 Eyberg, Funderburk, Hembree-Kigin, McNeil, Querido & Hood, 2001 Gallagher, 2003 Herschell, Calzada, Eyberg & McNeil, 2002 Hood & Eyberg, 2003 Neary & Eyberg, 2002 Runyon, Deblinger, Ryan & Thakkar-Kolar, 2004 Ware, Fortson & McNeil, 2003

CARE: Child-Adult Relationship Enhancement

Outcomes	**What assessments or measures are used as part of the intervention or for research purposes, if any?** Child Adult Relationship Enhancement Evaluation **If research studies have been conducted, what were the outcomes?** None at this time
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** There are no material requirements in order to implement CARE. **Supervision requirements** *(e.g., review of taped sessions)***?** Shelters who implement CARE are required to receive CARE training and are offered on-going consultation. **To ensure successful implementation, support should be obtained from:** Trained CARE trainers (see below).
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** Child Adult Relationship Enhancement Manual, Trauma Treatment Training Center, Cincinnati Children's Hospital **How/where is training obtained?** Training is being offered to Massachusetts family homeless shelters through the National Center on Family Homelessness and the Trauma Center at Justice Resource Institute. CARE training is offered on an agency-by-agency basis at the Trauma Treatment Training Center in Cincinnati. Trainers can train CARE onsite at local agencies, or agencies can bring staff to The Trauma Treatment Training Center. **What is the cost of training?** The Trauma Treatment Training Center in Cincinnati offers CARE trainings at their home offices in Ohio. Contact them directly for rates (per person rate in 2005 was approximately $60). The National Center on Family Homelessness and the Trauma Center at JRI can provide trainings to homeless serving systems interested in adapting/adopting CARE. Please contact us directly (see below) for agency/individual rates. **Are intervention materials** *(handouts)* **available in other languages?** ❒ **Yes** ☒ **No** **If YES, what languages?** Currently being adapted in Spanish **Other training materials &/or requirements** *(not included above)***:** Agency training for staff will vary depending on agency needs, but generally falls within 3–6 hours. Active skills-building practice in small groups may add additional time to the training, although extensive practice is not necessary to train the basic CARE program.

CARE: Child-Adult Relationship Enhancement

Training Materials & Requirements continued	Thus CARE training exists in two basic forms: 1) Lecture, demonstrations, and practice (3 hours) 2) Lecture, demonstrations, practice, and live coaching (6 hours)
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** This is an intervention that can be implemented by non-clinical professionals working with traumatized children and their caregivers. PCIT, the foundation for CARE, has been strongly supported by over 30 years of research. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** CARE is not a treatment intervention and is meant to occur adjunctively to other kinds of trauma-based treatment.
Program Developer	The National Center on Family Homelessness and the Trauma Center at Justice Resource Institute have adapted CARE for use in homeless shelter settings for both children and their caregivers. CARE was initially developed by the Trauma Treatment Training Center (TTTC), a collaboration of the Mayerson Center for Safe and Healthy Children and The Childhood Trust at Cincinnati Children's Hospital Medical Center (CCHMC). Contact information: Trauma Treatment Training Center, Cincinnati Children's Hospital Medical Center 3333 Burnet Avenue MLC 3008 Cincinnati, OH 45229-3039 Lacey.Thieken@cchmc.org 513-636-0043 www.cincinnatichildrens.org/TTTC www.OhioCanDo4Kids.org
Contact Information	**Name:** Kristina Konnath, LICSW **Address:** The National Center on Family Homelessness, 181 Wells Ave., Newton Centre, MA 02459 **Phone number:** (617) 964-3834 x31 **Email:** Kristina.Konnath@familyhomelessness.org
	Name: Dawna Gabowitz, Ph.D. **Address:** The Trauma Center at JRI, 1269 Beacon St., Brookline, MA 02446 **Phone number:** (617) 232-1303 x220 **Email:** dgabowitz@traumacenter.org **Website:** www.traumacenter.org

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Eyberg, S. M., Boggs, S. & Algina, J. (1995). Parent-Child Interaction Therapy: A psychosocial model for the treatment of young children with conduct problem behavior and their families. *Psychopharmacology Bulletin, 31,* 83-91.

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Herschell, A. D., Calzada, E. J., Eyberg, S. M. & McNeil, C. B. (2002). Parent-Child Interaction Therapy: New directions in research. *Cognitive and Behavioral Practice, 9,* 9-16.

Hood, K. K. & Eyberg, S. M. (2003). Outcomes of Parent-Child Interaction Therapy: Mothers' reports of maintenance three to six years after treatment. *Journal of Clinical Child and Adolescent Psychology, 32(3),* 419-429.

Neary, E. M., & Eyberg, S. M. (2002). Management of disruptive behavior in young children. *Infants and Young Children, 14*, 53-67.

Runyon, M. K., Deblinger, E., Ryan, E. E. & Thakkar-Kolar, R. (2004). An overview of child physical abuse: Developing an integrated parent-child cognitive behavioral treatment approach. *Trauma, Violence, and Abuse, 5(1),* 65-85.

Ware, L. M., Fortson, B. L. & McNeil, C. B. (2003). Parent-Child Interaction Therapy: A promising intervention for abusive families. *The Behavior Analyst Today, 3(4),* 375-382.

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. The intervention is designed to be used in many different settings that serve a range of individuals with diverse cultural backgrounds. Child-Adult Relationship Enhancement (CARE) is a field initiated modification of the evidence-based Parent Child Interaction Therapy (PCIT). This modification uses specific PCIT skills (i.e., praise, reflection, and behavioral descriptions) for general usage by non-clinical adults who interact with children in a variety of settings. Clinicians are trained to tailor this intervention to their specific setting and to the specific cultural groups they work with (i.e., each of the skills are discussed in terms of the function and utility for the specific population that they work with and adapted as needed). These adaptations have been implemented within homeless shelter settings that serve women and children from a range of ethnic and cultural backgrounds; domestic violence shelters; residential facilities; hospitals; and daycare settings. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** The nature of the intervention emphasizes the importance of tailoring CARE to the environment within which it is implemented such as understanding familial and/or organizational norms, values, roles, and belief systems.
Language Issues	**How does the treatment address children and families of different language groups?** Training is provided to staff who are multilingual and therefore are able to use the model with families of different linguistic backgrounds. **If interpreters are used, what is their training in child trauma?** N/A **Any other special considerations regarding language and interpreters?** N/A
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?** Although this question has not yet been specifically examined, clinical evidence suggests that there is extensive diversity in history and presentation among the populations with which CARE is currently used. Core issues are often relatively similar across sites, but their relative expression, intensity, and specific manifestation may vary.

Symptom Expression continued	**If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?** The intervention is designed to address symptom expression in consistent ways regardless of the specific symptoms, however, emphasis on specific skill areas may change depending on the symptom 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?** Coding is done in order to assess mastery of taught skills. What skills you measure may vary between cultural groups. There is no normative data available at this time. **If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** Coding is designed to assess the mastery of taught skills and once mastery is achieved the caregiver/provider is considered to be ready to implement CARE. **What, if any, culturally specific issues arise when utilizing these assessment measures?** Not yet assessed.
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** Not to date. **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)***.** Yes; trainers work with implementing sites to adapt skills in a manner that is applicable to their specific population and/or setting; although core concepts remain the same, implementation often varies. For instance, in family homeless shelter settings the implementation of the intervention has been altered so that shelter staff are trained to utilize the skills with the mothers, providing modeling, and then train the mothers to utilize the skills with their children. Given that shelter staff are working with the adults, the skills taught are modified to be more applicable for working with adults in a shelter setting (i.e., behavioral descriptions/play by play has not been taught as a skill). **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?** Not at this time.

Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** Treatment is designed to be adaptable so that implementers who best know their populations and specific target areas make changes as needed (i.e., intervention emphasizes different skills when used with adults in a homeless shelter setting rather than when it is used with children in a residential setting). **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 is not a clinic-based treatment. It is designed to be implemented in community/ milieu settings. **Are there cultural barriers to accessing this treatment** *(i.e., treatment length, family involvement, stigma, etc.)***?** There is no specific length of treatment, but the amount of time clients are exposed to this treatment is dependent on the length of stay in the setting where CARE is being implemented. Additionally, caregivers may choose not to be trained in this intervention despite it being offered in the setting and modeled within the setting. **Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** These factors are site-specific. **Are these barriers addressed in the intervention and how?** No **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)***?** CARE is a treatment that is designed to be implemented in the community setting including all levels of staff within the setting (i.e., in a shelter setting, case managers, support staff, administrators, and residents are all trained in the intervention).
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** Identification of specific cultural issues in training is still a work in progress as information is gathered through implementation of this model in a wide range of settings. Information is shared between network training sites who are implementing this model. **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** Not yet addressed **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** Not yet addressed.

NCTSN The National Child Traumatic Stress Network

CPP: Child-Parent Psychotherapy

GENERAL INFORMATION

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** CPP **Average length/number of sessions:** 50 **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** Integrates a focus on the way the trauma has affected the parent-child relationship and the family's connection to their culture and cultural beliefs, spirituality, intergenerational transmission of trauma, historical trauma, immigration experiences, parenting practices, and traditional cultural values. **Trauma type** *(primary)*: Domestic violence **Trauma type** *(secondary)*: Maltreatment **Additional descriptors** *(not included above)***:** Dyadic attachment-based treatment for young children exposed to interpersonal violence.
Target Population	**Age range:** *(lower limit)* 0 **to** *(upper limit)* 6 **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** Latino (Mexican, Central and South American) from a wide range of acculturation levels including recent immigrants and African-Americans **Other cultural characteristics** *(e.g., SES, religion)***:** Wide range of acculturation, parents with chronic trauma, children who have experienced multiple traumas, wide income range although predominantly lower-income **Language***(s)***:** English, Spanish **Region** *(e.g., rural, urban)***:** Urban **Other characteristics** *(not included above)***:** Has also been used with Whites, Asians, and Native Americans
Essential Components	**Theoretical basis:** Based in attachment theory but also integrates psychodynamic, developmental, trauma, social learning, and cognitive behavioral theories. **Key components:** Focus on safety, affect regulation, improving the child-caregiver relationship, normalization of trauma related response, joint construction of a trauma narrative, with the goal of returning the child to a normal developmental trajectory

CPP: Child-Parent Psychotherapy

Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** ❒ **Yes** ☒ **No** ❒ **Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)***.** 4 **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** ❒ **Yes** ☒ **No** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***?** ☒ **Yes** ❒ **No** **If YES, please include citation:** Lieberman, Van Horn & Ghosh Ippen, 2005; 2006 **Has this intervention been presented at scientific meetings?** ☒ **Yes** ❒ **No** **If YES, please include citation:** Academy of Child and Adolescent Psychiatry (AACAP): Lieberman, 2005 NCTSN All-Network Meeting: Lieberman & Ghosh Ippen, 2006 **Are there any general writings which describe the components of the intervention or how to administer it?** ☒ **Yes** ❒ **No** **If YES, please include citation:** The citation for the treatment manual is: Lieberman & Van Horn, 2005 Guidelines for the treatment of Childhood Traumatic Grief using CPP have also been published: Lieberman, Compton, Van Horn & Ghosh Ippen, 2003 **Has the intervention been replicated anywhere?** ☒ **Yes** ❒ **No** **Other clinical and/or anecdotal evidence** *(not included above)***:** The treatment has been conducted and studied by an independent research team. Randomized trials conducted by this team are cited below. Cicchetti, Rogosch & Toth, 2006; Toth, Maughan, Manly, Spagnola & Cicchetti, 2002

Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Published Case Studies		Lewis & Ghosh Ippen, 2004; Van Horn & Lieberman, 2006
Randomized Controlled Trials	**N=**75 **By gender:** 48% boys; 52% girls	Lieberman, Van Horn & Ghosh Ippen, 2005; 2006 (Please see notes below for description of other randomized trials).

CPP: Child-Parent Psychotherapy

Research Evidence	Sample Size (N) and Breakdown *(by gender, ethnicity, other cultural factors)*	Citation
Randomized Controlled Trials continued	**By ethnicity:** 37% mixed ethnicity (predominantly Latino/Caucasian), 28% Latino, 14.5% African American, 10.5% White, 7% Asian, and 2% of another ethnicity	

Outcomes

What assessments or measures are used as part of the intervention or for research purposes, if any?

Assessment measures vary by study and include:

- Child trauma symptoms (Trauma Symptom Checklist for Young Children, Posttraumatic Stress Disorder Semi-structured Interview and Observational Record)
- Child trauma exposure (Traumatic Events Screening Inventory)
- Child symptoms (CBCL 1 ½ - 5)
- Child developmental functioning (Ages and Stages Questionnaire, WPPSI-III)
- Caregiver trauma history (Life Stressors Checklist–Revised)
- Caregiver trauma symptoms (Davidson Trauma Scale or Clinician Administered PTSD Scale, Trauma Related Dissociation Scale)
- Caregiver other symptoms (SCL-90-R, Beck Depression Inventory, Beck Anxiety Inventory)
- Parent child relationship (Parenting Stress Index–Short Form; Crowell Observation Procedures)

If research studies have been conducted, what were the outcomes?

There have been three randomized control trials of CPP with trauma-exposed children. These trials are summarized below. In addition, four published studies provide support for the efficacy of relationship-based models with at risk samples, including anxiously attached dyads (Lieberman et al., 1991) and children of depressed mothers (Cicchetti et al., 2000; Cicchetti et al., 1999; Toth et al., 2008). The Lieberman et al. (1991) study involved a sample of low-income Spanish speaking women and their babies.

CPP: Child-Parent Psychotherapy

Outcomes continued	• Lieberman, Van Horn, & Ghosh Ippen (2005) conducted a randomized controlled trial of CPP for children referred because they had witnessed domestic violence. Ethnicity of children is reported in the table above. At posttreatment, CPP children showed significantly greater reductions in total behavior problems (d=.24) and traumatic stress symptoms (d=.64). CPP mothers showed significantly greater reductions in avoidant symptomatology (d=.50). Results from the 6-month follow up, suggest that improvements in children's behavior problems (d=.41) and in maternal symptoms (d=.38) continue after treatment ends (Lieberman, Ghosh Ippen & Van Horn, 2006). • Toth et al. (2002) examined the efficacy of CPP to alter preschoolers' representations of their mothers and themselves. They reasoned that these representations, also known as schema or internal working models, represent an important outcome as they form the basis of children's future relationship expectations. Maltreated preschoolers are likely to have negative models of relationships and to generalize them to others. The study included 112 maltreated preschoolers of whom 76.2% were reportedly ethnic minorities. Abuse types included physical abuse, sexual abuse, emotional maltreatment, and neglect, with 60% of children experiencing more than one form of maltreatment. Multiple findings suggest that the CPP intervention was more effective in improving representations of self and caregivers. • Cicchetti et al. (2006) conducted a study designed to examine the relative efficacy of a relationship-based versus a behavioral intervention in changing maltreated children's attachment classification. Participants included 137 12-month infants and their mothers. Of the mothers, 74.1% were reported to be ethnic minorities. Results indicate significantly greater change in attachment classification when compared to community standard treatment.
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** No material requirements **Supervision requirements** *(e.g., review of taped sessions)***?** Process notes and/or taped sessions **To ensure successful implementation, support should be obtained from:** Child's parents

CPP: Child-Parent Psychotherapy

Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** The citation for the treatment manual is: Lieberman & Van Horn, 2005 Guidelines for the treatment of Childhood Traumatic Grief using CPP have also been published: Lieberman, Compton, Van Horn & Ghosh Ippen, 2003 **How/where is training obtained?** Training depends on the needs of the participants. Training includes boosters and supervision (weekly, monthly or bimonthly). **What is the cost of training?** $1500/day **Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ❒ **No** **If YES, what languages?** Spanish (assessment tools are available in Spanish)
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** This is one of the few empirically validated treatments for children under the age of 6. In addition, it is one of the few empirically validated treatments that is routinely conducted with ethnic minorities. The treatment is flexible and allows for incorporation of a discussion of cultural values and culture-related experiences. The treatment appears to be well accepted by clinicians. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** The treatment length is long compared to other treatments. Because of the nuances of working with young children, and the need for a flexible approach with this age group, the treatment is somewhat more difficult to learn than treatments that are manualized with a session by session approach.
Contact Information	**Name:** Chandra Ghosh Ippen, Ph.D. **Address:** Child Trauma Research Project, University of California, San Francisco 1001 Potrero Avenue Bldg 20 Suite 2100 Room 2122 San Francisco, CA 94110 **Phone number:** 415-206-5312 **Email:** chandra.ghosh@ucsf.edu

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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."** The model is broadly tailored. The basic theoretical principles and core goals of CPP are thought to apply across diverse groups. The treatment has been used extensively with a wide range of minority groups: Latino (Mexican, Central, and South American), African-American, and Asian (Chinese). Clinical and research data, including four randomized trials conducted with predominantly ethnic minority samples, document the efficacy of this approach with culturally diverse groups. **Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.** Interventions are tailored to the specific family and their context. Culture is considered to be an important aspect of context. The following publications detail ways that cultural issues are integrated into CPP: Lieberman, 1990; Lewis & Ghosh Ippen, 2004. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** CPP involves a flexible approach. Clinicians are encouraged to tailor engagement strategies depending on the needs and background of the family. Specific strategies include, but are not limited to, providing outreach and intake services in English and Spanish, providing case management to reduce barriers to treatment, engaging in dialogue about cultural beliefs related to participating in treatment, and providing CPP in the family's native language.
Language Issues	**How does the treatment address children and families of different language groups?** Clinicians make every attempt to see families in their native language. The treatment is regularly conducted in English, Spanish, Cantonese, and Mandarin. This has been accomplished through the hiring of bilingual, bicultural staff and by training bilingual, bicultural providers in community clinics. For example, at the Child-Trauma Research Project (CTRP), where the treatment was developed, 75% of the staff are bilingual and speak both Spanish and English. CTRP also trained Cantonese and Mandarin speaking community mental health clinicians to provide CPP at clinics in San Francisco that serve monolingual Chinese speaking clients. CPP does not use many printed materials. If handouts or forms are used (e.g., consent and release of information forms and assessment tools) they are translated into the family's language. **If interpreters are used, what is their training in child trauma?** Interpreters are not used. **Any other special considerations regarding language and interpreters?** Every attempt is made to see children and families in their native language. On occasion, there has been a family that speaks a rare language, and there are no available clinicians that speak that particular language. If no other referral can be made, treatment is conducted in English.

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?** Young children manifest trauma symptoms differently from adults and older children. The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised (DC:0-3R) contains various diagnostic classifications for young children and serves as a more valid system for children under age 6 compared to the DSM-IV. The Early Trauma Treatment Network, ETTN, of the NCTSN is currently engaged in studies to examine trauma symptoms in young children. ETTN publications in this area include: Scheeringa, Peebles, Cook & Zeanah, 2001; Scheeringa, Zeanah, Myers & Putnam, 2003. ETTN members are also conducting studies that examine cultural differences in caregivers and young children's symptom expression. For example, a study, which will be presented at the 115th annual meeting of the American Psychological Association explores ethnic differences in Posttraumatic Stress Disorder (PTSD) and related symptomatology among women who have experienced traumatic events. **If there are differences in symptom expression, in what ways does the theoretical conceptual framework of this treatment address culturally specific symptoms?** Specific details regarding symptom expression and treatment in young children and in ethnically diverse groups are provided in the following CPP-related publications: Lieberman & Van Horn, 2005; Lieberman, Compton, Van Horn & Ghosh Ippen, 2003; Lewis & Ghosh Ippen, 2004; Lieberman & Van Horn, 2004.
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?** Overall there is a dearth of measures for young children. Few measures exist whose psychometrics have been examined with ethnically diverse groups. Empirical research on CPP has been conducted using the same measures for all ethnic groups. When studies have involved Latinos, all assessment measures have either been available from the publishers in Spanish (e.g., Child Behavior Checklist [CBCL], Trauma Symptom Checklist for Young Children [TSCYC], Parenting Stress Index [PSI], Davidson Trauma Scale) or were translated and back-translated by a group of Spanish speaking clinicians. Norms are available for some measures (e.g., CBCL, PSI, TSCYC), but they often do not involve an ethnically diverse sample. Information regarding some of the specific measures used in CPP studies are available on the NCTSN Measures Review Database (NCTSN.org/measures). The reviews (click the assets tab for the full PDF) provide details regarding the use with diverse cultural groups. As of June, 2007 reviews can be found for the following child measures: Trauma Symptom Checklist for Young Children; Infant Toddler Social and Posttraumatic Stress Disorder Semi-Structured Interview and Observational Record, and Parenting Stress Index. In addition, reviews of the following measures used to assess parents are included: Beck Depression Inventory, Beck Anxiety Inventory.

Assessment continued	**If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** Randomized control trials have examined pre to post-test reductions in symptoms and improvements in functioning. Studies show that relative to comparison groups, CPP children and mothers show greater improvements. Clinically, data are examined in the following ways. First many of these measures have clinical cutoffs. Clinicians can examine whether a child moves from being above the cutoff to below. Second, change on individual items with clinical relevance (e.g., enuresis, aggression towards others) is examined. **What, if any, culturally specific issues arise when utilizing these assessment measures?** Clinicians make every attempt to ensure that measures are understandable. Assessments are conducted in an interview format, so if an individual does not understand, the clinician can help explain the item.
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** Cultural issues have been specifically addressed throughout various writings about the treatment, including the treatment manual (Lieberman & Van Horn, 2005) and guidelines for the treatment of traumatic bereavement in infancy and early childhood (Lieberman et al., 2003). There have also been two culture-focused publications that detail ways that cultural issues are integrated into CPP (Lieberman, 1990; Lewis & Ghosh Ippen, 2004). **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)***.** The basic principles of CPP are thought to apply broadly to different cultural groups. Reflective supervision and training are used to individually tailor the treatment to the family, given their cultural background, trauma history, and context. **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, but the developers are interested in examining this. A randomized controlled trial consisting of 100% Latino immigrant mothers reported an attrition rate of 18% (Lieberman, Weston & Pawl, 1991). Attrition rates for other studies involving predominantly ethnic minority samples are 14.3% (Lieberman, Van Horn & Ghosh Ippen, 2005) and 19.4% (Toth et al., 2002). Another trial involving 74% ethnic minorities reported that prior to engagement the attrition rate was 39.6% for the CPP group and 51% for the comparison group, which received a psychoeducational parenting intervention (PPI). Following engagement, the overall attrition rate was 21.7%. The community standard showed an attrition rate of 42.9% and there were no differences in attrition for the CPP or PPI groups (Cicchetti et al., 2006).

Intervention Delivery Method/ Transportability & Outreach

If applicable, how does this treatment address specific cultural risk factors *(i.e., increased susceptibility to other traumas)***?**

This treatment is intended for multiply-traumatized populations. In a randomized trial of preschoolers exposed to domestic violence (Lieberman, Van Horn, & Ghosh Ippen, 2005), caregivers reported experiencing on average 12 stressful life events. Data collected as part of the NCTSN show that on average children have experienced 4 traumatic events. The treatment focuses on reconnecting your children to caregivers and helping caregivers understand how trauma has disrupted their relationship and their child's development. By focusing on the caregiver-child relationship, the treatment targets a universal risk factor. Treatment also encourages caregivers to engage in culturally consistent parenting practices that are appropriate given their context. Culture-specific issues such as immigration trauma and family separation due to immigration are addressed in this treatment. Case management to help families deal with problems of daily living is an integral component of treatment.

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?**

CPP was originally developed as a home-visiting model. It can and has been implemented in the home, clinic, and school settings as well as in a variety of other settings, such as play grounds, hospitals, etc. Data from randomized trials are based on both home and clinic implementation of treatment.

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

While the treatment is conducted in a way that attempts to minimize barriers, there are certain cultural issues that can arise. Stigma is always a cultural barrier. For example, some families do not want to be thought of as "crazy." Also, in some families that have experienced domestic violence, fathers may not want the family to participate in treatment. Although CPP is an intensive treatment with a long duration (50 sessions), this does not appear to be a barrier. When consumers provide feedback about treatment, the most common complaint is that it is too short.

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

For some families, including immigrant families, there are real life constraints to accessing this treatment. For example, some families need to cancel sessions because they must work to survive and the type of work (e.g., babysitting or house cleaning) often means needing to work at a moments notice. Generally, attempts are made to accommodate these issues. Occasionally there are clinic barriers to providing an intensive treatment of this type. The developers are aware that the treatment is expensive to implement; however, they believe that the treatment is cost-effective in the long run based on the extensive research that has been done underscoring the detrimental effects of trauma on the rapidly developing brains of young children.

Intervention Delivery Method/ Transportability & Outreach continued	**Are these barriers addressed in the intervention and how?** Reflective supervision and reflective practice are key components of this flexible intervention. Through these mechanisms, clinicians and supervisors work to identify what (if any) barriers exist and how interventions should be crafted to meet a family's individual needs. **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)***?** A portion of the intervention is spent focusing on issues related to case-management. As such, clinicians will partner with the community and connect families to services on a case by case basis. Partnerships have been developed with domestic violence shelters, battered women organizations, the court system, restraining order clinics, day care providers and preschools.
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** As part of the ETTN's NCTSN SAMHSA grant, the treatment developers are putting together a diversity training manual. Currently all CPP trainees are provided training using this manual. The manual contains a framework for identifying conflicts related to difference. The manual also contains vignettes related to diversity conflicts. They are meant to encourage reflection and dialogue regarding potential differences and how they influence intervention. This discussion is continued during reflective supervision and case conferences. The diversity training model and key theoretical models related to working with culturally diverse families are presented in the following chapter: Ghosh Ippen, (in press). **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** While this varies based on the individual supervisor and clinician, supervisors encourage open discussion of cultural issues. During reflective supervision, cultural issues are discussed on a case by case basis (i.e., if the case demands it). **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** See above. Again, cultural issues are generally addressed on a case by case basis. **Has this guidance been provided in the writings on this treatment?** The diversity training manual and a book chapter in press (see above) will provide guidance on these topics in the near future. **Any other special considerations regarding training?** At least five recent national trainings on CPP have been focused on integrating issues of diversity into this treatment and on working with culturally diverse families.

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CBITS: Cognitive Behavioral Intervention for Trauma in Schools

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** CBITS **Average length/number of sessions:** 10 **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** During the CBITS training and ongoing consultation with sites, we have specifically included in our training ways to implement this program to address cultural competency. We encourage sites to use culturally appropriate examples during the treatment, and we discuss the cultural issues pertinent to each trainee's site. Although there are examples for each of the exercises in the manual, clinicians are encouraged to substitute these for culturally salient ones. For example, in working with immigrant populations, we focused some of the parent sessions on separation and loss issues that so many had experienced during the migration process. When we've worked in Catholic schools, faith-based clinicians openly discussed the students' examples of coping through prayer and complementing this with CBT skills. CBITS is an ideal trauma intervention for underserved ethnic minority students who frequently do not receive services due to a whole host of barriers to traditional mental health services. This school-based program is designed to be delivered in school settings, whether it is in an urban or midwestern public school serving a diverse student body or a religious private school providing outreach to an immigrant community. CBITS has been successfully used in a wide variety of communities because it can be flexibly implemented and addresses barriers such as transportation, language, and stigma. In addition, CBITS has also addressed the barrier of parent and family involvement that can be so common in many communities. We have used a community-based participatory partnership model of including ethnic minority parents from the community being served along with community leaders, clinicians, and researchers to design the implementation plan so that the program is presented in a relevant and culturally congruent way. **Trauma type** *(primary)*: Community violence **Trauma type** *(secondary)*: Domestic violence **Additional descriptors** *(not included above)***:** CBITS is appropriate for a wide range of traumas including: physical abuse, disasters, accidents, witnessing death, assault, war, terrorism, immigration related trauma, and traumatic loss.
Target Population	**Age range:** 10 **to** 15 **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** CBITS has been used in a broad range of populations across the US and internationally.

CBITS: Cognitive Behavioral Intervention for Trauma in Schools

Target Population continued	Immigrant Populations: CBITS has been delivered to newly immigrated students such as Latino (primarily from Mexico and Central America), Korean, Russian, and Western Armenian students. Acculturation Levels: CBITS has been implemented and evaluated with a broad range of acculturation levels, from newly immigrated youth to highly acculturated youth, as well as multigenerations of African Americans. Ethnic/Racial Groups Served: CBITS has been successfully delivered to Latinos, African Americans, Asian American/Pacific Islanders, and Native American communities (the Navajo, Chippewa-Cree, Black Feet, and Yakima communities). **Other cultural characteristics** *(e.g., SES, religion)*: Faith-based: CBITS has been delivered in a Catholic school by clinicians with lay health promotors and parish nurses providing outreach and parenting support. We are in the process of conducting an evaluation (RCT) in this setting. SES: CBITS has been used in communities of wide ranges of SES including the very poor and middle class populations across the United States. **Language***(s)*: Spanish, Korean, Russian, Western Armenian, Japanese **Region** *(e.g., rural, urban)*: Urban, suburban, and rural **Other characteristics** *(not included above)*: High Risk Populations: CBITS has also been delivered in schools for students in Special Education, for youth at risk for HIV and for children who are war refugees.
Essential Components	**Theoretical basis:** Cognitive Behavioral **Key components:** CBITS is a program developed for use in schools for a broad array of traumas and populations. CBITS was originally developed in a community-based participatory research partnership with school-based clinicians, clinician researchers, and community members which has enhanced its relevancy for school communities. CBITS is a skills-based, child group intervention that is aimed at relieving symptoms of Posttraumatic Stress Disorder (PTSD), depression, and general anxiety among children exposed to multiple forms of trauma. CBITS Child Groups: The program consists of ten group sessions (6-8 children/group) of approximately an hour in length, usually conducted once a week in a school setting. The CBITS intervention has also been delivered in other settings, such as mental health clinics.

CBITS: Cognitive Behavioral Intervention for Trauma in Schools

Essential Components continued	One unique aspect of CBITS is the focus on trauma from the child's perspective. For those children who have multiple traumas, CBITS recommends that the child be the one to choose, with help from the clinician, which trauma will be the focus of treatment. Frequently, although a clinician will perceive one trauma to be the most salient for a child, the child will associate greater impact from another trauma. In addition to the group sessions, participants receive 1-3 individual sessions, usually held before the exposure exercises. CBITS also includes two parent education sessions and one teacher education session. CBITS teaches six cognitive-behavioral techniques: • Education about reactions to trauma • Relaxation training • Cognitive therapy • Real life exposure • Stress or trauma exposure • Social problem-solving Parental permission is sought for children to participate. A screening procedure is recommended to assist in identifying children in need of the program. A brief screening instrument has been developed for this purpose and should be followed by an individual meeting with a clinician to confirm the screening results.
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** **❒ Yes ☒ No ❒ Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)***.** 5 **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** **❒ Yes ☒ No** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***? ☒ Yes ❒ No** **If YES, please include citation:** Kataoka, Stein, Jaycox, Wong, Escudero, Tu, et al., 2003 **Has this intervention been presented at scientific meetings? ☒ Yes ❒ No**

CBITS: Cognitive Behavioral Intervention for Trauma in Schools

Clinical & Anecdotal Evidence continued

If YES, please include citation*(s)* **from last five presentations:**
San Diego International Conference on Child and Family Maltreatment: Cohen, Kolko, Mannarino & Stein, 2006

US Department of Education: Wong, 2006; 2005

Latino Resarch Program Project: Kataoka, Langley, Stein, Jaycox, Zhang & Wong, 2005

Association for the Advancement of Behavior Therapy (AABT): Langley, Jaycox, Stein, Kataoka, Wong & Dean, 2004

Are there any general writings which describe the components of the intervention or how to administer it? ☒ **Yes** ❒ **No**

If YES, please include citation:
Stein, Kataoka, Jaycox, Steiger, Wong, Fink, et al., 2003; Jaycox, 2004

Has the intervention been replicated anywhere? ☒ **Yes** ❒ **No**

Other countries? *(please list)* Australia, Japan

Other clinical and/or anecdotal evidence *(not included above)***:**

Adaptation and community

- Adaptation and community-based participatory research collaboration with the faith-community described in: Kataoka, Fuentes, O'Donoghue, Castillo-Campos, Bonilla, Halsey, et al., in press.
- Implementation of different adaptations of CBITS described in: Jaycox, Kataoka, Stein, Wong & Langley, in press.
- The following papers describe the screening component of CBITS: Jaycox, Stein, Kataoka, Wong, Fink, Escudero & Zaragoza, 2002; Dean, Stein, Jaycox, Kataoka & Wong, 2004.

Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Clinical Trials *(w/control groups)*	**N=**199 **By gender:** 50% females **By ethnicity:** Mexico: 57% El Salvador: 18% Guatemala: 11% Other: 13%	Kataoka, Stein, Jaycox, Wong, Escudero, Tu, et al., 2003

Clinical Trials *(w/control groups* **continued**	**By other cultural factors:** All participants had immigrated to the US in the past 3 years. The intervention was conducted in Spanish by bilingual, bicultural clinicians.	
Randomized Controlled Trials	**N=**126 **By gender:** 54% females	Stein, Jaycox, Kataoka, Wong, Tu, Elliott & Fink, 2003.

Outcomes

What assessments or measures are used as part of the intervention or for research purposes, if any?

Screening Measures:

- Modified Life Events Scale (Singer, 1995) to assess the level of exposure to violence
- Child PTSD Symptom Scale (Foa, 2001)

Outcome measures:

- Child PTSD Symptom Scale (Foa, 2001)
- Children's Depression Inventory (Kovacs, 1983)
- Pediatric Symptom Checklist

If research studies have been conducted, what were the outcomes?
In a randomized controlled study, children in the CBITS intervention group had significantly greater improvement in PTSD and depressive symptoms compared to those on the waitlist at a three-month follow-up. Parents of children in the CBITS intervention group also reported significantly improved child functioning compared with children in the wait list group. The improvements in symptoms and functioning in the CBITS group continued to be seen at a subsequent follow-up at 6 months. Results from another study showed that those in the CBITS intervention group had significantly fewer self-reported symptoms of PTSD and depression at post-test, adjusting for relevant covariates, as did children in a comparison group.

Training Materials & Requirements

List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.
Copies of the treatment manual can be ordered from Sopris West Educational Services: (800) 547-6747, www.sopriswest.com.

How/where is training obtained? Contact Audra Langley for details, alangley@mednet.ucla.edu.

CBITS: Cognitive Behavioral Intervention for Trauma in Schools

Training Materials & Requirements continued	**What is the cost of training?** Dependent on the training arrangements made with Dr. Langley. **Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ❒ **No** **If YES, what languages?** Spanish **Other training materials &/or requirements** *(not included above)*: Other implementation materials available upon request.
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** • CBITS is specifically designed and evaluated in multicultural and multilingual populations. • CBITS has been used in mulitple languages including: Spanish, Korean, Western Armenian, Russian, and Japanese. • CBITS has been adapted for use on a variety of Native American reservations. • CBITS has been used successfully in a faith-based private school. • CBITS has been used throughout the U.S. and internationally (Japan and Australia). • CBITS treatment materials have been translated into other languages. • CBITS is a flexible, manualized intervention that can be easily adapted for different populations. • CBITS is specifically designed for use in schools and by school-based clinicians with training that specifically focuses on implementation of trauma services in the school setting. • CBITS' school-based format alleviates common obstacles to treatment such as transportation barriers, stigma of seeking "mental health" care, and dependence on parents and families to seek and find care. • CBITS includes training on important factors involved in delivering a program in the schools successfully such as integrating the program into the school calendar, using a brief assessment tool to detect eligible students, and understanding and supporting the roles of school staff. • CBITS is an intervention that can be readily accessible to all eligible students, regardless of parent ability to be involved in treatment. • CBITS has had significant involvement of multiple stakeholders in the development and implementation of the program. • CBITS is the only trauma intervention that has been found to be effective in a RCT for multiply traumatized youth.

CBITS: Cognitive Behavioral Intervention for Trauma in Schools

Pros & Cons/ Qualitative Impressions continued	**What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** CBITS is not yet adapted for early elementary school students (K-2) and for older adolescents/young adults. **Other qualitative impressions:** The CBITS team has conducted multiple focus groups across the Los Angeles area in private and public schools and has found an overwhelming need identified by communities for an intervention in schools. These focus group participants have also described the school and faith-based settings to be, not only appropriate, but ideal for delivering CBITS for traumatized youth.
Contact Information	**Name:** Sheryl Kataoka **Address:** 10920 Wilshire Blvd., #300; Los Angeles, CA 90024 **Phone number:** 310-794-3727 **Email:** skataoka@ucla.edu **Website:** pending
References	Cohen, J., Kolko, D., Mannarino, T. & Stein, B. D. (2006, January). *Pittsburgh STEELERS—Steel city's trauma efficacy and effectiveness: Leading research studies.* Presented at the 20th Annual San Diego International Conference on Child and Family Maltreatment, San Diego, CA. Dean, K. L., Stein, B. D., Jaycox, L. H., Kataoka, S. H. & Wong, M. (2004). Acceptability of asking parents about symptoms in their traumatized children. *Psychiatric Services, 55*(8), 866. Foa, E. B., Johnson, K. M., Feeny, N. C. & Treadwell, K. R. H. (2001). The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties. *Journal of Clinical Child Psychology, 30*, 376–384. Jaycox, L. (2004). *Cognitive-Behavioral Intervention for Trauma in Schools.* Longmont, CO: Sopris West. Jaycox, L. H., Kataoka, S. H., Stein, B. D., Wong, M. & Langley, A. (in press). Responding to the needs of the community: A stepped care approach to implementing trauma-focused interventions in schools. Jaycox, L. H., Stein, B. D., Kataoka, S. H., Wong, M., Fink, A., Escudero, P. & Zaragoza, C. (2002). Violence exposure, PTSD, and depressive symptoms among recent immigrant school children. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(9), 1104-1110. Kataoka, S., Fuentes, O'Donoghue, V., Castillo-Campos, P., Bonilla, A., Halsey, K., Avila, J. & Wells, K. (in press). Piloting of a faith-based intervention for children exposed to violence. Kataoka, S., Langley, A. K., Stein, B. D., Jaycox, L., Zhang, L. & Wong, M. (2005, April). *Violence exposure and PTSD: The role of English language fluency on Latino children.* Presented at the Latino Research Program Project Annual Meeting. Kataoka, S., Stein, B. D., Jaycox, L. H., Wong, M., Escudero, P., Tu, W., Zaragosa, C. & Fink, A. (2003). A school-based mental health program for traumatized Latino immigrant children. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*(3), 311-318. Kovacs, M. & Beck, A. (1983). The Children's Depression Inventory: a self-rating depression scale for school-aged youngsters. Unpublished manuscript, Western Psychiatric Institute and Clinic, Pittsburgh, PA.

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Stein, B. D., Kataoka, S., Jaycox, L. H., Steiger, E. M., Wong, M., Fink, A., Escudero, P. & Zaragoza, C. (2003). The mental health of immigrants project: Program design and participatory research in the real world. In M. D. Weist, S. W. Evans & N. A. Lever (Eds.), *Handbook of school mental health: Advancing practice and research* (pp. 1779-1790). New York: Kluwer Academic/Plenum Publishers.

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Wong, M. (2005). *National videoconference on school emergency response and crisis management: Effective recovery strategies in schools.* Presented at the US Department of Education, Washington, DC.

Wong, M. (2006, January). *The recovery phase of school crisis management: Evidence based practices.* Presented at the Emergency Response and Crisis Management Conference, US Department of Education, Atlanta, GA.

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."** Our approach to cultural competency with CBITS has occurred at several phases. CBITS was originally developed for recent immigrant students from Latino, Russian, Armenian, and Korean backgrounds. From its inception, CBITS was created from a partnership with community members from each of these groups and has been modified over time in response to formal (focus groups) and informal feedback from parents and community members from diverse ethnic backgrounds. During this period, school mental health providers from diverse backgrounds (Korean, Armenian, Vietnamese, and various Spanish speaking cultures) were instrumental in adapting and forming CBITS. Secondly, during the pre-training phase, our team consults with local providers to better understand the population to be served and to help them think through how they might be able to apply this program in their community. Then during the actual CBITS training, cultural issues are discussed throughout in terms of how each component of treatment can be implemented in a culturally competent manner. Discussion regarding activities and examples to use in place of or in addition to those examples offered in the actual manual in order to convey the concepts in the most culturally and contextually salient manner is an important part of each training. A significant portion of the pre-training and training is also devoted specifically to implementation issues, to discuss the best way to meet the needs of the community being served while being both school system competent as well as culturally competent. We do not have specific manuals for each cultural group, since there exists much within group variation that is relevant to practicing culturally competent care. The specific groups with whom we have utilized this form of culturally competent practice of CBITS include: poor, urban, rural communities; ethnic/racial groups both new immigrants and multigenerational families from the following backgrounds: African Americans, Latinos (mainly Mexican and Central American), Asian (including Hmong, Korean, Japanese), Native American (Chippewa-Cree, Blackfeet, Salish, Kootenai, Pend d'Oreille, Lakota, Navajo, Yakama); and Catholic communities serving Latino, African American, and Caucasian families in diverse regions of the United States; and internationally in Japan and Australia, and it will soon be adapted for use in Vietnam. **Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.** Our engagement with specific groups have been based on an approach of community participatory partnerships in which we work with multiple stakeholders within a community to discuss the most appropriate ways to engage the community and provide the CBITS intervention. For example, with some Latino communities, our engagement process prior to implementation has consisted of planning meetings with stakeholders (parents, teachers, community leaders) to discuss the specific needs of the community. We have partnered with a parent on the planning committee to present information together at parent groups with the parent representative being available informally to discuss more details about the program.

Engagement continued	We have worked with Lay Health Promoters (*Promotores/as*) in the Latino community to help provide trauma informed information in an easily accessible way to parents and other community members. Our approach has been to build on existing engagement strategies that communities are already using and have found to be successful. In our multicultural schools serving both African American and Latino families, it has been important to work with existing parent groups and school staff who are very familiar with their communities and represent each of these groups, for example using the parents and community representatives from the local school Parent Center. We have also conducted focus groups in these communities to better understand how this program can best be implemented in a way that cuts across racial divides and tensions that may exist. For example, in one school we discovered that it was crucial to present all information about CBITS to both African American and Latino families together, which meant that all activities were simultaneously translated for parents, to minimize mistrust across groups. We also worked with clinicians serving some Native American tribes or students to thread culturally relevant people and materials throughout the CBITS program, both to increase engagement and clinical salience. For example, a tribal elder burned sweet grass and offered a blessing both before the CBITS trainings as well as at the outset of the actual school groups. For faith-based schools, the parish priest also offered similar prayers for groups of students and parents. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** Yes throughout, as described above.
Language Issues	**How does the treatment address children and families of different language groups?** We describe how this intervention was first developed for multiple immigrant populations in our school district. We have always worked with bilingual bicultural staff who not only provide the intervention in the preferred language of the family but also practice in a way that takes into account norms, beliefs, values and practices of that group. Materials have also been carefully translated to meet the language needs of participating parents and students. Careful consideration was also placed by using several translators to cross check for language variations, content, and comprehensive matter across regional language differences. **If interpreters are used, what is their training in child trauma?** We have not typically used interpreters. Staff trained and implementing the program are generally bilingual and/or native speakers. However, we have had all types of providers such as case managers, nurses, parents, and lay health promoters attend our CBITS training and trauma awareness sessions so that everyone who is involved in the CBITS program, from initial engagement to parent outreach can be conversant in trauma informed practices even if they will not ultimately implement CBITS groups. **Any other special considerations regarding language and interpreters?** Throughout our trainings we encourage that all staff involved with traumatized students should be trauma-informed.

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?** We have a manuscript under review that describes our work with Latino students of varying English language fluency. We found that those students with higher English language fluency reported greater violence exposure and PTSD symptoms. Results also show that students with lower English fluency reported greater impact on academic performance than Latino students with higher language fluency (Kataoka, Langley, et al., under review). **If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?** All children in the group are taught and involved in each treatment component. However, the training emphasizes the importance of treating individuals and the manual includes an individual case conceptualization and treatment plan to assist clinicians in thinking about the individual needs of each child based on their endorsed symptoms as well as functional impairment.
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?** We initially pre-tested several measures and the assessment measures that we currently use were those found to be the most acceptable and that had the greatest face validity (Singer, 1995; Foa, 2001). **What, if any, culturally specific issues arise when utilizing these assessment measures?** We have found that when using assessment measures with students and their parents, we often need to assess the best way to administer the instruments. For some of our immigrant populations, for example, we administer the screening instrument in small groups and read aloud the instrument in their preferred language (instead of self-administered). Similarly with some parent groups, we find that their preferred administration of the assessment is in-person and assisted, especially in low literacy populations.
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** See Kataoka et al., 2003 for a description of the CBITS evaluation in a Latino immigrant population. **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)***.** See above for details. **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 have been found.

Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** Please see above regarding approach. **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?** CBITS was originally created in schools with school clinicians and community partners as active participants in the iterative process of developing the treatment manual. CBITS was created to decrease the negative effects of trauma exposure in children while being deliverable with the following contextual factors in mind: 1) the real world-setting of schools, and 2) cultural sensitivity to a primarily low SES, multi-ethnic and multi-linguistic community. **Are there cultural barriers to accessing this treatment** *(i.e., treatment length, family involvement, stigma, etc.)***?** This intervention was developed expressly to minimize cultural barriers. A key strength of CBITS is that it has been delivered in the school system, which has decreased barriers that have often been cited as preventing access to care by ethnic minority populations such as Latinos. We have also addressed possible cultural barriers of outreaching to parents and family members by involving community members (other parents, lay health providers). **Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** No. **Are these barriers addressed in the intervention and how?** N/A **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)***?** Community stakeholders have been an integral part of CBITS since its inceptions. See descriptions above.
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** As previously discussed, throughout the training and supervision/consultation process, there is an emphasis on the local clinician applying their cultural and contextual knowledge of and experience with their student population to the manner in which they convey each of the core treatment concepts and activities. Examples and activities should be salient to the children they serve. Many clinicians working with diverse populations find the examples and language in the manual to be relevant and we encourage trainees to use those that are and to replace or augment those that aren't with other meaningful examples, terminology, or language. We encourage all clinicians to bring in examples inclusive of themes and interests that are of interest to the youth.

Training Issues continued	For example, to use TV or comic book characters (i.e., "That's So Raven", Spongebob Squarepants), sports, community, or historical heroes (Kobe Bryant, a tribal leader, Rosa Parks), musicians, songs, storybooks, etc. to convey examples of treatment concepts (i.e., cognitions, problem solving) or to include elements relevant to the given population, such as burning sweet grass during relaxation exercises with certain Native American Groups. Within the context of demonstrating treatment concepts during the training, there is ongoing discussion of cultural sensitivity, such as not discounting a response as unrealistic if it may be appropriate for the child's family or cultural beliefs (i.e., belief in ghosts). The goal is for CBITS to be realized in each setting in a way that makes the most sense for the children being served while maintaining fidelity to the core treatment concepts and specific ways of doing this are part of the discussion throughout training. **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** Not applicable. **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** Not applicable.
References	Foa, E. B., Johnson, K. M., Feeny, N. C. & Treadwell, K. R. H. (2001). The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties. *Journal of Clinical Child Psychology, 30,* 376–384. Kataoka, S. H., Stein, B., Jaycox, L. H., Wong, M., Tu, W., Escudero, P., et al. (2003). A school based mental health program for traumatized Latino immigrant children. *Journal of the American Academy of Child and Adolescent Psychiatry, 42,* 311-318. Kataoka, S. H., Langley, A., Stein, B. D., Jaycox, L. H., Zhang, L., Sanchez, N. & Wong, M. (under review). Screening in schools for violence exposure and PTSD: The role of English language fluency in Latino youth. Singer, M. I. Anglin, T. M., Song, L. Y. & Lunghofer, L. (1995). Adolescents' exposure to violence and associated symptoms of psychological trauma. *Journal of the American Medical Association. 273,* 477-482.

NCTSN The National Child Traumatic Stress Network

GENERAL INFORMATION

CPC-CBT: Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** CPC-CBT **Average length/number of sessions:** Parents and children attend weekly two hour group sessions over a 16-week period. Parent and child interventions are conducted concurrently for the first 75 minutes of the session by four group therapists while the second 45 minutes involves the integrated joint parent-child sessions. **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** Transportation, babysitting, cultural and/or religious values and beliefs, particularly as they relate to parenting practices **Trauma type** *(primary)*: Physical abuse/harsh parenting practices **Trauma type** *(secondary)*: Sexual abuse and domestic violence **Additional descriptors** *(not included above)***:** A cognitive behavioral therapy (CBT) treatment protocol for children and families at risk for physical abuse that incorporates elements from empirically supported CBT models for sexually abused children as well as those targeting families in which physical abuse and domestic violence occur. It includes three goals: 1. Reduce the recurrence of child physical abuse by helping parents learn nonviolent disciplining and anger-control strategies, assisting them in altering faulty beliefs about who is responsible for the abuse, and challenging unrealistic expectations and misattributions about the causality of their children's behavior; 2. Decrease children's emotional distress by assisting them in processing their abusive experiences and developing adaptive coping skills; and 3. Increase positive parent-child interactions that are necessary for beneficial developmental outcomes for children.
Target Population	**Age range:** 14 **to** 17 **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** Hispanic, Black/African-American, Caucasian, and Multiracial. Some individuals enrolled in our study were first and second generation immigrants; all spoke English; they functioned at various levels of acculturation with some remaining very traditional in their beliefs and values. Implemented with families who only speak Spanish outside of our treatment study. **Other cultural characteristics** *(e.g., SES, religion)***:** Diverse SES and religious backgrounds **Language***(s)***:** English as a first and second language; Spanish as a first language (not involved in treatment study)

CPC-CBT: Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse

Target Population continued	**Region** *(e.g., rural, urban)*: Rural and urban as we serve 7 counties over a diverse geographic region; many do hail from inner city areas **Other characteristics** *(not included above)*: Targeted to families with a history of physical abuse and inappropriate physical discipline/coercive parenting strategies. Symptoms include PTSD, depression, abuse-related attributions, and externalizing behavior problems in children. Parental anger, child behavior management skills, coercive and/or violent parenting behavior, and parent-child relationship.
Essential Components	**Theoretical basis:** Cognitive-behavioral **Key components:** 1. Child intervention, 2. Parent intervention, and 3. Parent-child intervention.
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** ❒ **Yes** ☒ **No** ❒ **Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)*. 1 **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** ☒ **Yes** ❒ **No** See attached paragraph **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)*? ☒ **Yes** ❒ **No** **If YES, please include citation:** Overall, there is a 33% drop-out rate for those families who are offered treatment through our treatment study. Of the families who actually attend the first two treatment sessions which involve motivational interviewing, only 8% drop-out. The treatment model was developed in conjunction with client's feedback on satisfaction surveys. Initially, clients requested more culturally relevant materials. As such, we incorporated a number of elements (see Qualitative Impressions section below). Participants in Dr. Runyon's treatment development study also reported that the model assisted them in the following areas: helped them feel less alone (81%), gain their child's cooperation (87.5%), children's behavior improved (88%), improve their parent-child relationship and helped them more effectively manage their anger (94%). Parents whose children were involved in treatment identified the skills they learned as the most helpful aspect of the group. **Has this intervention been presented at scientific meetings?** ❒ **Yes** ☒ **No** **If YES, please include citation***(s)* **from last five presentations:** Accepted for presentation at a scientific meeting in Oregon in April, 2007 **Are there any general writings which describe the components of the intervention or how to administer it?** ☒ **Yes** ❒ **No**

CPC-CBT: Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse

Clinical & Anecdotal Evidence continued	**If YES, please include citation:** Runyon, Deblinger, Ryan & Thakkar-Kolar, 2004 **Has the intervention been replicated anywhere?** ☒ **Yes** ❒ **No** **Other countries?** *(please list)* We are providing ongoing consultation to two sites in New Jersey who are using the model with their clients. We just initiated consultation calls with an agency at Duke University who plans to implement the model. **Other clinical and/or anecdotal evidence** *(not included above)*: We are in the process of organizing training for dissemination of the treatment program in Sweden at multiple agencies; they are presently arranging to translate the treatment manual into Swedish.	
Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Pilot Trials/Feasibility Trials *(w/o control groups)*	**N=**9 parents and 16 children **By gender:** 9 females, 7 males **By ethnicity:** 25% Caucasian, 37% African-American, 25% Hispanic, 13% other **By other cultural factors:** diverse ethnic and religious backgrounds	Manuscript is being submitted
Randomized Controlled Trials	**N=**75	
Studies Describing Modifications	**By gender:** 41 males, 34 females **By ethnicity:** 17% Caucasian, 48% African-American, 21% Hispanic, 14% other **By other cultural factors:** diverse SES and religious backgrounds; 55% of the participants are economically disadvantaged and the majority are single mothers	In final stages; Final treatment group of trial will be completed in 01/07; See Qualitative Impressions (below) for preliminary results

CPC-CBT: Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse

Outcomes	**What assessments or measures are used as part of the intervention or for research purposes, if any?** See Qualitative Impressions section (below) **If research studies have been conducted, what were the outcomes?** Based on the pilot study mentioned above, pre- and post-pilot data were collected from a small sample of children and caregivers who participated in the 16-session pilot groups following the parent-child CBT treatment protocol. Based on this preliminary data, all participating children demonstrated significant improvements from pre- to post-treatment in the number of PTSD symptoms reported on the K-SADS. Caregivers also reported significant improvements in internalizing and externalizing behavior for all children. Caregivers also reported significant improvements in anger toward their children as well as significant improvements in consistent parenting and reductions in the use of corporal punishment. Children reported significant decreases in corporal punishment utilized by their parents as well. Preliminary findings of the randomized trial (NIMH-funded R21 referenced above demonstrated significant within group changes from pre- to post-test for the Combined Parent-Child CBT group (described here) and a similar Parent-Only CBT group. There were significant improvements from pre to post in self-reported parental depression, parental anger, and parenting skills. Children also showed significant improvements in depression and PTSD as well as parent-reported internalizing and externalizing problem behaviors. Both parents and children reported a significant reduction in the use of corporal punishment in general. While both conditions produced significant pre- to post-test changes, it is notable that the effect size for children's PTSD in the Combined Parent-Child condition (described here) is nearly twice that of the Parent-Only. Additionally, one of the most frequently spontaneous, hand-written complaints from parents participating in the Parent-Only condition was that they would have liked for their children to be involved in treatment and they would have liked to interact with their children during sessions.
Implementation Requirements & Readiness	**Supervision requirements** *(e.g., review of taped sessions)***?** Weekly supervision required; direct observation of sessions and/or listening to audiotapes preferred
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** A detailed preliminary manual has been developed. **How/where is training obtained?** Introductory training generally consists of two days of didactic training that includes case examples, role plays, and demonstrations. **What is the cost of training?** $2,000-$3000 per day plus travel expenses **Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ❒ **No**

Training Materials & Requirements continued	**If YES, what languages?** We are in the process of translating materials; the manual and client handouts are currently being translated into Swedish; the client handouts have been translated into Spanish.
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** Motivational interviewing to increase offending parent's compliance, provide transportation and babysitting to remove these barriers, incorporates parent and child to reduce violence in the home, to assist child in healing from the trauma, and to strengthen the parent-child relationship **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** Obtaining buy-in of offending parents, case management efforts to minimize drop-outs **Other qualitative impressions:** Some of our efforts toward enhancing the cultural competence/relevance of our model have been based on consumer feedback and are notable. See the CPC-CBT Culture-Specific Fact Sheet (following this General Fact Sheet), for more information. **Assessment Measures** Child-Report Outcome Measures Parent-Child Conflict Tactics Scale (CTSPC; Straus et al., 1998) Children's Depression Inventory (CDI-II; Kovacs & Beck, 1983) K-SADS Post-Traumatic Stress Disorder Interview (K-SADS PTSD; Orvaschel & Puig-Antich, 1987) Children's Anger Inventory (CIA; Nelson & Finch, 2000) Children's Attributions and Perceptions Scale (CAPS; Mannarino, Cohen, & Berman, 1994). Alabama Parenting Questionnaire-Child Report (APQ; Frick, 1991) **Parent-Report Outcome Measures** Parent-Child Conflict Tactics Scale (CTSPC; Straus et al., 1998) Beck Depression Inventory (BDI; Beck, Steer, & Brown, 1996) Parental Anger Inventory (PAI; MacMillan, Olson, & Hanson, 1988) Alabama Parenting Questionnaire-Parent Self-Report (APQ; Frick, 1991) Achenbach Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983)
Contact Information	**Name:** Melissa K. Runyon, PhD **Address:** UMDNJ-SOM, CARES Institute, 42 East Laurel Rd., Suite 1100B, Stratford, New Jersey 08084 **Phone number:** (856) 566-7036 **Fax number:** (856) 566-6108 **Email:** runyonmk@umdnj.edu

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Runyon, M. K., Deblinger, E., Ryan, E. & Thakkar-Kolar, R. (2004). An overview of child physical abuse: Developing an integrated parent-child cognitive-behavioral treatment approach. *Trauma, Violence, & Abuse: A Review Journal, 5,* 65-85.

Straus, M. A., Hamby, S. L., Finkelhor, D., Moore, D. W. & Runyan, D. (1998). Identification of child maltreatment with the Parent-Child Conflict Tactics Scales: Development and psychometric data for a national sample of American parents. *Child Abuse and Neglect. 22,* 249-270.

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."** The treatment incorporates elements as described below to respond to the needs of many groups. **Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.** Some of our efforts toward enhancing the cultural competence/relevance of our model and enhancing our ability to engage clients of all cultural backgrounds have been based on consumer feedback and are notable. With regard to the relevance of interventions, it is notable that other interventions utilizing similar CBT strategies have found no differential treatment effects based on ethnicity. Research has also suggested that African-Americans and other minority populations may be more amenable to structured therapy approaches that seem more like a class than therapy. As such, we are cognizant of how we describe our therapy when introducing it to families via the telephone prior to the initial assessment and during subsequent sessions. The treatment included a number of aspects that, while not necessarily culture-specific, may have increased the relevance of the treatment protocol to the families served and engaged them in the treatment process. For example, the therapists established collaborative working relationships with families. A primary goal was to empower our parents to feel as though they were an effective agent of change in their environments, particularly with regard to their children's behavior. They also initiated discussions and demonstrated respect for families' cultural beliefs and traditions (i.e., cultural, ethnic, religious, gender, etc.) and worked with families to determine how some new skills might fit into their preexisting environment and how others might not work. Other families presented with specific goals in mind for their families and their children, some of which were related to their cultural beliefs, traditions, and backgrounds. By establishing a collaborative relationship with them, listening to them educate us about their beliefs and goals and discussing what the treatment offers that may help them achieve those goals, families appeared to become more engaged in the treatment process. In sum, engagement strategies are tailored to each family regardless of culture. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** Compounded by other culturally-relevant factors, many children and families who are referred for child physical abuse may be distrustful and reluctant to participate in treatment and be open about abusive experiences to systems due to the discriminatory and oppressive practices directed towards them by these very systems (Fontes, 1993), as well as their fears of being judged and persecuted by treatment providers. We establish collaborative working relationships to determine how we can work with families to find available options to attain their goals.

Engagement continued	We also empathize and align with parents in a non-judgmental fashion while keeping the delicate balance of holding them accountable for their abusive behavior(s). We also utilize a motivational procedure/consequence review (Donohue, Van Hasselt, et al., 1998) to motivate parents and engage them in the treatment process.
Language Issues	**How does the treatment address children and families of different language groups?** We have incorporated Spanish-language parenting books (Whitham, 2002, 2003) into the treatment. We have also translated many of our handouts into Spanish and the protocol has been utilized with families who speak Spanish only who were not involved in the treatment studies. **If interpreters are used, what is their training in child trauma?** N/A **Any other special considerations regarding language and interpreters?** N/A
Symptom Expression	**If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?** N/A
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?** We have carefully selected assessment measures that were normed on diverse populations. We use the same measures across cultural groups. Some of the measures have been translated into Spanish and others are published in Spanish. **If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** Normative data for diverse populations exists for some of the assessment measures. We are cautious about interpreting measures not normed on Spanish-speaking populations and often examine only the individual items. **What, if any, culturally specific issues arise when utilizing these assessment measures?** N/A
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** None to date.

Cultural Adaptations continued	**Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)***.** Boyd-Franklin highlights a need to help parents understand that while certain forms of spanking may have a place in the overall disciplinary program, an exclusive reliance can be counterproductive. Our approach has been not to tell parents that they are bad or that spanking is bad, but to discuss with them non-violent alternatives to keep their children safe and to avoid any further negative consequences for themselves or their children. We have also incorporated culturally sensitive parenting materials into our protocol, such as Howard Stevensen's parenting book (Stevenson, Davis & Abdul-Kabir, 2001), articles about praise from Essence magazines, Spanish language parenting books (Whitham, 2002, 2003), and Nancy Boyd-Franklin's book about raising black men.
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 included a number of aspects that while not necessarily culture specific may have increased the relevance of the treatment protocol to the families served. For example, the therapists established collaborative working relationships with families. A primary goal was to empower our parents to feel as though they were an effective agent of change in their environments, particularly with regard to their children's behavior. They also initiated discussions and demonstrated respect for families' cultural beliefs and traditions and worked with families to determine how some new skills might fit into their pre-existing environment and how others might not work. Boyd-Franklin (1989, 1993) cites literature indicating that African-American children are overrepresented in special education classes. Our therapists provided case management services to empower African-Americans, and all of our families, to advocate for their children at school and obtain positive results. In four cases, the plan was to extricate the children from the regular school system. After our involvement, therapists and parents were able to work with the school in order to maintain these children in the regular school system. With regard to the relevance of interventions, it is notable that other interventions utilizing similar CBT strategies have found no differential treatment effects based on ethnicity. Research has also suggested that African-Americans and other minority populations may be more amenable to structured therapy approaches that seem more like a class than therapy. **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?** Clinic-based treatment. **Are there cultural barriers to accessing this treatment** *(i.e., treatment length, family involvement, stigma, etc.)***?** We are careful in the way we approach clients about the treatment and in our own descriptions of the treatment in our initial phone contacts and subsequent sessions, being mindful that the stigma attached to abuse-related and mental health-related issues may be a barrier to them attending treatment.

Intervention Delivery Method/ Transportability & Outreach continued	**Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** We offer transportation and babysitting of siblings in our waiting room which have been identified as barriers for many of our clients. A majority of our clients do not pay out of pocket for these services. We have a variety of resources (i.e., grants, child protection contract, etc.) that permit us to offer these services free of charge to the families. **Are these barriers addressed in the intervention and how?** To eliminate barriers that might prohibit families, regardless of culture, from accessing services, we offer a variety of support services, such as client transportation and volunteer babysitting for young clients and their siblings. **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)***?** Our therapists provided case management services to empower African-Americans, and all of our families, to advocate for their children at school and obtain positive results. In four cases, the plan was to extricate the children from the regular school system. After our involvement, therapists and parents were able to work with the school in order to maintain these children in the regular school system.
Training Issues	**If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** During our supervision/team meetings, we have frequent discussions related to the cultural context of corporal punishment and physical abuse and how this may impact our approach with and the response from particular clients. As mentioned above, we tailor engagement strategies to the specific clients and culture is one variable that may be addressed in planning our approach. Much of the work described above was done in response to formal, confidential feedback elicited from our clients, 71% of whom identified themselves as African-American, Hispanic, and Biracial.
References	Boyd-Franklin, N. (1989). *Black families in therapy: A multisystems approach.* New York, NY: Guilford Press. Boyd-Franklin, N. (1993). Race, class, and poverty. In Walsh, F. (Ed.), *Guilford family therapy series: Normal family processes* (2nd ed., pp. 361-376). New York, NY: Guilford Press. Donohue, B., Van Hasselt, V. B., Hersen, M. & Perrin, S. (1998). Role-play assessment of social skills in conduct disordered and substance abusing adolescents: An empirical review. *Journal of Child & Adolescent Substance Abuse, 8,* 1-28. Fontes, L. (2003). *Reducing violence in multicultural schools.* In P. Pedersen & J. C. Carey (Eds.), *Multicultural counseling in schools: A practical handbook* (2nd ed., pp. 211-233). Boston: Alwyn & Bacon. Stevenson, H. C., Davis, G. & Abdul-Kabir, S. (2001). *Stickin' to, watchin' over, and gettin' with: An African American parent's guide to discipline.* San Francisco: Jossey-Bass. Whitham, C. (2002). *La respuesta es no: Aprenda a decir no y cómo mantenerlo.* Barcelona, Spain: Amat Editorial. Whitham, C. (2003). *Gana la guerra de los berrinches y otras contiendas: Un plan de paz familiar.* Glendale, CA: Perspective Publishing.

NCTSN The National Child Traumatic Stress Network

GENERAL INFORMATION

CM-TFT: Culturally Modified Trauma-Focused Treatment

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** CM-TFT **Average length/number of sessions:** 12-16 sessions **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** Spirituality, Gender Roles, *Familismo, Personalismo, Respeto, Sympatia, Fatalismo,* Folk Beliefs **Trauma type** *(primary)*: Sexual abuse **Trauma type** *(secondary)*: Physical abuse **Additional descriptors** *(not included above)***:** This intervention was developed for use with Latino children and is based on Trauma-Focused Cognitive Behavioral Therapy, with the addition of modules integrating cultural concepts throughout treatment.
Target Population	**Age range:** 4 **to** 18 **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** Latino/Hispanic; range of acculturation level; recently immigrated to second generation; majority of children are of Mexican descent, with some children from other Central and South American countries. **Other cultural characteristics** *(e.g., SES, religion)***:** Majority of families are low income; some children are from migrant agricultural worker families; majority of families are Catholic with varying degrees of participation in formal religious practices. **Language***(s)***:** Spanish, English **Region** *(e.g., rural, urban)***:** Rural and urban
Essential Components	**Theoretical basis:** Cognitive Behavioral Therapy **Key components:** • Psycho-education • Emotional regulation skills • Coping skills training • Distinguishing thoughts, feelings, and behaviors, including trauma-related • Gradual exposure (trauma narrative) • Cognitive and affective processing of trauma experiences • Parallel parent treatment • Risk reduction skills

CM-TFT: Culturally Modified Trauma-Focused Treatment

Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** ❒ **Yes** ☒ **No** ❒ **Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)***.** 5 **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** ❒ **Yes** ☒ **No** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***?** ❒ **Yes** ☒ **No** **Has this intervention been presented at scientific meetings?** ☒ **Yes** ❒ **No** **Are there any general writings which describe the components of the intervention or how to administer it?** ☒ **Yes** ❒ **No** **If YES, please include citation:** de Arellano & Danielson, 2005 **Has the intervention been replicated anywhere?** ❒ **Yes** ☒ **No**	
Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Pilot Trials/Feasibility Trials *(w/o control groups)*	**N=**10 **By gender:** 9 Girls, 1 Boy **By ethnicity:** Latino (Mexican)	Rivera & de Arellano, 2008
Outcomes	**What assessments or measures are used as part of the intervention or for research purposes, if any?** • CBCL • UCLA PTSD Scale • TSCC • Semi-structured Clinical Interview **If research studies have been conducted, what were the outcomes?** Pilot feasibility trials are in progress.	

CM-TFT: Culturally Modified Trauma-Focused Treatment

Implementation Requirements & Readiness	**Space, materials or equipment requirements?** Treatment sessions are held in home, schools, or other community sites that parents or children find convenient (e.g., churches or the parent's workplace). **Supervision requirements** *(e.g., review of taped sessions)***?** While beginning implementation of the intervention, regular supervision (e.g., weekly) is necessary, especially focused on issues more likely to be encountered in community-based than office-based treatment (e.g., safety, privacy, condition of home environment). Ideally, supervision should be provided by someone trained and experienced in community-based implementation of evidence-based treatment. Audio and/or video tapes can facilitate the supervision process. **To ensure successful implementation, support should be obtained from:** Supervision/consultation should be obtained from clinicians trained and experienced in community-based implementation of evidence-based treatments.
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** de Arellano & Danielson, 2005 **How/where is training obtained?** Contact developers (Michael A. de Arellano and Carla Kmett Danielson) at National Crime Victims Research and Treatment Center at the Medical University of South Carolina. **What is the cost of training?** Dependent on the training/ongoing supervision needs of the site. **Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ❒ **No** **If YES, what languages?** Spanish **Other training materials &/or requirements** *(not included above)***:** Workshops at national meetings.
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** The importance of cultural concepts to the child and family are assessed and treatment is tailored to address those cultural issues. This helps to increase the perceived relevance of the intervention and engagement in treatment. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** The addition of the cultural modifications can increase the length of sessions and treatment overall.

CM-TFT: Culturally Modified Trauma-Focused Treatment

Pros & Cons/ Qualitative Impressions continued	**Other qualitative impressions:** While maintaining the "therapeutics" of TF-CBT, CM-TFT targets engagement in treatment to reduce treatment drop-outs and no-shows, while increasing adherence with homework assignments and in session activities.
Contact Information	**Name:** Michael A. de Arellano, Ph.D. and Carla Kmett Danielson, Ph.D. **Address:** National Crime Victims Research and Treatment Center, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, 165 Cannon Street, P.O. Box 250852, Charleston, SC 29425 **Phone number:** (843) 792-2945 **Email:** dearelma@musc.edu, danielso@musc.edu **Website:** www.musc.eu/ncvc
References	deArellano, M. A. & Danielson, C. K. (2005). *Culturally-Modified Trauma Focused Treatment*. Unpublished Manuscript, Medical University of South Carolina. Rivera, S. & de Arellano, M. A. (2008, January). *Culturally Modified Trauma-Focused Treatment for Hispanic children: Preliminary findings.* Presented at the 22nd Annual San Diego International Conference on Child and Family Maltreatment, San Diego, CA.

CM-TFT: Culturally Modified Trauma-Focused Treatment

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."** The intervention was developed for use with Latino children. While early development focused primarily on children from Mexican immigrant families, further development and piloting has been conducted with a broad range of Latino children from various nationalities (e.g., Central and South American), geographic locations (e.g., Florida, Texas, California, New York), and socioeconomic backgrounds. **Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.** Yes, the intervention utilizes a flexible approach that can be adapted to Latinos with different belief systems and levels of acculturation. A number of cultural constructs (e.g., spirituality, traditional gender roles, *familismo*, *personalismo*) are assessed and integrated throughout treatment depending on their importance and relevance to the family's belief system. This approach permits tailoring of the intervention to a wide variety of belief systems across Latino populations. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** Therapists are trained to be respectful of and responsive to cultural beliefs including norms for interpersonal interactions (e.g., *personalismo*) which facilitate providing services within an appropriate cultural context. Therapists are also trained to assess and address potential challenges to the development of strong therapeutic relationships, including previous interactions that families have had with mental health treatment providers or "the system" in general, as well as racism and discrimination.
Language Issues	**How does the treatment address children and families of different language groups?** When available and/or preferred, treatment is provided in Spanish. Various handouts and other therapy materials are available in Spanish. At times, therapy is provided in English and Spanish to facilitate treatment for children who have learned English as a second language. Language issues, such as the language in which trauma-related memories, thoughts, and feelings are encoded are also considered. **If interpreters are used, what is their training in child trauma?** Interpreters should be certified to interpret. Additionally, interpreters should receive general training in trauma and trauma-related problems and specific training in the overall intervention. Consistency of interpreters working with each child and family can help facilitate the therapeutic process. **Any other special considerations regarding language and interpreters?** Interpreters should be certified. Family members should not be used as interpreters.
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?** Some research suggests a greater tendency to express somatic symptoms (e.g., aches and pains, lethargy) among Latinos experiencing depression and/or anxiety.

Symptom Expression continued	In cases in which significant levels of somatization exist, efforts should be made to assess somatic symptoms (e.g., Children's Somatization Inventory) throughout treatment to monitor progress. **If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?** It is believed that somatic symptoms are an expression of depression and/or anxiety and, as such, should also improve given that this intervention targets depressive and anxiety symptoms.
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?** The following measures have been used with children from various Latino backgrounds: • Acculturation Rating Scale for Mexican Americans-II (ARSMA: Cuellar, Arnold & Maldonado, 1995) • Multiphasic Assessment of Cultural Constructs–Short Form (Cuellar, Arnold & Gonzalez, 1995) **If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** Normative data is available for use with Latinos. The ARSMA was designed for Mexican Americans and in this form only has normative data for this population. **What, if any, culturally specific issues arise when utilizing these assessment measures?** These measures permit the efficient assessment of a number of cultural concepts, and can help facilitate discussion of cultural beliefs held by the child and caregivers.
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** Descriptions of the treatment outline the culture-specific assessment strategy of cultural constructs and the strategy for tailoring treatment based on this assessment. **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)***.** Adaptations have been made for individual components across the treatment intervention. **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?** Anecdotal evidence suggests that the cultural modifications help enhance engagement and consequently leads to reduced premature termination.
Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** While not a "cultural risk factor," some communities have risk factors for different types of trauma (e.g., residing in a border community increasing risk for drug-related kidnappings). Such risks are addressed in treatment and attempts are made to reduce the risk of future exposure to such events.

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?** Treatment has been provided in office-based and community-based (e.g., church) settings. Preliminary pilot work suggests that the treatment is efficacious in community settings as well. **Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** Given that Latino families are over represented below the poverty line, many families can have difficulties accessing services due to lack of transportation, employment barriers (e.g., no time off), and being uninsured/underinsured. Undocumented immigrant families can often experience additional barriers, including concerns about arrest and deportation. **Are these barriers addressed in the intervention and how?** Potential barriers are assessed and addressed in treatment, including assisting families with basic needs financial assistance, and legal assistance. **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)***?** Collaboration and coordination with faith-based organizations, schools, and other agencies within the community is essential to serving difficult-to-reach populations, such as some Latino communities. Developing such relationships also facilitates the provision of community-based services.
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** In addition to learning about the specific cultural group that will be served, therapists are encouraged to be aware of their own cultural background, beliefs, and biases, which can have an impact on working with families from that cultural group. **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** As needed, cultural issues are identified and discussed in supervision as they pertain to the provision of services or personally for the therapist. **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** Therapists are encouraged to include cultural beliefs and practices as an integral part of treatment. Strategies are discussed for tailoring treatment to be responsive to specific cultural beliefs important to the child and family. **Has this guidance been provided in the writings on this treatment?** Specific guidance has been provided to encourage therapists to integrate cultural constructs into treatment as needed for each family.
References	Cuellar, I., Arnold, B. & Gonzalez, G. (1995). Cognitive referents of acculturation: Assessment of cultural constructs in Mexican Americans. *Journal of Community Psychology, 23*(4), 339-356. Cuellar, I., Arnold, B. & Maldonado, R. (1995). Acculturation Rating Scale for Mexican Americans-II: A revision of the original ARSMA scale. *Hispanic Journal of Behavioral Sciences, 17*, 275-304.

NCTSN The National Child Traumatic Stress Network

GENERAL INFORMATION

IFACES: International Family Adult and Child Enhancement Services, Heartland Health Outreach

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** IFACES **Average length/number of sessions:** Sessions are as needed and tailored to the needs of each program participant. **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** War trauma, refugee trauma, migration and acculturative stress, as well as multiple barriers to treatment that are overcome through outreach and by providing services in participants' homes or other locations **Trauma type** *(primary)*: War trauma **Trauma type** *(secondary)*: Migration and acculturation **Additional descriptors** *(not included above)***:** The IFACES program provides comprehensive community-based mental health services to refugee children, adolescents, and families. Outreach is seen as the cornerstone of the program and occurs throughout the treatment process. It includes identifying refugee children who can benefit from services, engaging them and their families in services, retaining them in services, and supporting them as necessary after the active treatment phase has ended.
Target Population	**Age range:** All ages **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** The target population is refugee and immigrant children who have experienced trauma as a result of war or displacement. This includes children who emigrated themselves as well as children of refugees/immigrants. The program is designed to provide services to a variety of ethnic groups, and no one is turned away from services because of their cultural or linguistic background. Racial groups include White (European refugees), Black (African refugees), Asian (including Southeast Asia and South Asia), and Hispanic (Central and South America). **Other cultural characteristics** *(e.g., SES, religion)***:** All are low SES, various religions **Language***(s)***:** A wide variety of languages are spoken. For example, 66 children and adolescents on whom extensive data is available and who were served in a 2-year time frame spoke 19 languages, including the following: Amharic, Anuak, Arabic, Bassa, Bosnian/Serbo-Croatian, Bosnian/Roma, English, French, Kpelle, Ogoni. During the same time period, staff, including clinicians and ethnic mental health workers, spoke 15 languages among them, including the following: Oromo, Spanish, Krahn, Romanian, Swahili, Tigrenya, Ukrainian, Urdu. When a language match between provider and participant cannot be made, staff utilize trained interpreters to communicate with the children and families. **Region** *(e.g., rural, urban)***:** Urban and rural

IFACES: International Family Adult and Child Enhancement Services, Heartland Health Outreach

Target Population continued	**Other characteristics** *(not included above)*: The program is designed to meet the needs of diverse children and adolescents from a variety of cultural and language backgrounds. Those seeking services are not turned away if the language or cultural competence is not represented among staff; rather, in these situations services are provided through trained interpreters. The goal is to meet the mental health needs of all refugee children seeking services, regardless of their background, by providing flexible and comprehensive services.
Essential Components	**Theoretical basis:** Client-centered and community-based, extensive outreach, and openness to problem-solving any barriers to treatment. **Key components:** • Multidisciplinary team includes psychotherapists; art, occupational, and dance therapists; psychiatrists; and ethnic mental health workers from refugee communities served. • Multicultural ethnic mental health workers provide cultural and linguistic competence and work as part of a mental health team. • The team shares responsibility for program participants, with multiple providers providing diverse services to a participant and family. • Team approach allows for services to be individualized to particular participants' needs, and for staff to give support to one another. • Services are provided at locations that are most comfortable to program participants, including home, school, office and other community locations. • Comprehensive services address mental health as part of a range of needs that refugee children and families have as they are adjusting to their new life. • Coordination with refugee resettlement services within the same agency allows IFACES to establish relationships with families before they need services, which helps reduce stigma. • Ethnic mental health workers provide extensive outreach, often for prolonged periods of time, before a participant is engaged in mental health services.
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** **❒ Yes ☒ No ❒ Uncertain** **Extent to which cultural issues have been described in writings about this intervention** The approach is culturally sensitive, in that staff constantly assess ways in which the participants' cultural background impacts their functioning and services. An article describing the approach is currently under review (Birman, Beehler, Merrill Harris, Everson, Batia, Liautaud, et al., under review).

Clinical & Anecdotal Evidence continued

The rationale for the program design is presented in the article as well, and is informed by empirical evidence regarding refugee and immigrant mental health. This approach has also been described in Mental Health Interventions for Refugee Children in Resettlement: White Paper II (Refugee Trauma Task Force, National Child Traumatic Stress Network, 2005).

This intervention is being used on the basis of anecdotes and personal communications only *(no writings)* **that suggest its value with this group.**
❒ **Yes** ☒ **No**

Are there any anecdotes describing satisfaction with treatment, drop-out rates *(e.g., quarterly/annual reports)***?** ☒ **Yes** ❒ **No**
Satisfaction with treatment is regularly assessed and the ratings are consistently high. Anecdotes are available.

If YES, please include citation:
Documents internal to Heartland Health Outreach IFACES

Has this intervention been presented at scientific meetings? ☒ **Yes** ❒ **No**

If YES, please include citation*(s)* **from last five presentations:**
International Society for Traumatic Stress Studies: Birman, Ho, Basu, Pulley & Beehler, 2004; Birman, Basu & Pulley, 2003

Annual Midwest Eco Conference: Birman, Pulley, Blanton & Beehler, 2004

Are there any general writings which describe the components of the intervention or how to administer it? ☒ **Yes** ❒ **No**

If YES, please include citation:
Birman, Beehler, Merrill Harris, Everson, Batia, Liautaud, et al., under review

Has the intervention been replicated anywhere? ❒ **Yes** ☒ **No**

Other clinical and/or anecdotal evidence *(not included above)***:**
The program has evolved from decades of providing services to refugees at the agency, and is informed by experience providing resettlement, social, and mental health services to this population. Further, the team approach and comprehensive services aspects of the model have been influenced by Assertive Community Treatment and other community-based approaches used by agency programs that work with individuals who are homeless and have a serious mental illness.

IFACES: International Family Adult and Child Enhancement Services, Heartland Health Outreach

Research Evidence	Sample Size (N) and Breakdown *(by gender, ethnicity, other cultural factors)*	Citation
Other Research Evidence	**N=**66 **By gender:** 45.5% female; 54.5% male **By ethnicity:** born in 26 different countries, represent 27 different ethnic groups, and speak 19 different primary languages	Birman, Beehler, Merrill Harris, Everson, Batia, Liautaud, et al., under review

Outcomes

What assessments or measures are used as part of the intervention or for research purposes, if any? The Child and Adolescent Functional Assessment Scale (CAFAS), UCLA PTSD-RI, and Child Depression Index (CDI) have been used with some participants as well.

If research studies have been conducted, what were the outcomes?

- Children and adolescents receiving services (N=66) improved as a group over the course of treatment, and the amount of improvement was statistically significant.
- All but 5 of the children received services in more than one location, with an average of 4.4 locations (SD=2). On average, each participant received services from 2.7 providers (SD=1.5). All but 12 of the participants received services from multiple providers.
- Language match between the service providers and the program participants was determined from information available on the language capacity of the providers assigned to each case, and the primary language of the participant. In all, out of the sample of 66, 31 participants were matched on language with at least one of the providers from whom they received services during the three-year period, and 35 were not matched. Those who were not matched either spoke English fluently enough to participate in treatment, or were treated with assistance of interpreters brought in from other services. Those matched on language stayed in treatment longer than those not matched.
- Dosage of services was not related to outcome.
- Participants with greater needs (more trauma, more caregiver trauma, and younger) received more intensive services (at more locations, from a greater number of providers, and more overall).

IFACES: International Family Adult and Child Enhancement Services, Heartland Health Outreach

Implementation Requirements & Readiness	**Space, materials or equipment requirements?** Very intensive, requires multidisciplinary treatment team including ethnic workers knowledgeable about the cultures of current refugee groups and the community. **Supervision requirements** *(e.g., review of taped sessions)***?** Because ethnic workers are most often trained in mental health treatment through the program, extensive supervision is required. Group supervision has been found to be helpful given the nature of the clinical work and that each client often works with several staff. **To ensure successful implementation, support should be obtained from:** Heartland Health Outreach IFACES
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** DVD: International FACES: A Collaborative Approach to Healing and the Refugee Experience **How/where is training obtained?** No formal training manuals are currently established. Staff provides training in a wide range of community settings on refugee and multicultural issues. **What is the cost of training?** Rates vary according to time and location. **Are intervention materials** *(handouts)* **available in other languages?** ❒ **Yes** ☒ **No** **Other training materials &/or requirements** *(not included above)***:** Interpreter Manual
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** The program is very effective at overcoming multiple barriers to service, including stigma and transportation. Access to services is enhanced and treatment is highly individualized. Treatment model is effective with an array of cultural and language groups. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** Services to those in greater need are intensive, and require commitment of time for the transportation, staff meetings, and travel required. Service is provided through grant funds. It would be difficult to collect reimbursement for travel/transportation and other community-based aspects of the service model.

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GENERAL INFORMATION

IFACES: International Family Adult and Child Enhancement Services, Heartland Health Outreach

Contact Information

Name: Joan Liautaud, Psy.D.

Address: Heartland Health Outreach IFACES, 4750 N. Sheridan, Suite 500, Chicago, IL 60640

Phone number: (773) 751-4054

Fax number: (773) 751-4174

Email: jliautaud@heartlandalliance.org

Website: www.heartlandalliance.org

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Refugee Trauma Task Force, National Child Traumatic Stress Network (2005). *Mental health interventions for refugee children in resettlement: White paper II.* Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.

IFACES: International Family Adult and Child Enhancement Services, Heartland Health Outreach

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."** Immigrants/refugees **Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.** Engagement is done in the community and in tandem with resettlement organizations. Much of the engagement takes the form of mental health case management, targeting basic needs and accompanying families to various medical, benefit-related, or school appointments. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** Trust, relationship building
Language Issues	**How does the treatment address children and families of different language groups?** We use interpreters and support families in ESL classes. Alternative therapies including art, dance-movement and occupational are offered and do not rely exclusively on language. **If interpreters are used, what is their training in child trauma?** There is not necessarily training in child trauma, though many are certified to interpret within a mental health context. **Any other special considerations regarding language and interpreters?** Where interpreters are from and long-standing tribal or cultural conflicts in country of origin are considered.
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?** Yes, populations manifest them differently and we assess from many perspectives–including somatic complaints. **If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?** Narrative and participant-directed reporting.
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?** None

IFACES: International Family Adult and Child Enhancement Services, Heartland Health Outreach

Assessment continued	**If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** We have used norms already established with general child populations, as guidelines for a baseline measure and then have monitored each child's progress throughout treatment–compared them to each other and conducted before and after analyses. **What, if any, culturally specific issues arise when utilizing these assessment measures?** Children and families do not understand MANY of the questions, as they do not experience symptoms as they are described in our measures. Explaining symptoms is common which likely jeopardizes the validity of the measure being used.
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** Yes. They are addressed in the assessment and considered throughout.
Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** Part of the narrative work is to use strength-based, empowerment focused interviewing. **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 is community-based and place of service varies. **Are there cultural barriers to accessing this treatment** *(i.e., treatment length, family involvement, stigma, etc.)***?** Yes. **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)***?** Much collaboration as part of the treatment is to link participants with their communities.
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** Place of birth, family roles, family constitution, gender, discipline, religion, values, traditional medical practices, asking for support. **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** Psychoeducation, didactic and process. **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** Psychoeducation, didactic and process. **Has this guidance been provided in the writings on this treatment?** Some

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ITCT: Integrative Treatment of Complex Trauma

GENERAL INFORMATION

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** ITCT **Average length/number of sessions:** 16 to 36 **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** Relevant for a range of cultural groups and addresses specific challenges for more disadvantaged groups. **Trauma type** *(primary)*: Physical abuse, sexual abuse, emotional abuse and neglect, community violence, domestic violence, medical trauma, traumatic loss. **Trauma type** *(secondary)*: Parental substance abuse **Additional descriptors** *(not included above)***:** Most clients with complex psychological trauma present with more than one type of trauma and frequently have parent-child attachment issues (e.g., parental abandonment, multiple foster placements).
Target Population	**Age range:** 2 **to** 21 **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** Hispanic-American, African-American, Caucasian, Asian-American **Other cultural characteristics** *(e.g., SES, religion)***:** Applicable for all SES groups; particularly adapted for economically disadvantaged and culturally diverse clients. **Language***(s)***:** Interventions also adapted in Spanish **Region** *(e.g., rural, urban)***:** Urban; can be adapted for rural clients.
Essential Components	**Theoretical basis:** Assessment-driven treatment, with standardized trauma specific measures administered at 3 month intervals to identify symptoms requiring special clinical attention. ITCT is based on developmentally appropriate, culturally adapted approaches that can be applied in multiple settings: outpatient clinic, school, hospital, inpatient and involves collaboration with multiple community agencies. **Key components:** Treatment follows standardized protocols involving empirically-based interventions for complex trauma and includes multiple treatment modalities: cognitive therapy, exposure therapy, play therapy, and relational treatment in individual and group therapy. Specific collateral and family therapy approaches are also integrated into treatment. • Therapeutic exposure and exploration of trauma is facilitated in a developmentally–appropriate and safe context, balanced with attention to increasing affect regulation capacities, enhanced self-esteem, and a greater sense of self-efficacy.

ITCT: Integrative Treatment of Complex Trauma

Essential Components continued	• ITCT incorporates specific approaches for complex trauma treatment including aspects of the Self Trauma model (Briere, 2002; Briere & Scott, 2006), Trauma-Focused Cognitive Behavioral Therapy (Cohen et al., 2004), and traumatic grief therapy (Saltzman et al., 2003). • The relationship with the therapist is deemed crucial to the success of therapy; safety and trust are necessary components. • Multiple adaptations for (a) children presenting to clinic and (b) children in the school system. • Clients receive treatment based on needs identified through regular administration of standardized assessment protocols, developmental and cultural considerations. • Immediate trauma-related issues such as anxiety, depression, and posttraumatic stress are addressed earlier in treatment (when possible), in order to increase the capacity to explore more chronic and complex trauma issues. • Complex trauma issues are addressed as they arise, including attachment disturbance, chronic negative relational schema, behavioral and affect dysregulation, interpersonal difficulties, and identity-related issues.
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** **❒ Yes ☒ No ❒ Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)***.** 5 **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** **❒ Yes ☒ No** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***? ☒ Yes ❒ No** **If YES, please include citation:** NCTSN 2004-2005 Annual Report **Has this intervention been presented at scientific meetings? ☒ Yes ❒ No** **If YES, please include citation***(s)* **from last five presentations:** ISTSS (2002, 2003); NCTSN All-Network Meeting (2003, 2004, 2005, 2006); APSAC (2004, 2006) **Are there any general writings which describe the components of the intervention or how to administer it? ☒ Yes ❒ No** **If YES, please include citation:** *Principles of trauma therapy* (Briere & Scott, 2006)

ITCT: Integrative Treatment of Complex Trauma

Clinical & Anecdotal Evidence continued	**Has the intervention been replicated anywhere?** ☒ **Yes** ❒ **No** **Other countries?** *(please list)* Multiple trainings in Canada, New Zealand, Scotland	
Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Pilot Trials/Feasibility Trials *(w/o control groups)*	**Two studies:** **N=**21 (storefront/ alternative school) **N=**11 (regular school-based) **By gender:** male and female (vary by study) **By ethnicity:** Hispanic-American, African-American, Caucasian, Mixed (vary by study)	Not yet published (presented at multiple conferences).
Other Research Evidence	**Clinic Based, N=**64 **By gender:** 27 male, 37 female **By ethnicity:** 45.3% Hispanic-American, 28.1% African-American, 17.2% Caucasian, 9.4% Asian-American	Not yet published (presented at multiple conferences).
Outcomes	**What assessments or measures are used as part of the intervention or for research purposes, if any?** • Initial clinical interview(s) with child or adolescent and caretaker • Trauma Symptom Checklist for Children (TSCC and TSCC-A) • Trauma Symptom Checklist for Young Children (TSCYC) • Trauma Symptom Inventory • Children's Behavior Checklist (CBCL)–parent and youth self-report • Children's Depression Inventory • UCLA Trauma Reaction Index • Trauma Symptom Review for Adolescents • Child Sexual Behavior Inventory	

Outcomes continued	**If research studies have been conducted, what were the outcomes?** For school-based program studies, there were significant decreases in depression, posttraumatic stress, dissociation, internalizing symptoms, and externalizing symptoms. For clinic-based studies, clients reported significantly reduced symptoms on all trauma-related areas as measured by the TSCC: anxiety, depression, anger, posttraumatic stress, dissociation, and sexual concerns.
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** Manuals for children and adolescents in progress; interventions for older adolescents described in a recent book (Briere & Scott, 2006). **How/where is training obtained?** Miller Children's Abuse and Violence Intervention Center University of Southern California Child and Adolescent Trauma Program (MCAVIC), USC, at other NCTSN sites, national conferences and trainings offered throughout the U.S.A. **What is the cost of training?** No cost if provided at MCAVIC or USC; other national trainings require a registration fee. **Are intervention materials** *(handouts)* **available in other languages?** ❒ **Yes** ☒ **No** **Other training materials &/or requirements** *(not included above)***:** Training also available for family-focused interventions with medical trauma.
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** Can be used with multiple cultural and socioeconomic groups, and is developmentally adapted for clients aged 2 years to 21 years. Complicated challenges associated with complex trauma are addressed with this intervention model. Empirical findings support the effectiveness of ITCT. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** Longer treatment sometimes required; less structured/manualized than some approaches; empirical/research support does not yet include comparison with control groups.

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ITCT: Integrative Treatment of Complex Trauma

GENERAL INFORMATION

Contact Information	**Name:** Cheryl Lanktree, Ph.D.; John Briere, Ph.D. **Address:** MCAVIC-USC Child and Adolescent Trauma Program, Miller Children's Abuse and Violence Intervention Center, 2865 Atlantic Ave., Suite 110, Long Beach, CA. 90806 **Phone number:** 562-933-0590 **Email:** clanktree@memorialcare.org; jbriere@usc.edu **Website:** www.johnbriere.com
References	Briere, J. (2002). Treating adult survivors of severe childhood abuse and neglect: Further development of an integrative model. In Myers, J. E. B., Berliner, L., Briere, J., Hendrix, C. T., Jenny, C., et al. (Eds), *The AP-SAC handbook on child maltreatment* (2nd ed., pp. 175-203). Thousand Oaks, CA: Sage Publications, Inc. Briere, J. & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment.* Thousand Oaks, CA: Sage Publications. Cohen, J. A., Deblinger, E., Mannarino, A. P. & Steer, R. A. (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry, 43,* 393-402. Saltzman, W. R., Layne, C. M., Steinberg, A. M., Arslanagic, B. & Pynoos, R. S. (2003). Developing a culturally and ecologically sound intervention program for youth exposed to war and terrorism. *Child and Adolescent Psychiatric Clinics of North America, 12,* 319-342.

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."** Integrative Treatment for Complex Trauma (ITCT) was specifically developed for use with children, adolescents, and adults (aged 3 to 21 years) who are seen in clinic, school, and hospital settings located in a culturally diverse urban area. Specific cultural groups for which ITCT has been used include low SES, ethnic minorities (African American, Latino American, Asian American, and Pacific Islander Americans), gender specific child and adolescent groups, and immigrants from Mexico, Central America, Pacific Islands, and Southeast Asia. ITCT has also been adapted for use in urban schools in economically impoverished areas, including alternative (e.g., storefront) school settings. **Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.** Yes. Engagement occurs at the community as well as client level. Clinicians at all levels (staff and interns/trainees) are culturally diverse, representing all cultural groups being served. Outreach efforts to engage the multiple cultural groups within the local geographic community served include quarterly monthly Consumer/Family Advisory Council meetings attended by clinic staff, hospital staff, community mental health workers, parents who are former clients, school representatives, youth service volunteers, religious and other community leaders; ongoing psychoeducational presentations to school and hospital personnel; trainings to culturally diverse professional groups in the community and at Miller Children's Hospital, and more recently, alliance building meetings with a nonprofit multi-service site for Cambodian individuals and families. Additionally, national trauma experts who are members of the Miller Children's Abuse and Violence Intervention Center University of Southern California Child and Adolescent Trauma Program (MCAVIC-USC) Expert Panel as well as professionals from the local community provide presentations and consultation on culturally appropriate trauma interventions to MCAVIC-USC staff and interns/trainees. Issues of access to treatment, including language, financial constraints, and transportation needs are addressed through availability of no cost services in Spanish, as well as English, and vouchers for transportation cost. Client level interventions that address culture are discussed below. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** Yes. ITCT is a multimodal therapeutic approach and includes individual, group, and family therapy. Culture specific strategies are enacted with the first contact, typically by telephone. Bilingual Spanish clinicians are available for monolingual clients and their families. Parenting classes are also available in Spanish.

Engagement continued	ITCT is assessment-based and utilizes measures modified for cultural groups when available. At present, a core set of assessment measures is available in both English and Spanish. Respect for cultural traditions at all levels of treatment is enacted continuously through the interpersonal process. Beyond general cultural competencies (e.g., awareness of own cultural assumptions and how these may impact the therapeutic relationship, knowledge of specific cultural groups; Sue, Ivey, & Pedersen, 1996), clinicians gather information about specific individual client and family cultural norms, values, and beliefs to understand and conceptualize client problems and related treatment goals. An example of a specific therapeutic strategy informed by consideration of cultural norms other than the dominant culture is addressing cultural differences between therapist and client to facilitate mutual exploration of the potential impact of difference on the therapeutic relationship. Another culturally informed intervention utilized involves demonstrating respect of family members by addressing adults formally (i.e., Mr., Mrs., Ms.) unless, and until, invited to a more informal first name basis.
Language Issues	**How does the treatment address children and families of different language groups?** Current clinical staff includes a balance of mainstream and bicultural individuals, with some bilingual (Spanish, Hmong) service providers. Clinical forms and core measures are available in Spanish and English. **If interpreters are used, what is their training in child trauma?** Interpreters are not typically used. **Any other special considerations regarding language and interpreters?** N/A
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?** Yes. Various studies and clinical experience indicate that clients from different cultures vary in the ways they experience and express the impacts of trauma (e.g., Marsella, et al., 1996). In some cases, there may be culture-specific syndromes. In others, there may be less obvious but important differences in sociocultural perceptions and responses. Although existing assessment instruments typically do not tap these differences, ITCT stresses clinician sensitivity to cultural variation in trauma response and expression. **If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?** As an assessment based approach, the ITCT framework utilizes results of regular assessment as well as clinical judgment to guide the focus of treatment. In this way, ITCT addresses the core issues underlying symptoms of complex trauma (i.e., attachment disturbance, affect dysregulation, identity disturbance, dissociation). At the same time, such assessment highlights social and cultural issues that may require modified approaches to these core issues.

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?** Yes. The Trauma Symptom Checklist for Children (TSCC: Briere, 1996), the Trauma Symptom Checklist for Young Children (TSCYC: Briere, 2005), the UCLA PTSD Index for DSM-IV (UCLA PTSD Index-Adolescent version: Rodriguez et al., 1999), and the Child Behavior Checklists (CBCL: Achenbach, 1991) are available in both English and Spanish. Only the CBCL checklists have Spanish language normative data available. **If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** Client responses on measures are reviewed by clinician and supervisor; clinician explores endorsed items further with client and/or caretaker. **What, if any, culturally specific issues arise when utilizing these assessment measures?** Measures have been developed from a dominant cultural perspective and may not fully capture the majority of culture-specific symptom expressions. Additionally, cultural differences in acknowledging distress with non-family members or professionals are likely to impact level of disclosure for some clients. Without culturally appropriate normative data, cut off levels may differ among cultural groups and require clinical judgment.
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** Yes. As ITCT has been developed with culturally diverse traumatized children and adolescents, treatment manuals currently being developed will include culture-specific interventions. **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)***.** Components of ITCT are being adapted for use with group treatment with culturally diverse sexually abused adolescent females and have been adapted for high risk traumatized youths in alternative school settings. **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?** Research suggests that dropout may be greater for clients from nondominant cultural groups when traditional therapies are applied. To date, differential dropout rates have not been examined in ITCT samples. However, ITCT stresses the need to continually address possible sociocultural barriers to the therapeutic alliance. Additionally, preliminary outcome studies suggest that the effectiveness of ITCT does not differ according to client race.

Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** Adolescents transferred to alternative school settings due to aggressive and/ or violent behaviors encounter additional setbacks (e.g., social losses, academic losses) and increased risk of being re-traumatized. ITCT has been implemented in a modified form in several alternative school settings. **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?** ITCT has been implemented in clinic settings, mainstream school and alternative school settings, as well as hospital inpatient and outpatient settings. Preliminary results indicate significant reduction in symptoms across these settings. **Are there cultural barriers to accessing this treatment** *(i.e., treatment length, family involvement, stigma, etc.)***?** Length of treatment for primary clients is dependent on progress as well as by age (21 is upper limit). Family involvement is preferable, but not mandatory in all cases. Stigma associated with seeking mental health services is an issue for all groups, but is more prevalent with some clients and their families. Additionally, dynamics of stigma influence which providers are culturally sanctioned to treat mental health problems. **Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** Transportation needs for many clients. Child care. **Are these barriers addressed in the intervention and how?** Taxi vouchers are provided and transportation arranged for clients by clinicians. Some child care support is provided in the waiting area of the clinic. ITCT is funded primarily by NCTSN Category II grant and other private foundation grants so there is no fee for clients receiving evaluation or therapy services. A minimal fee is collected for parenting classes when appropriate. **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 primary Center for ITCT is an outpatient clinic of a major children's hospital (Miller Children's Hospital, Long Beach, CA), collaborating with the University of California for the MCAVIC-USC Child and Adolescent Trauma Program. ITCT providers engage in ongoing outreach and assessment of community needs for service through two monthly collaborative community meetings with first responders (e.g., law enforcement, child protection, and medical providers), mental health professionals, and a variety of additional child advocates.

Intervention Delivery Method/ Transportability & Outreach continued	This collaboration facilitates continuous coordination of care and advocacy for clients referred from the hospital and community agencies. The clinic also facilitates a quarterly Consumer/Family Advisory Council collaborative group and meetings with community members of the Expert Panel (local university) that focus on enhancing engagement of low SES groups as well as ethnic minority groups. Psychoeducational presentations regarding trauma-informed and trauma-specific approaches are provided several times per month for school personnel, community agency professionals, and hospital-related health professionals. Although this level of integration may not be transferable to all NCTSN sites that employ ITCT, it is a defined goal for ITCT implementation.
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** Potential cultural issues include parenting practices, cultural beliefs, family system functioning, impact of parent-child separation caused by immigration, and cultural differences in symptom expression. **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** Potential cultural issues are identified and addressed in individual and group supervision as well as ongoing training for staff and interns/trainees (several sessions per month). **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** Same as above **Has this guidance been provided in the writings on this treatment?** No, but is included in treatment manuals currently being developed. **Any other special considerations regarding training?** Not at this time.
References	Achenbach, T. M. (1991) *Integrative guide to the 1991 CBCL/4-18, YSR, and TRF profiles.* Burlington, VT: University of Vermont, Department of Psychology. Briere, J. (2005). *Trauma Symptom Checklist for Young Children (TSCYC) professional manual.* Odessa, FL: Psychological Assessment Resources. Marsella, A. J., Friedman, M. J., Gerrity, E. T. & Scurfield, R. M. (Eds.). (1996). Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications. Washington, D.C.: American Psychological Association. Rodriguez, N., Steinberg, A. & Pynoos, R. S. (1999). *ULCA PTSD index for DSM-IV instrument information: Child version, parent version, adolescent version.* Los Angeles, CA: UCLA Trauma Psychiatry Service. Sue, D. W., Ivey, A. E. & Pedersen, P. B. (Eds). (1996). *A theory of multicultural counseling and therapy.* Belmont, CA: Thomson Brooks/Cole Publishing Co.

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GENERAL INFORMATION

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

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** MMTT **Average length/number of sessions:** Fourteen group sessions with 6-8 members per group delivered during one class period a week. An individual pullout session is done mid-protocol to introduce narrative exposure in a controlled way. (An individual assessment session is also done prior to group work.) This allows the therapist to adjust treatment so that the balance between child, individual and group trauma processing can be optimized. **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** The protocol lays out a components-based approach of key tasks that allows flexibility to accommodate individual and group membership needs. Adaptation to specific population needs is encouraged. Consultation can guide this if requested. **Trauma type** *(primary)*: See below **Additional descriptors** *(not included above)***:** MMTT is a skills-oriented, cognitive-behavioral treatment (CBT) approach for children exposed to single incident trauma and targets posttraumatic stress disorder (PTSD) and collateral symptoms of depression, anxiety, anger, and external locus of control. It was designed as a peer-mediating group intervention in schools. It has been shown to be easily adaptable for use as group or individual treatment in clinic populations as well.
Target Population	**Age range:** 9 **to** 18 **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Region** *(e.g., rural, urban)***:** English, French **Other characteristics** *(not included above)***:** Children and adolescents in grades 4 through high school who have experienced single-incident traumatic stressors (disaster, exposure to violence, murder, suicide, fire, accidents)—recognizing the fact that most children have experienced more than one PTSD qualifying stressor. MMTT can address intrafamilial violence/abuse in individual treatment or in clinic-based groups where homogeneity of group membership can be assured and the treatment adapted to the needs of the child and family members.
Essential Components	**Key components:** **Major components noted below by session:** Session 1: Psychoeducation Session 2: Anxiety Management Session 3: Anxiety Management and Cognitive Training (Thinking, Feeling, Doing, and Stress Thermometer) Session 4: Cognitive Training (Traumatic Reminders) Session 5a: Anger Coping Session 5b: Grief Management Session 6: Individual Pull-out Session (Narrative Exposure)

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

Essential Components continued	Session 7: Setting up the Stimulus Hierarchy (Group) Session 8: Group Narrative Exposure Session 9: Group Narrative Exposure (Cognitive and Affective Processing) Session 10: Group Narrative Exposure (Worst Moment) Session 11: Worst Moment Cognitive and Affective Processing Sessions 12-13: Relapse Prevention and Generalization Session 14: Graduation Ceremony
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** **❒ Yes ☒ No ❒ Uncertain** **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** **❒ Yes ☒ No** **Has this intervention been presented at scientific meetings? ☒ Yes ❒ No** **If YES, please include citation***(s)* **from last five presentations:** American Academy of Child and Adolescent Psychiatry (AACAP): Amaya-Jackson, 1996; 2000; March & Amaya-Jackson, 1996 International Society for Traumatic Stress Studies: Amaya-Jackson, 1998 **Are there any general writings which describe the components of the intervention or how to administer it? ☒ Yes ❒ No** **If YES, please include citation:** March, Amaya-Jackson, Murray & Schulte, 1998 Amaya-Jackson, Reynolds, Murray, McCarthy, Nelson, Cherney, et al., 2003 **Has the intervention been replicated anywhere? ☒ Yes ❒ No** **Other countries?** *(please list)* South Africa, Nigeria, India, Australia, and France **Other clinical and/or anecdotal evidence** *(not included above)***:** MMTT was also replicated in a randomized controlled (unpublished as yet) study in a residential treatment setting (Michael, Hill, Hudson & Furr, 2002) This work received two awards: 1996 American Academy of Child & Adolescent Psychiatry Norbert and Charlotte Reiger Excellence in Service Award 1998 American Academy of Child & Adolescent Psychiatry Scientific Achievement Award MMTT has been used as a model and prototype for several other empirically supported school and clinical setting trauma-focused cognitive-behavioral treatments, such as “Cognitive-Behavioral Treatment in Schools” (Jaycox, 2004) and “Preschool PTSD Treatment” (Scheeringa, Amaya-Jackson & Cohen, 2002).

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GENERAL INFORMATION

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

Research Evidence	Sample Size (N) and Breakdown *(by gender, ethnicity, other cultural factors)*	Citation
Pilot Trials/Feasibility Trials *(w/o control groups)*	**N=**21 **By other cultural factors:** rural	Amaya-Jackson, Reynolds, Murray, McCarthy, Nelson, Cherney, et al., 2003
Clinical Trials *(w/control groups)*	**N=**17	March, Amaya-Jackson, Murray & Schulte, 1998
Randomized Controlled Trials		Michael, Hill, Hudson & Furr, 2002
Studies Describing Modifications	**N=**7	Amaya-Jackson, Reynolds, Murray, McCarthy, Nelson, Cherney, et al., 2003
Other Research Evidence	**N=**4	Berthiaume & et Turgeon, 2004

Outcomes

If research studies have been conducted, what were the outcomes?

The following were used in the 1998 study (research tools):

- Child and Adolescent Trauma Survey—CATS (March & Amaya-Jackson, 1997)
- Clinician-Administered PTSD Scale—CAPS-C
- Children's Depression Inventory (Kovacs, 1985)
- Clinical Global Improvement (Guy, 1976)
- Multidimensional Anxiety Scale for Children—MASC (March et al., 1997)
- Stait-Trait Anger Expression Inventory (Spielberger, 1988)
- Nowicki-Strickland "What Am I Like" Scale (Nowicki & Strickland, 1973)
- Conner's Teacher Rating Scale for ADHD (Conner, 1995)

General Treatment Measure Recommendations for the model:

- Any measure of PTSD, depression, and anxiety can be used. An exposure to violence measure is also suggested as part of the assessment and several can be recommended.
- The CATS is a screening tool that is useful in settings such as schools to identify child candidates for group membership in conjunction with teacher/counselor recommendations. Group membership may be selected via other strategies as well.

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

Outcomes continued	MMTT was the first controlled study of a protocol-driven CBT intervention for children and adolescents suffering from PTSD arising in the context of a single incident trauma (March et al., 1998). Experimental control across time and setting in a small sample (in two elementary and two junior high schools) demonstrated robust beneficial effects of treatment for reducing PTSD, depression, anxiety, and anger using an 18 session protocol. Locus of control remained external from pre- to posttreatment but became strongly internal at follow-up. Additional studies using a shortened (14 session), developmentally enhanced protocol in two elementary schools, one high school, and a community based clinic revealed similar (published) findings.
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** • Clinical supervisors with training in trauma specific CBT and a good working knowledge of the model • Clinical staff with training in the model • Established relationship with school, school personnel & designated school staff collaborating on implementation • Determine if a school counselor will be co-leading group (not required but should be considered—especially in elementary school settings) • Private rooms conducive to group treatment • Flip boards, chalk boards • Consideration of target population needs and if adjunct services are necessary **To ensure successful implementation, support should be obtained from:** School administrators, parents
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** Manuals available (no charge) by contacting Dr. Briggs-King. **How/where is training obtained?** Contacting Drs. Briggs-King or Murphy **What is the cost of training?** Depends on intensity and use of Learning Collaborative methods **Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ☐ **No** **If YES, what languages?** French **Other training materials &/or requirements** *(not included above)***:** • Recommended for clinician supervisors and therapists with a master's degree or higher.

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

Training Materials & Requirements continued	• Readiness assessment for general CBT experience • Basic understanding of childhood PTSD and related symptoms • Reading the manual and select articles • Organizational Readiness assessment for school and/or clinic intervention Training depends on extent of training/experience with trauma-focused mental health interventions. • (Recommend) Intensive skills based training, one to two days • (Recommend) Ongoing expert consultation from trainers for 4-6 months (this may require longer if consultation is needed on establishing the relationship with school or school district). • Advanced training as requested
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** Specifically developed in schools and groups. Allows both group & individual pullout component benefits. Has been tested in elementary, middle, and high school groups and in individual, group clinic settings and residential settings. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** School based treatments require consents and may or may not be reimbursable depending on ability to bill. No difficulty in clinic/residential settings.
Contact Information	**Name:** Ernestine Briggs-King, PhD, Director, Trauma Evaluation and Treatment Program; or Robert Murphy, PhD, Executive Director, Center for Child and Family Health, NC **Address:** Center for Child and Family Health, Durham, NC **Phone number:** (919) 419-3474 ext. 228 or ext. 291 **Email:** brigg014@mc.duke.edu or Robert.Murphy@duke.edu **Website:** www.ccfh.nc.org

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

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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.

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.

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

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.

PCIT: Parent-Child Interaction Therapy

GENERAL INFORMATION

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** PCIT **Average length/number of sessions:** 12-20 **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** Can be delivered at home. **Trauma type** *(primary)*: Interpersonal complex traumas (i.e., physical, sexual, and emotional abuse and neglect) PCIT is an evidenced-based treatment model with highly specified, step-by-step, live coached sessions with both the parent/caregiver and the child. Parents learn skills through PCIT didactic sessions. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. Generally, the therapist provides the coaching from behind a one-way mirror. The emphasis is on changing negative parent/caregiver child patterns. The goals of treatment are: • An improvement in the quality of the parent-child relationship or, in residential treatment centers and foster homes, the caregiver-child relationship • A decrease in child behavior problems with an increase in prosocial behaviors • An increase in parenting skills, including positive discipline • A decrease in parenting stress
Target Population	**Age range:** 2 **to** 12 **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** All **Other cultural characteristics** *(e.g., SES, religion)***:** All **Language***(s)***:** English; PCIT has been translated into Spanish. **Region** *(e.g., rural, urban)***:** All **Other characteristics** *(not included above)***:** • PCIT adaptations have been made for treatment settings that lack one way mirrors and/or "bug-in-ear" devices by using walkie-talkies or having the therapist sit in the room. • PCIT has been used and evaluated with foster parents and in Head Start settings for parents of at-risk African American children. Some Network centers are adapting and using PCIT in residential treatment settings and shelters. • PCIT is being used and evaluated with families and children with prenatal exposure to alcohol and other drugs.

PCIT: Parent-Child Interaction Therapy

Target Population continued	• PCIT is currently being adapted for use in the home as part of a larger intervention. • PCIT has been adapted for use in a group treatment. • PCIT has been adapted for use with children 8-to-12 years of age. • PCIT has been used with families where child abuse has occurred. • PCIT has been adapted for use with children with medical conditions. • PCIT has been evaluated for use with physically abusive families. • PCIT is currently being adapted for use with Native American families (University of Oklahoma Health Sciences Center). • PCIT is also in the process of being adapted from a distance-learning perspective.
Essential Components	**Theoretical basis:** Developmental; Social Learning Theory; Attachment **Key components:** The intervention uses a two-stage approach aimed at relationship enhancement and child behavior management. The parent is taught and coached in relationship-building skills: Praise, Reflection, Imitation, Description, and Enthusiasm (PRIDE.) The parent/caregiver is coached while interacting with the child during relationship-enhancement treatment sessions until criteria are reached. The parent is then instructed and coached in a positive discipline program including effective delivery of commands, with an appropriate parent response for child compliance and strategies designed to increase compliance. The skills are gradually expanded for use from a structured implementation in treatment sessions to structured sessions in the home to more unstructured situations and finally to use in public situations. Skills are observed and coached through a one-way mirror at each treatment session. Specific behaviors are coded and charted on a graph at each session, and parents are provided with immediate feedback about progress and mastery of skills. Parents are given homework assignments to complete to enhance their skills between sessions. Efforts are made to incorporate ethnic and cultural practices and values.
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** **❒ Yes ☒ No ❒ Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)***.** 3 **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** **❒ Yes ☒ No** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***? ☒ Yes ❒ No** **If YES, please include citation:** Matos, Torres, Santiago, Jurado & Rodriguez, 2006

PCIT: Parent-Child Interaction Therapy

GENERAL INFORMATION

Clinical & Anecdotal Evidence continued	**Has this intervention been presented at scientific meetings?** ☒ Yes ❒ No **Are there any general writings which describe the components of the intervention or how to administer it?** ☒ Yes ❒ No **Has the intervention been replicated anywhere?** ☒ Yes ❒ No **Other countries?** *(please list)* Hong Kong, England, Russia, Canada, The Netherlands, Australia **Other clinical and/or anecdotal evidence** *(not included above)*: PCIT needs little modification to be effective with children with developmental disabilities. Techniques for adapting PCIT for children with DD are presented (McDiarmid & Bagner, 2005).	
Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Published Case Studies		Bagner, Fernandez & Eyberg, 2004; Borrego, Anhalt, Terao & Urquiza, 2006; Borrego, Urquiza & Rasmussen, 1999; Dombrowski, Timmer & Blacker, 2005; Fricker-Elhai, Ruggiero & Smith, 2005; Timmer, Urquiza, Herschell, McGrath, Zebell, Porter & Vargas, 2006
Randomized Controlled Trials	**N=**110	Chaffin, Silovsky, Funderburk, Valle, Brestan, Balachova, Jackson & Bonner, 2004.
Studies Describing Modifications		McCabe, Yeh, Garland & Lau, 2005 Pincus, Eyeberg & Choate, 2005; Choate, Pincus, Eyberg & Barlow, 2005
Outcomes	**What assessments or measures are used as part of the intervention or for research purposes, if any?** Core battery of assessment procedures include: • Semi-structured intake interview • Child Behavior Checklist (parent form) • Eyberg Child Behavior Inventory • Parenting Stress Index (short form) • Dyadic Parent-Child Interaction Coding System • Sutter-Eyberg Student Behavior Inventory (as appropriate)	

PCIT: Parent-Child Interaction Therapy

Outcomes continued	PCIT concludes with a post-treatment evaluation. In most cases, the pre-treatment assessment procedures are repeated, including parent reports, teacher report, child report, and direct observation measures. The Dyadic Parent-Child Interaction Coding System observations are repeated at the end of the last discipline coaching session. Parents also complete a parent-report measure of consumer satisfaction called the Therapy Attitude Inventory. Parents and child return for post-treatment feedback sessions where pre- and post-treatment videotapes and accomplishments are reviewed. Brief parent report measures (Eyberg Child Behavior Inventory, Parenting Stress Index) can be completed at booster sessions to assist in tracking maintenance of behavioral improvements or for long-term follow-up of treatment. **If research studies have been conducted, what were the outcomes?** Chaffin, Silovsky, Funderburk, Valle, Brestan & Balachova, et al. (2004) randomly assigned physically abusive parents (N = 110) to one of three intervention conditions: (a) PCIT, (b) PCIT plus individualized enhanced services, or (c) a standard community-based parenting group. At a median follow-up of 850 days, 19 percent of parents assigned to PCIT had a re-report for physical abuse compared with 49 percent of parents assigned to the standard community group. Additional enhanced services did not improve the efficacy of PCIT. The relative superiority of PCIT was mediated by greater reduction in negative parent–child interactions consistent with the PCIT change model. Hood & Eyberg (2003) examined the long-term maintenance of changes following PCIT for young children with Oppositional Defiant Disorder (ODD) and associated behavior disorders. Three to six years after treatment, 29 of 50 treatment completers were located for this study. Results indicated that the significant changes that mothers reported in their children's behavior and their own locus of control at the end of treatment were maintained at long-term follow-up.
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** One way mirror or monitor (optimal but not required); 2-way radio system to coach caregiver **Supervision requirements** *(e.g., review of taped sessions)***?** It involves 40 hours of direct training with ongoing supervision and consultation for approximately the next four-to-six months. The latter can be accomplished through conference calls, videotapes, and distance-learning technology. **To ensure successful implementation, support should be obtained from:** Implementation is most successful in settings in which agency management and supervisors are familiar with this intervention and fully supportive of staff who undertake it.

PCIT: Parent-Child Interaction Therapy

Training Materials & Requirements

List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.
Assessment instruments and scoring forms as well as the step-by-step clinician guide are needed for training (Hembree-Kigin & McNeil, 1995). Manuals for detailed implementation of the treatment program, coding of sessions, and handouts for use in treatment will complement the guide.

How/where is training obtained? There are a number of settings within the Network that train PCIT, including the University of Oklahoma Health Sciences Center and the Trauma Treatment Training Center (Cincinnati Children's Hospital). Other sites include Dr. Sheila Eyberg of the University of Florida and the University of California, Davis CAARE Center. Go to www.pcit.org for more information about non-network trainings and other resources.

What is the cost of training? Costs vary.

Are intervention materials *(handouts)* **available in other languages?**
☒ **Yes** ❒ **No**

If YES, what languages? Materials have been or are being translated into Spanish

Other training materials &/or requirements *(not included above)***:**
The training is for mental health professionals with a minimum of a master's degree in psychology or a related field. Competency criteria will be assessed at the completion of the 40-hour training with fidelity checks throughout the supervision and consultation period.

Pros & Cons/ Qualitative Impressions

What are the pros of this intervention over others for this specific group *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?**
Original PCIT protocol developer, Dr. Sheila Eyberg, has stated that PCIT can be described as parent-child interaction training, rather than as parent-child interaction therapy, for populations for whom mental health treatment may be stigmatized. Engagement with caregivers avoids a deficit model of prior parenting and instead describes PCIT as offering special skills for caregivers who are dealing with children or situations that pose special challenges. PCIT can and has been delivered in home settings for those families who have transportation issues.

What are the cons of this intervention over others for this specific group *(e.g., length of treatment, difficult to get reimbursement)***?**
This is a mastery-based rather than a time-limited treatment, and treatment length can vary depending on parental skill acquisition. PCIT requires extensive parental involvement, and some parents are unable or unwilling to provide this.

Other qualitative impressions:
Because PCIT offers concrete, practical parenting skills transmitted using live coaching in caregiver interactions with children, it can be effective with many kinds of families and other caregivers: single parents, foster parents, families with cognitive limitations, two-parent families, and ethnically and culturally diverse families.

PCIT: Parent-Child Interaction Therapy

GENERAL INFORMATION

Contact Information

Name: Erica Pearl, PsyD & Erna Olafson, PhD, PsyD

Address: Trauma Treatment Training Center, Cincinnati Children's Hospital, 3333 Burnet Ave, MLC 3008, Cincinnati, Ohio, 45229

Phone number: 513 636-734; 513 558-4067

Email: erica.pearl@cchmc.org; erna.olafson@uc.edu

Website: www.OhioCanDo4Kids.org; www.cincinnatichildrens.org/TTTC

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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.** Original PCIT protocol developer, Dr. Sheila Eyberg, has stated that PCIT can be described as parent-child interaction training, rather than as parent-child interaction therapy, for populations for whom mental health treatment may be stigmatized. McCabe et al. (2005) describe tailoring PCIT for Mexican Americans through the GANA Program, renamed *Guiando a Ninos Activos* (Guiding Active Children). The therapist is referred to as a Teacher (*Maestro*), and the Relationship Enhancement Stage is referred to as Communication Exercises. When adapting PCIT for Native American families, Dolores BigFoot, Ph.D. of the Oklahoma Health Sciences Center, suggests the therapist involve extended family in training sessions, grant children a multitude of choices, accept long pauses and silences during therapy, modify praise and positive reinforcement to include humor, teasing, name-giving, and ceremonies, incorporate opportunities for parents to tell stories, modify play areas to include culturally sensitive toys including paints, leather scraps, beads, clay, etc., and adopt talking circles as an environment where parents can practice learned skills. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** The GANA program describes the procedure of unlimited contact through telephone/home visits before the first session to address issues such as prior experiences with mental health and discussion about how to overcome concrete obstacles. Making contact with other family members (i.e., grandparents) prior to treatment so that the participating parent is more likely to gain support from extended family.
Language Issues	**How does the treatment address children and families of different language groups?** The UC Davis CAARE Center regularly conducts PCIT with Spanish-speaking PCIT therapists and has provided intensive training to a group of clinicians in Hong Kong. The emphasis on coaching skills lends itself well to families who cannot read or who are not native speakers vs. treatments where concepts are only taught verbally. **If interpreters are used, what is their training in child trauma?** Interpreters are not used in our setting.
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?** Some traumatized children may present with more internalizing symptoms instead of externalizing symptoms and behaviors. Although PCIT was originally designed for children with disruptive behavior disorders, increasing evidence now exists for its effectiveness with children who have trauma histories.

Symptom Expression continued	**If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?** PCIT trainers emphasize that both parent-child attachment and children's disruptive behaviors are variously defined and expressed culturally, and they are alerted at every stage (including on the ECBI) to consult with parents about treatment goals syntonic for them in their settings. PCIT does not pathologize normal cultural variations or impose a single standard of parenting and child behavior on clients. PCIT is grounded in attachment theory, and one of its components works through live coaching by the therapist on parent-child relationship enhancement. However, expressions of normal parent-child attachment behaviors vary according to culture; therefore, researchers working with Latino and Native American populations have adapted the relationship building component of PCIT culturally. Cultural variations in tolerance for "disruptive" behavior in children are addressed in Dr. Eyberg's teaching by asking parents during live coaching if a particular child behavior is something they want to see reduced through strategic ignoring.
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?** The Eyberg Child Behavior Inventory (ECBI) has been studied with 154 African American caregivers to test parental tolerance for misbehavior (Butler, Eyberg & Brestan, 2006). CBCL and Parenting Stress Index have been translated into Spanish and have normative data. A Chinese Version of the DPICS coding system was developed in Hong Kong. **What, if any, culturally specific issues arise when utilizing these assessment measures?** Reliability/validity when measures are translated
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** Borrego et al. (2006) discuss how the focus on enhancing the parent-child relationship in PCIT fits with the familism value in many Hispanic families. In addition, they note that the emphasis of discipline and compliance is consistent with the value of respect for authority figures. McNeil, Capage, & Bennett, 2002. **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)***.** GANA Program-Adaptation (McCabe et al., 2005).

Cultural Adaptations continued	**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?** McNeil, Capage & Bennett (2002) found no difference in drop-out rates for African American and Caucasian clients but differences may be because clients were matched on SES. Werba et al. (2002) found ethnicity predicted neither response nor attrition in PCIT. PCIT with Latino populations resulted in midtreatment attrition with non-acculturated Spanish speaking families (McCabe, 2002).
Intervention Delivery Method/ Transportability & Outreach	**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?** Yes, preliminary data suggests in-room and in-home coaching still are efficacious. **Are there cultural barriers to accessing this treatment** *(i.e., treatment length, family involvement, stigma, etc.)***?** Stigma of mental health treatment is one barrier. Engaging fathers in treatment is another (Bagner & Eyberg, 2003), but results of their study regarding father involvement suggested that scheduling sessions around fathers' work schedules may increase participation. **Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** No transportation. Rural families may not have access. Because PCIT is a dyadic parent-child interaction, single parents with many children may find it very difficult to take part in therapy. **Are these barriers addressed in the intervention and how?** PCIT can be provided in-home or in-room when transportation issues are a problem. Group PCIT has been found to be successful as well, which can decrease overall costs of the treatment. Providing care for siblings during sessions can increase attendance. Partner with agencies to help them get foundation grants to provide, not only transportation but also simple toys to use for home play therapy practice between parent and child. **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)***?** Querido, Eyberg & Boggs (2001) designed a model of PCIT for Head Start Families and a form of Teacher Child Interaction Therapy (TCIT) has also been developed.
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** Comfort and differences in use of praise. There are differences among clinicians/caregivers regarding child behaviors to be ignored (e.g., swearing). The PCIT therapist must be comfortable in behavioral approaches and being directive, which may pose a challenge for therapists from certain cultures and theoretical orientations.

Training Issues continued	**If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** Through open discussion and collaborative openness. For example, teaching PCIT to psychologists from Japan invites extensive exchanges about the use of labeled praises with children, differences between our cultures in the father-child/mother-child relationships, and so on. Trainers who remain open and receptive to cultural issues and differences maintain rapport with trainees. **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** Cultural differences in discipline/use of corporal punishment. This is addressed and discussed in a didactic session, and a variety of reasons are presented with opportunities for discussion with the parent (client) for why PCIT uses time-out vs. corporal punishment. **Has this guidance been provided in the writings on this treatment?** Yes, there is a lengthy explanation in the standard manual about timeout versus corporal spanking. **Any other special considerations regarding training?** Advances in technology for distance learning for rural clinicians. Lack of trained therapists in PCIT in many areas of the country
References	Bagner, D. M. & Eyberg, S. M. (2003). Father involvement in parent training: When does it matter? *Journal of Clinical Child and Adolescent Psychology. 32*, 599-605. Borrego, J., Anhalt, K., Terao, S. Y., Vargas, E. C. & Urquiza, A. J. (2006). Parent-Child Interaction Therapy with a Spanish speaking family. *Cognitive and Behavioral Practice, 13,* 121-133. Butler, A., Eyberg, S. M. & Brestan, E. V. (2006, January). *Examination of the Eyberg Child Behavior Inventory Discrepancy Hypothesis.* Paper presented at the Sixth National Parent Child Interaction Therapy Conference, Gainesville, FL. McCabe, K. M. (2002). Factors that predict premature termination among Mexican-American children in outpatient psychotherapy. *Journal of Child and Family Studies, 11*(3), 347-359. McCabe, K. M., Yeh, M., Garland, A. F. & Lau, A. (2005). The GANA Program: A tailoring approach to adapting Parent Child Interaction Therapy for Mexican Americans. *Education & Treatment of Children, 28*(2), 111-129. McNeil, C. B., Capage, L. C. & Bennett, G. M. (2002). Cultural issues in the treatment of young African American children diagnosed with disruptive behavior disorder. *Journal of Pediatric Psychology, 27*, 339-350. Querido, J. G., Eyberg, S. M. & Boggs, S. R. (2001). Revisiting the accuracy hypothesis in families of young children with conduct problems. *Journal of Clinical Child Psychology, 30,* 253-261. Werba, A. (2002). Transmission between generations. Secrets and ancestral mourning. *Psicoanálisis: Revista de la asociación Psicoanalitíca de Buenos Aires, 24,* 295-313.

RLH: Real Life Heroes

GENERAL INFORMATION

Treatment Description

Acronym *(abbreviation)* **for intervention:** RLH

Average length/number of sessions:
The intervention involves six-to-eighteen months of weekly therapy sessions (one session per week for a total of 36 to 108 hours including child and parent/guardian sessions whenever possible). Number of sessions depends on safety, developmental level, extent and number of traumas, attachments, legal status, and stability of the child.

Aspects of culture or group experiences that are addressed *(e.g., faith/spiritual component, transportation barriers)***:**
Chapter by Chapter guidelines in the *Real Life Heroes Practitioner's Manual* provide specific tips to integrate each child's family and cultural heritage into life story work from assessment through the conclusion of treatment including service planning targeting community integration. Activities and tools engage strengths within the child's family, community resources, and cultural heritage, including stories of overcoming adversity, faith, ties to religious organizations, and spirituality. A *Heroes Library* provides books geared to children with different ethnic backgrounds grouped by three reading levels. The *Practitioners Manual* also has specific chapters providing guidelines for adaptations for adolescents, preschool children, children with disabilities, and families with adopted children.

Trauma type *(primary)*: Neglect, Physical and Sexual Abuse, Abandonment, Losses, Placements, Domestic Violence, Disasters, Terrorism or War, especially relevant for Complex Trauma

Trauma type *(secondary)*: Medical

Additional descriptors *(not included above)***:**
Real Life Heroes utilizes an activity-based workbook to help children with traumatic stress build the skills and interpersonal resources needed to re-integrate painful memories and to foster healing after abuse, neglect, family violence, severe illness, losses, deaths, or abandonment. The workbook utilizes creative arts and life story work to engage children and caring adults in trauma and attachment-centered therapy and to rebuild (or build) positive, enduring relationships between hurt (and often hurting) children and adults committed to guiding children into adulthood. The curriculum integrates nonverbal and verbal modalities and helps children and caring adults move step-by-step from trauma narratives to life stories highlighting mastery, helping others, and nurturing relationships.

Real Life Heroes was especially designed for children in child and family service programs who frequently lack safe, nurturing homes and secure relationships with caring and committed adults. The model assists therapists and family members to recover and enhance family and cultural strengths and to promote safety planning, affect management, social skill building, attachments, and trauma processing. The model can be used by programs and agencies as a prescriptive methodology to address primary goals including preventing placements, reuniting families, finding and engaging alternate committed families for children in foster or group care who cannot return to biological parents.

RLH: Real Life Heroes

GENERAL INFORMATION

Target Population	**Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)*: *RLH* is easily adapted to enhance family and cultural strengths of children and families and can be used with refugees, immigrants, and children in a range of countries. The *Life Storybook* and the accompanying textbook, *Rebuilding Attachments with Traumatized Children,* were translated into Chinese with modified drawings for children of Chinese heritage. **Other cultural characteristics** *(e.g., SES, religion)*: Useful for all SES and many religions **Language***(s)*: English and Chinese **Region** *(e.g., rural, urban)*: Rural, Urban, Suburban **Other characteristics** *(not included above)*: School-age children, early adolescents, and caring adults who have experienced losses, family violence, disasters, severe and chronic neglect, physical and sexual abuse, repeated traumas, and 'post-traumatic developmental disorder.' In addition, children in, or at risk for, placement in foster family care, residential treatment, detention centers, psychiatric hospitals, as well as families involved with adoption or post adoption programs. In pilot studies, children typically presented with anxiety, depression, PTSD, disruptive behaviors, sexualized behaviors, and functional impairment in multiple areas.
Essential Components	**Theoretical basis:** RLH was based on research on traumatic stress and attachment disruption. The model incorporates core components of evidence-supported trauma and attachment-centered therapies adapted for children who have experienced multiple traumas, Complex Trauma, including physical and sexual abuse, severe neglect, and abandonment and for children who may lack a safe, non-offending parent willing and able to work in trauma therapy and a secure home. Creative arts activities foster nonverbal and later verbal re-integration. Life story work provides structure for engaging and sharing with safe, caring adults and re-shaping children's perceptions of themselves and their families. The model incorporates tenets in desensitization therapies–that enabling children to remain safe with a trusted therapist during prolonged safe exposures to 'tough times' can lead to reduction in traumatic stress symptoms. **Key components:** The life storybook (built around the metaphor of heroes) provides a structured, phased-based approach to engage children and caring adults to rebuild safety, hope, attachments, skills, and resources necessary for trauma therapy. Creative arts activities are utilized to develop affect recognition, affect regulation skills, and replace shaming and dysfunctional beliefs with confidence, and constructive beliefs. Components include psychoeducation on traumatic stress, activities to foster attunement and trust with caring adults, development of social support, development of skills for affect recognition, affect management, trauma processing, desensitization to triggers, and sharing a coherent life story including a past, present, and future.

Essential Components continued	The model engages caring adults to validate children by building on family strengths, fostering an understanding of traumatic stress, reducing shaming/blaming, and strengthening each child's family and cultural heritage. The goal is to transform troubled children into tomorrow's heroes.
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** ❒ **Yes** ☒ **No** ❒ **Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)*. 4 **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** ❒ **Yes** ☒ **No** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***?** ☒ **Yes** ❒ **No** **If YES, please include citation:** Kagan, 2007a Kagan, Douglas, Hornik & Kratz, in press **Has this intervention been presented at scientific meetings?** ☒ **Yes** ❒ **No** **If YES, please include citation***(s)* **from last five presentations:** Annie E. Casey Foundation: Kagan, 2008 American Professional Society on the Abuse of Children (APSAC): Kagan, 2007 International Society for Traumatic Stress Studies (ISTSS): Douglas, Kagan & Hornik, 2006 Tennessee Chapter of the National Child Advocacy Centers: Kagan, 2006 Vizinet: Kagan, 2006 **Are there any general writings which describe the components of the intervention or how to administer it?** ☒ **Yes** ❒ **No** **If YES, please include citation:** Kagan, 2004; Kagan, 2007a; Kagan, Douglas, Hornik & Kratz, in press **Has the intervention been replicated anywhere?** ☒ **Yes** ❒ **No** **Other countries?** *(please list)* Taiwan **Other clinical and/or anecdotal evidence** *(not included above)***:** The model is being tested at several community practice sites of the National Child Traumatic Stress Network and at other child and family agencies.

Clinical & Anecdotal Evidence continued	Therapists have consistently reported positive results during eight years of case studies with children with Complex PTSD involved in home-based or clinic-based family counseling and with children who have been living in foster families and residential treatment centers due to dangerous behaviors and often repeated experiences of physical or sexual abuse, and neglect. Practitioners have also reported that use of the model contributed to reduced trauma symptoms, PTSD symptoms, and negative behaviors. In addition, children have been observed to demonstrate behaviors associated with increased attachment, trust, and affiliation. Therapists reported that the model helped them to engage children and caring adults and that the curriculum helped therapists persevere with application of cognitive behavioral therapy components over time as noted on chapter checklists and in informal feedback sessions. Use of nonverbal creative arts modalities has been helpful as a precursor to asking children to utilize words.	
Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Pilot Trials/Feasibility Trials *(w/o control groups)*	**N=**41 **By gender:** Male: 59%; Female: 41% **By ethnicity:** African-American: 26%; Hispanic or Latino: 22%; European American: 65%; Biracial: 9%	Kagan, Douglas, Hornik & Kratz, in press
Outcomes	**What assessments or measures are used as part of the intervention or for research purposes, if any?** In current practice and clinical trials, practitioners are using the Trauma Symptom Checklist for Children (TSCC), the UCLA PTSD Index for DSM IV, and the Security Scale along with fidelity measures including a standardized session protocol/progress note that includes a checklist for critical steps. The *Real Life Heroes Practitioner's Manual* includes a detailed trauma and attachment assessment guide along with an attachment questionnaire for children. In the pilot research study (Kagan, Douglas, Hornik & Kratz, in press), assessments were conducted at baseline and four month intervals to twelve months, including interviews for children, parents/caregivers, and practitioners, the TSCC, the UCLA PTSD Index for DSM IV, the Security Scale, the Connors Parent Behavior Rating Scale (Long Version), the Parent Report of Posttraumatic Symptoms (PROPS), the Child Perceived Self Control Scale, the Hopelessness Scale, the Multidimensional Social Support Scale, and the Working Alliance Inventory. In addition, practitioners completed session and chapter checklists to assess fidelity.	

Outcomes continued	**If research studies have been conducted, what were the outcomes?** In the pilot research study, results at four months (Kagan, Douglas, Hornik & Kratz, in press) included significant levels ($p < .05$) of improvement reported on child self-reports of trauma symptoms (TSCC) and fewer problem behaviors reported on caregiver checklists (Connors). At twelve months, significant levels of improvement were found correlating the decrease in parent reports of child trauma symptoms (PROPS) with the number of workbook chapters completed and also for child reports of increased security (Security Scale) with caring adults. These results support the effectiveness of the model. However, the lack of a comparison group, the small size of the sample, and the difficulty separating the shared variance between time and the intervention limit the scope of conclusions regarding the effectiveness of RLH on improved clinical outcomes.
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** The *Practitioner's Manual* lists inexpensive equipment (and low cost suppliers) recommended for this model. Creative arts materials include markers, colored pencils, paper, a two-octave xylophone, and materials useful for self-soothing, centering and mindfulness exercises such as peacock feathers. Drums for rhythm expression can be hand-made or purchased. A copy of the *Real Life Heroes Life Storybook* is also needed. **Supervision requirements** *(e.g., review of taped sessions)***?** Biweekly consultation is highly recommended along with supervision by trained practitioners within the therapist's agency or practice location. **To ensure successful implementation, support should be obtained from:** Richard Kagan, Ph.D. (rmkagan@nycap.rr.com) and experienced practitioners trained in use of RLH.
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** Kagan, 2004; Kagan, 2007b; Kagan, 2007a All books are available from www.haworthpress.com and also from amazon.com, bn.com, and other on-line book stores. Haworth books are available in paperback and at a large discount in bulk quantities. **How/where is training obtained?** At national and regional conferences (e.g., APSAC and the Tennessee Chapter of the Children's Advocacy's Center in 2006) as well as on site in agencies by request. **What is the cost of training?** Typically $4000-5000 for initial two-day workshop plus expenses **Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ☐ **No** **If YES, what languages?** Chinese

Training Materials & Requirements continued	**Other training materials &/or requirements** *(not included above)***:** Clinicians (typically MSWs) attend a two-day workshop and participate in consultation groups every other week. Childcare staff and foster parents are also involved in training as team members and caring adults and may participate in sessions or assist with 'homework.' Training materials include a *Life Storybook* for both children and caring adults and a *Practitioner's Manual* that includes key objectives, an overview, step-by-step guidelines, checkpoints (essential elements), pitfalls, and troubleshooting tips to help practitioners for each chapter as well as tools and handouts for activities and trauma psychoeducation. A session summary/progress note and a bookmark (reminder list) are provided to help practitioners incorporate key components and sequence into sessions. Program has been running since 1998.
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** *Real Life Heroes* engages child, family, and cultural strengths with its focus on identifying heroes for the child within the child's family and culture, and the emphasis on transforming troubled children into tomorrow's heroes. Trauma psychoeducation and the workbook format decreases shame and sensitivity increasing the likelihood of children and adults beginning trauma therapy. The focus on building skills and 'doing with' activities within the workbook has proven attractive to children and caring adults while providing a safe structure for practitioners to introduce and work on critical elements of evidence-supported therapies for children with traumatic stress including Complex Trauma. Critical elements introduced include safety planning, affect recognition, affect modulation, self-soothing, trauma psychoeducation, resource building, countering dysfunctional beliefs, problem solving, and desensitization of traumatic events. The life story framework promotes redefinition of children's identities from victims to heroes who help others. The model can be utilized in a wide range of programs ranging from home-based family interventions and mental health clinics to residential treatment and psychiatric hospitals. The model can also be utilized when children lack caring, committed and non-offending parents or guardians and safe, secure homes. This makes the model especially useful in child welfare programs and with children who have moved from home to home. *RLH* has been a particularly valuable resource for children in foster family care as well as for children who have returned from placement to parents, relatives, kinship foster homes, or adoptive families. The model can be utilized to help caring adults build or rebuild trust with children. When children lack safe, caring adults, the workbook can be utilized to help search for family members or other adults willing to help children rebuild trust and overcome traumatic stress. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** The time needed to complete the workbook is helpful to develop and practice skills and to reinforce lasting connections with children who lack trust. However, the number of sessions is longer than other models designed for children who have safe, secure homes and non-offending parents or permanent guardians willing and able to work in trauma therapy.

Pros & Cons/ Qualitative Impressions continued	Components of the model can be utilized in groups but the entire model requires a therapist working with one child and caring adult at a time with parallel tracks for children and caring adults. Ideally, sessions would include 30-45 minutes for children and 30-45 minutes for adults. This may be difficult for reimbursement. **Other qualitative impressions:** Results of the pilot study supported the hypothesized relationship between children's increased perception of security with caring adults and a reduction in trauma symptoms over time. Specifically, the 'doing with' activities in *Real Life Heroes* appeared to enhance children's perception that they were not alone and could count on support from important people in their lives. Working with therapists and safe adults on opening up and recovering memories of children being nurtured, valued, and doing good things appeared to foster the strengths needed for children and parents or guardians to reduce traumatic stress reactions and strengthen attachments.
Contact Information	**Name:** Richard Kagan, Ph.D. **Address:** One Pinnacle Place, Suite 200, Albany, NY 12203 **Phone number:** (518) 426-2600 ext. 2725 **Email:** rmkagan@nycap.rr.com **Website:** Under construction
References	Douglas, A., Kagan, R. & Hornik, J. (2006, November). *Real Life Heroes: Pilot research study of a treatment intervention for children with traumatic stress.* Poster session presented at the International Society for Traumatic Stress Studies, Los Angeles, California. Kagan, R. (2004). *Rebuilding attachments with traumatized children: Healing from losses, violence, abuse and neglect.* Binghamton, NY: Haworth Press. Kagan, R. (2006). *Rebuilding trust with traumatized children.* Presented at the annual meeting of the Tennessee Chapter of the National Child Advocacy Centers, Nashville, Tennessee. Kagan, R. (2006, September). Rebuilding attachments with traumatized children. Presented at the annual meeting of Vizinet, Omaha, Nebraska. Kagan, R. (2007a). *Real Life Heroes practitioner's manual.* Binghamton, NY: Haworth Press. Kagan, R. (2007b). *Real life heroes: A life storybook for children.* 2nd edition. Binghamton, NY: Haworth Press. Kagan, R. (2007, July). *Real Life Heroes pilot study: Evaluation of a trauma and attachment-centered intervention for children.* Poster session presented at the annual meeting of the American Professional Society on Abuse of Children, Boston, Massachusetts. Kagan, R. (2008, May). *Trauma-informed permanency practice with youth and families.* Presented at the National Convening on Youth Permanence, Annie E. Casey Foundation/Casey Family Services and Casey Family Programs, Washington D.C. Kagan, R., Douglas, A., Hornik, J. & Kratz, S. (in press). *Real Life Heroes* Pilot Study: Evaluation of a Treatment Model for Children with Traumatic Stress. *Journal of Child and Adolescent Trauma, 1*(1).

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. The model encourages adaptation for specific cultural groups. For Chinese children and parents, the Chinese translations of the workbook and text, *Rebuilding Attachments with Traumatized Children,* are used. An agency has been testing adaptation for Latino clients. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** Yes, training provides tips for engaging African American and Gay/Lesbian youth with references to stories of heroism in communities (e.g., Stonewall riots and local Underground Railroad heroes). Heroes Library can be used to help engage youths and families with stories of heroes listed by reading level, age, and ethnic heritage.
Language Issues	**How does the treatment address children and families of different language groups?** The model and accompanying textbook are translated into Chinese; otherwise English is utilized for the workbook. **If interpreters are used, what is their training in child trauma?** The model includes handouts and tools that foster an understanding of traumatic stress for everyone involved. **Any other special considerations regarding language and interpreters?** Safety issues for the child are delineated and apply to interpreters.
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?** Yes. Assessments stress understanding symptoms in the context of cultural and other factors. For example, the model's attachment ecogram, assessment guidelines, and assessment summary worksheets guide practitioners to include cultural strengths, family and cultural stories of overcoming adversity, and traumatic events that may be associated with cultural experiences. **If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?** A strength-based perspective is incorporated into the model with stress on sharing and understanding stories of how family members have overcome adversity and also how family members have shown caring, support, and guidance for the child. Practitioners are encouraged at several points in the Practitioner's Manual to learn about the family's cultural heritage and tie this into shared stories of overcoming adversity and interventions.

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?** Evidence-supported assessment measures are recommended but not required as part of the model (e.g., the TSCC and UCLA PTSD Index). Some of the recommended measures include references to testing and guidelines for specific populations. **If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** Practitioners are encouraged to use an understanding of the child and family's culture to frame assessments and the model's developer has encouraged testing the model with different populations. However, this is not sufficiently addressed in the model. Baseline levels are used to examine generic levels of symptoms and strengths. Outcome measures are primarily used to assess for change from baseline and to then guide further interventions. **What, if any, culturally specific issues arise when utilizing these assessment measures?** These vary with the measure utilized. The model guides practitioners to look for cultural factors but does not address this with specific guidelines.
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** This has not been specifically addressed in the Manual beyond general guidelines and references, e.g., the Heroes Library. **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)***.** A Chinese translated workbook and text are available but otherwise, culture-specific adaptations have not yet been developed. **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?** This has not been addressed.
Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** This has not been addressed. **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 model has been tested in home-based work, in clinics, in foster family care, and in residential treatment. Children in the pilot study showed similar gains across a range of settings, from home-based to residential treatment. **Are there cultural barriers to accessing this treatment** *(i.e., treatment length, family involvement, stigma, etc.)***?** This has not been noted to date in the pilot research or in practitioner reports.

Intervention Delivery Method/ Transportability & Outreach continued	**Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** The model has been used effectively in child welfare programs as well as out-patient clinics. However, length of treatment can pose a problem as well as involvement of families in remote areas with family service agencies or programs. **Are these barriers addressed in the intervention and how?** No. However, recommendations are provided for home-based work and resource families to engage a wide target population. **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 model specifically guides practitioners to look for and engage mentors, clergy, and other caring adults for every child and to integrate children into positive groups. Community integration is specifically targeted in the initial service planning templates. The model can be used within schools by trained practitioners and has been used by a range of practitioners working in child and family service organizations.
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** A cultural understanding of heroes is stressed generically in training with references to identifying heroes and hero stories from specific cultural groups. Family-specific issues are addressed in consultation. The model stresses learning about cultural issues for each family and using openings provided by family members as part of life story work. **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** Supervisors are encouraged to model using their own understanding of their cultural heritage, to include strength-based assessments of each child's and family's cultural heritage, to provide links to resources about specific cultures, and to create safety in the supervisor-clinician relationship to address how cultural heritage factors affect relationships between clients and clinicians and as well as between clients and organizations. **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** The consultant guides practitioners to examine their own cultural heritage and to learn about each family's cultural heritage. This understanding is then used in consultation to stress promoting resilience and to adapt interventions for each family. **Has this guidance been provided in the writings on this treatment?** No. **Any other special considerations regarding training?** Follow up consultation is highly recommended.

NCTSN The National Child Traumatic Stress Network

Sanctuary Model

GENERAL INFORMATION

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** N/A **Average length/number of sessions:** N/A – the Sanctuary Model is a systemwide approach to creating a trauma-informed culture. **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** Addresses marginalization of specific cultural groups through exposure to trauma. **Trauma type** *(primary)*: Interpersonal **Trauma type** *(secondary)*: All types **Additional descriptors** *(not included above)***:** The Sanctuary Model® , is a trauma-informed, evidence-supported template for system change based on the active creation and maintenance of a nonviolent, democratic, productive community to help people heal from trauma.
Target Population	**Age range:** 4 **to** no upper limit **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** All **Other cultural characteristics** *(e.g., SES, religion)***:** All **Language***(s)***:** English and Spanish, but accessible for translation **Region** *(e.g., rural, urban)***:** All
Essential Components	**Theoretical basis:** The aims of the Sanctuary Model are to guide an organization in the development of a trauma-informed culture with seven dominant characteristics all of which serve goals related to recovery from trauma spectrum disorders while creating a safe environment for clients, families, staff, and administrators with measurable goals: • Culture of Nonviolence – building and modeling safety skills and a commitment to higher goals • Culture of Emotional Intelligence – teaching and modeling affect management skills • Culture of Inquiry & Social Learning – building and modeling cognitive skills • Culture of Shared Governance – creating and modeling civic skills of self-control, self-discipline, and administration of healthy authority • Culture of Open Communication – overcoming barriers to healthy communication, reduce acting-out, enhance self-protective and self-correcting skills, teach healthy boundaries

Sanctuary Model

GENERAL INFORMATION

Essential Components continued	• Culture of Social Responsibility – rebuilding social connection skills, establish healthy attachment relationships • Culture of Growth and Change – restoring hope, meaning, purpose **Key components:** • Shared language of Safety, Emotion Management, Loss and Future in the acronym SELF • Development of a core team for implementation • Concrete tools for intervention: community meetings, red flag reviews, psychoeducation in trauma, self-care planning, safety plans, team meetings and treatment planning conferences.
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** ❒ **Yes** ☒ **No** ❒ **Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)***.** 4 **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** ❒ **Yes** ☒ **No** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***?** ☒ **Yes** ❒ **No** **Has this intervention been presented at scientific meetings?** ☒ **Yes** ❒ **No** **Are there any general writings which describe the components of the intervention or how to administer it?** ☒ **Yes** ❒ **No** **Has the intervention been replicated anywhere?** ☒ **Yes** ❒ **No** **Other countries?** *(please list)* Mexico, Ecuador, Australia (pending)

Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Published Case Studies		Rivard, Bloom, Abramovitz, Pasquale, Duncan, McCorkle, et al., 2003
Pilot Trials/Feasibility Trials *(w/o control groups)*	**N=**18	Study is currently in progress at the Andrus Children's Center which measures changes in environment along domains aligned with the seven Sanctuary Commitments while measuring achievement of implementation milestones.

Sanctuary Model

GENERAL INFORMATION

Outcomes	**What assessments or measures are used as part of the intervention or for research purposes, if any?** • Demographic Survey • Implementation Survey • Environmental Survey, developed by the Andrus Children's Center's Department of Policy, Planning and Research. • COPES, developed by Moos. **If research studies have been conducted, what were the outcomes?** At this time, only baseline data has been collected.
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** No. **Supervision requirements** *(e.g., review of taped sessions)***?** Supervision of clinicians and other service providers should include assessment of perfomance along the seven Sanctuary commitments and the use of trauma-specific interventions. **To ensure successful implementation, support should be obtained from:** All levels of leadership in the organization.
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** Staff Training Manual, Implementation Guide,and Data Collection Manual are available through the Andrus Center for Learning and Innovation as part of the Sanctuary Leadership Development Institute. **How/where is training obtained?** Training can be obtained through the Sanctuary Leadership Development Institute at the Andrus Center for Learning and Innovation. **What is the cost of training?** $65,000 for 2.5 years of training and consultation **Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ❒ **No** **If YES, what languages?** Spanish **Other training materials &/or requirements** *(not included above)***:** Application and commitment from CEO required
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** Pros of the intervention are that it is easily adaptable for many cultures. It addresses the stigma of mental illness, has demonstrated reduction in restraints and improved staff retention. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** Funding for training may be difficult to obtain due to cost. Full implementation of the model may take 2-5 years.

Sanctuary Model

GENERAL INFORMATION

Pros & Cons/ Qualitative Impressions continued	**Other qualitative impressions:** The model provides a common language that is accessible to staff, clients and other stakeholders. It is not rigid, and therefore, can be adapted to many settings and populations. Practitioners are encouraged to be innovative in adapting it.
Contact Information	**Name:** Dr. Sandra Bloom **Address:** Andrus Children's Center, 1156 North Broadway, Yonkers, NY 10701 **Phone number:** 914-965-3700 **Website:** www.sanctuaryweb.com
References	Rivard, J. C., Bloom, S. L., Abramovitz, R., Pasquale, L. E., Duncan, M., McCorkle, D., et al. (2003). Assessing the implementation and effects of a trauma-focused intervention for youths in residential treatment. *Psychiatric Quarterly, 74*, 137-154.

Sanctuary Model

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."**

The Sanctuary Model is not specifically tailored to any cultural group, but as it is based on universal principles and commitments (e.g., commitment to nonviolence) it is easily available to culturally specific adaptation. The model has been used with groups of individuals of various SES, religions, races and, ethnicities. It has also been used in settings that are co-ed as well as single sex. It has been used with refugees and homeless populations and in urban, suburban and rural settings. Although it has not yet been used in settings that provide services exclusively to LGBTQ clients, many people who identify as sexual minorities have been included in other populations being served.

Within the Sanctuary Model it is recognized that in addition to recognizing cultures specific to such characteristics as race or ethnicity, there are many ways to conceptualize culture. This model begins with the premise that any treatment setting that provides services to people who have experienced adversity has its own culture. This treatment-setting culture, based on shared experience, must be considered and addressed in addition to the cultures which individual clientele might identify.

Because of this, the Sanctuary Model is not tailored to any one specific cultural group. The aim of the Sanctuary Model is the creation of a trauma-informed culture. The model places emphasis on organizational culture through commitments to nonviolence, emotional intelligence, social learning, shared governance, social responsibility, open communication and growth and change. These commitments shape the process of creating a culture that is trauma-sensitive, but not distinct or marginalized from the wider organizational culture or society at large.

Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible. As of April, 2007, clinicians working in different areas of the United States as well as in Mexico and Ecuador have adapted the model in a number of ways to tailor engagement for the individuals of specific cultural groups whom they serve. This has included tailoring the model for individuals in treatment for substance abuse, mental illness, for children, for individuals in both urban and rural settings, as well as for individuals of specific ethnic groups such as Native Americans, Mexicans and Ecuadorians.

There are a number of ways that clinicians have tailored engagement for these specific cultural groups. For clients being treated for substance abuse, clinicians have tailored the Sanctuary Model to align with the 12 steps and to incorporate the 12 step language to foster familiarity and introduce the concept of trauma. Clinicians working with young children have tailored the Sanctuary model's language to be more child-friendly and to include pop culture references in some of the lessons to engage youth more effectively. For Native American clients, clinicians have introduced the concept of incorporating tribal symbols into client or staff safety plans. In Mexico and Ecuador, staff members have created posters and signs in Spanish to explain the concepts of the Sanctuary Model to engage those walking into their setting.

Sanctuary Model

Engagement continued	**Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** The Sanctuary model includes the culture-specific engagement strategy of building community while providing trauma-specific treatment. This community includes both service providers and clients and focuses on leveled hierarchy in an organization. This strategy of engaging clients and staff in shared governance allows an experience that engages clients and staff from marginalized populations in a process that is more empowering. With an understanding that the experience of trauma can affect an individual's sense of efficacy, sometimes resulting in feelings of powerlessness or helplessness, the Sanctuary Model addresses issues of power and leadership as a way of creating a trauma-sensitive culture. Since the Sanctuary Model is aimed at engaging staff as well as clients, one of the strategies used is the development of a core team. The core team is the main vehicle for implementation of the model and includes a cross section of staff from all levels in the organization's hierarchy. Agencies are trained to develop a core team that is designed to include both formal and informal leaders as well as people from different races, ethnicities, SES, sexual orientations, genders, ages, positions within the organization, levels of education and experience. The inherent diversity in the core team, as well as the implementation of specific Sanctuary tools that require multiple voices representing different perspectives to plan interventions, are engagement strategies included in the model.
Language Issues	**How does the treatment address children and families of different language groups?** The Sanctuary Model strives to create a shared language among the community members who use it. This shared language has been translated into Spanish, and is easily accessible for translation into other languages. Because much of the material is in written form, it is also accessible to the deaf and hard of hearing. The model has also been translated from a language that was specific to adults to a language that is more accessible to children. This was accomplished by changing the acronym SAGE, which stands for safety, affect management, grief and emancipation, to SELF, which stands for safety, emotion management, loss and future. **If interpreters are used, what is their training in child trauma?** We have not had the experience of using translators, but as has been demonstrated by its translation into Spanish, the Sanctuary Model is accessible for translation into other languages. **Any other special considerations regarding language and interpreters?** None encountered.
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 is clinical evidence that lists the many ways that trauma can be expressed in symptoms.

Sanctuary Model

Symptom Expression continued	Symptoms are assessed differently in children through standardized measures specifically designed for assessing trauma symptoms and collecting information about exposure to trauma. Although the DSM-IV does not include a diagnosis of disorders of extreme stress not otherwise specified, as suggested by the DSM-IV PTSD Committee to include a diagnostic category that would capture the developmental impact of childhood adversity, the Sanctuary Model encourages service providers to understand the expression of trauma symptoms in the context of ongoing development when working with children. The model also encourages practitioners to recognize that trauma histories are associated with a host of other psychiatric problems and diagnoses. In assessing those who are in treatment for addiction, trauma symptoms are explored in the context of substance abuse. The Sanctuary Model has also been used in inpatient and outpatient settings, residential settings and detention settings. Each of these settings has developed ways to understand the symptoms and behaviors presented in their populations through the lens of trauma and reenactment. **If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?** The Sanctuary Model is open to using multiple treatment interventions and works on the level of creating a trauma-informed culture.
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?** The Sanctuary Model does not mandate any specific assessment measures, so it is open to trauma measures for specific cultural groups. The assessments that are used in the current implementation are focused on assessing the organizational culture as the Sanctuary Model is an organizational intervention. The measures used are an Environmental Assessment, Implementation Survey, Demographic Survey and COPES. **If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** The demographic, implementation and environmental measures are being piloted at this time with 18 organizations. The COPES has normative data. **What, if any, culturally specific issues arise when utilizing these assessment measures?** The assessment tools are used to measure organizational culture and staff perceptions of the extent to which the agency demonstrates a commitment to nonviolence, emotional intelligence, social learning, shared governance, open communication, social responsibility and growth and change. Any of these categories may touch on culturally specific issues for staff and should serve as an alert to an organization's leadership that there are issues to address.

Sanctuary Model

Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** Yes. Below is a small sample of published works on the Sanctuary Model that specifically discuss cultural issues. McCorkle & Yanosy, accepted for publication, April 2007 McCorkle & Peacock, 2005 Farragher & Yanosy, 2005 Bloom, Bennington-Davis, Farragher, McCorkle, Nice-Martine & Wellbank, 2003 **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)***.** The practitioners of the model have adapted components for use in the East Coast and Midwest of the US, Mexico and Ecuador, rural and urban settings, and with different racial and ethnic groups. **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?** At this time, only baseline data has been collected.
Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** The Sanctuary Model incorporates information from the study conducted by Kaiser Permanente and the CDC which found correlations between Adverse Childhood Experiences and a host of medical problems. This research has demonstrated increased risk for co-morbid medical problems for those who have experienced trauma. The work of Kenneth Hardy and John Rich, has shaped the Sanctuary Model to expand the understanding of loss to include the secondary losses experienced by marginalized groups. By creating a trauma-informed culture that focuses on safety, emotion management, loss and future, the Sanctuary Model provides a framework for addressing both general and culture-specific risk factors that increase an individual's susceptibility to trauma. The Sanctuary Model also recognizes the extent to which loss and the experience of trauma can be isolating. The community building aspect of the model provides relief from that isolation for clients as well as protection against vicarious trauma for workers. **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 Sanctuary Model has been adapted for use in outpatient, group homes, community based clinics and in-home settings. One adaptation has been "Sanctuary to Go," which is a tool kit for families to use at home that teaches the interventions that are applicable to a home setting (community meetings, safety plans, red flag meetings, psychoeducation).

Sanctuary Model

Intervention Delivery Method/ Transportability & Outreach continued

For clinic-based workers, the model has been adapted to focus on the organizational components of the model for the staff delivering treatment which focuses on maintaining the seven Sanctuary commitments. The model has been efficacious in inpatient, residential, outpatient, substance abuse treatment, group homes, homeless and domestic violence shelters and schools.

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

Apart from the need for language translation, there have been no specific cultural barriers identified. One barrier to treatment which is experienced in many cultures is the stigma of mental illness. This stigma could present a barrier to accessing Sanctuary informed care. However, effective practice of the Sanctuary Model requires treatment facilities to seek out stakeholders and collateral supports of both the individuals in treatment as well as the treatment agency. This serves as a way of mitigating against this stigma.

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

The barriers that are endemic to treatment providers as they currently exist are also barriers to treatment in this model. The fact that it is transportable may negate transportation issues. Health insurance coverage is a potential barrier to access.

Are these barriers addressed in the intervention and how?

The Sanctuary Model addresses these barriers with a focus on the normalization of symptoms as a response to trauma through psychoeducation and with a focus on empowerment through including clients in shared governance and teaching them civic responsibility and advocacy skills. The focus on future and building skills to manage emotions is also a way that the model engenders independence in self-reliance in clients and staff.

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 Sanctuary Model encourages collaboration with a community of practice called the Sanctuary Network. This is a group of organizations who are using the Sanctuary Model and can provide support and feedback to each other. In addition to the community of practice, the model encourages organizations to collaborate with and educate community stakeholders, specifically collateral service providers, by familiarizing them with the Sanctuary language and concepts. In educating collaborating organizations in the model's concepts this enhances the likelihood of a more seamless and effective continuum of care for the traumatized individuals seeking treatment.

Sanctuary Model

Training Issues

What potential cultural issues are identified and addressed in supervision/training for the intervention?
Supervision and training address issues of power and hierarchy as both potential cultural issues and factors that interact with culture-specific issues. Understanding that many staff may have trauma histories themselves and/or may be members of marginalized groups, the model allows for the consideration, discussion and intervention needed to assist potentially vulnerable staff working with clients who have experienced trauma. This capacity of the Sanctuary model enables agencies to decrease the likelihood of further trauma to client (for example, it highlights the necessity of monitoring for client and staff engagement in harmful traumatic reenactments during treatment).

If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?
In addition to the above, cultural issues are addressed in supervision and training in the context of shared governance, flattened hierarchy, shared responsibility, education on vicarious trauma and staff self-care.

If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?
Potential cultural issues between the clinician and the client are addressed in supervision and training by using the SELF (safety, emotion management, loss and future) framework for case conferences, treatment planning, individual, group or family sessions or supervision. In addition, continual focus and refreshers on the seven commitments aid staff in avoiding or mitigating against potential cultural issues between clinician and client.

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

Any other special considerations regarding training?
The Sanctuary Model is not an intervention but a full organizational system approach focused on helping injured children recover from the damaging effects of interpersonal trauma. Because it is a full system approach, effective implementation of the Sanctuary Model requires extensive leadership involvement in the process of change as well as staff and client involvement at every level of the process. All disciplines must become actively engaged in creating a Sanctuary environment.

References

McCorkle, D. & Yanosy, S. (accepted for publication, April 2007). When loss gets lost: Using the SELF Model to work with loss in residential care. In S. Bloom, & L. Vargas (Eds.), *Loss, hurt and hope.*

McCorkle, D. & Peacock, C. (2005). Trauma and the isms–a herd of elephants in the room: A training vignette. *Therapeutic Communities, 26*(1), 127-133.

Farragher, B. & Yanosy, S. (2005). Creating a trauma-sensitive culture in residential treatment. *Therapeutic Communities, 26*(1), 97-113.

Bloom, S., Bennington-Davis, M., Farragher, B., McCorkle, D., Nice-Martine, K. & Wellbank, K. (2003). Multiple opportunities for creating sanctuary. *Psychiatric Quarterly, 74*(2), 173-190.

SPARCS: Structured Psychotherapy for Adolescents Responding to Chronic Stress

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** SPARCS **Average length/number of sessions:** 16 sessions, 1 hour in length **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** Meaning making, which is culturally driven, is a central component of SPARCS. 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. **Trauma type** *(primary)*: Chronic interpersonal traumas. **Trauma type** *(secondary)*: Other chronic traumas. **Additional descriptors** *(not included above)***:** SPARCS is a group intervention that was specifically designed to address the needs of chronically traumatized adolescents who may still be living with ongoing stress and are experiencing problems in several areas of functioning. These areas include difficulties with affect regulation and impulsivity, self-perception, relationships, somatization, dissociation, numbing and avoidance, and struggles with their own purpose and meaning in life as well as worldviews that make it difficult for them to see a future for themselves. Overall goals of the program are to help teens cope more effectively in the moment, enhance self-efficacy, connect with others and establish supportive relationships, cultivate awareness, and create meaning. Groups are one hour in length and have been provided in a variety of settings including outpatient clinics, schools, group homes, boarding schools, residential treatment centers and facilities, and foster care programs. Sessions can be divided into two segments and conducted twice a week to accommodate class periods in a school setting. It is recommended that SPARCS be implemented in settings where adolescents can remain in treatment long enough to complete the intervention. SPARCS is predominantly cognitive-behavioral and draws upon Dialectical Behavior Therapy (Miller, Rathus & Linehan, 2007), Trauma Adaptive Recovery Group Education and Therapy (TARGET: Ford & Russo, 2006), and the UCLA Trauma/Grief Program (Layne, Saltzman, Pynoos, et. al., 2002).
Target Population	**Age range:** 12 **to** 19 **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** Any English speaking ethnic or racial group. SPARCS has been used with ethnically diverse groups, including African American, Latino, Native American adolescents and refugee/immigrant populations. **Language***(s)***:** English **Region** *(e.g., rural, urban)***:** Urban, suburban, rural

SPARCS: Structured Psychotherapy for Adolescents Responding to Chronic Stress

Target Population continued	**Other characteristics** *(not included above)*: SPARCS has also been used successfully with traumatized adolescents who are pregnant or parents of young children. There are plans to conduct SPARCS with lesbian, gay, bisexual, transsexual, and questioning youth.
Essential Components	**Theoretical basis:** Cognitive-Behavioral Therapy and Dialectical Behavior Therapy, Complex Trauma **Key components:** Mindfulness, Problem-Solving, Meaning-Making, Relationship-building/Communication Skills, Distress Tolerance. Also includes psychoeducation regarding stress and trauma.
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** ❒ **Yes** ☒ **No** ❒ **Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)*. 2 **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** ❒ **Yes** ☒ **No** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***?** ☒ **Yes** ❒ **No** **If YES, please include citation:** DeRosa & Pelcovitz, 2006 **Has this intervention been presented at scientific meetings?** ☒ **Yes** ❒ **No** **If YES, please include citation***(s)* **from last five presentations:** ISTSS 2003-2006 **Are there any general writings which describe the components of the intervention or how to administer it?** ☒ **Yes** ❒ **No** **If YES, please include citation:** DeRosa & Pelcovitz, in press **Has the intervention been replicated anywhere?** ☒ **Yes** ❒ **No** SPARCS has been replicated with foster care youth as part of a project with the Department of Children and Family Services in Illinois. **Other countries?** *(please list)* Portions of SPARCS have been adapted for use in Israel & Sri Lanka. **Other clinical and/or anecdotal evidence** *(not included above)*: School administrators in one school noted a dramatic decrease in physical confrontations between students in the school. At another site, several gang members voluntarily sought out their group leader for additional practice with the skills they were learning in order to apply them to their specific stressors. At multiple sites generalization of skills has been observed. Group members have applied affect regulation and communication skills to real-life situations.

SPARCS: Structured Psychotherapy for Adolescents Responding to Chronic Stress

Clinical & Anecdotal Evidence continued	Members have initiated and contributed to discussions with staff and teachers about conflicts on their unit or in school. Adolescents have also reported that they teach friends and family members SPARCS skills and have asked if they can bring friends and family to group.	
Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Published Case Studies	**N=**14 **By gender:** female **By ethnicity:** Caucasian, Latino, African-American	DeRosa & Pelcovitz, 2006
Pilot Trials/Feasibility Trials *(w/o control groups)*	**N=**37 (22 session pilot) **N=**62 (16 session pilot) **By gender:** 22 sessions–all females, 16 sessions–male & female **By ethnicity:** Caucasian, Latino, African-American **By other cultural factors:** recent immigrant	ISTSS: 2006 (22 session pilot) Paper in preparation (22 session pilot) Paper in preparation (16 session pilot)
Clinical Trials *(w/control groups)*	**N=**65 **By gender:** 37 females, 28 males **By ethnicity:** African-American, Caucasian, Latino	Lyons, et al., in press
Outcomes	**What assessments or measures are used as part of the intervention or for research purposes, if any?** Youth Outcome Questionnaire (YOQ), UCLA PTSD Reaction Index (RI) **If research studies have been conducted, what were the outcomes?** Pilot data indicates significant improvement in overall functioning (as measured by the YOQ) for both the 22 and 16 session versions, with changes noted more specifically in level of behavioral dysfunction, social problems, and interpersonal relations for the 22 session version. Self-reported conduct related problems and difficulties with attention and hyperactivity closely approached the non-clinical range following treatment. On a measure of coping responses, group members reported improvements in interpersonal coping, with a significant increase in support seeking behavior.	

Outcomes continued	Similar results were obtained using the 16 session version, with significant findings on YOQ subscales assessing intrapersonal distress, interpersonal relations, behavioral dysfunction and critical items. There was also a significant decline in PTSD symptoms in this sample, with improvements noted in the overall severity of posttraumatic stress symptoms, as well as in criterion scores assessing symptoms related to re-experiencing, avoidance, and hyper-arousal (Criterion B, C, and D respectively). An Evidence Based Practices Pilot conducted by the Illinois Department of Children and Family Services, found that adolescents in foster care receiving SPARCS were half as likely to run away, and one-fourth less likely to experience placement interruptions (i.e., arrests, hospitalizations, runaways, etc.) compared to a standard of care group. It should also be noted that each of the three interventions that contributed components to SPARCS has empirical evidence to support its effectiveness in traumatized populations.
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** DeRosa, Habib, Pelcovitz, Rathus, Sonnenklar, Ford, et al., 2006 **How/where is training obtained?** Contact treatment developers. **What is the cost of training?** Contact treatment developers. **Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ❒ **No** **If YES, what languages?** Some handouts available in Spanish. **Other training materials &/or requirements** *(not included above)***:** The SPARCS developers are dedicated to establishing a collaborative learning environment. The SPARCS training model is designed to promote a partnership that supports sharing challenges, successes, and employing creative problem solving strategies. This model differs from many traditional workshops because it includes several components over a period of approximately 6-12 months. Clinicians, supervisors, and trainers alike, from multiple sites may have the opportunity to learn from each other. These phases of work are designed to establish in-house SPARCS teams, to enhance planning efforts and resources, to capture successes for the future, to provide consultation, and to support ongoing problem solving and evaluation. This "learning collaborative" approach is intended to enhance trainees' ability to address inevitable barriers that arise when implementing a new practice and to promote sustainability. • **Pre-Training Phase:** During this phase SPARCS trainers partner with agencies to identify the resources that are available to support a new practice and consider potential challenges in order to facilitate successful treatment implementation. During this phase clinicians, supervisors, and administrators develop in-house SPARCS teams, complete the SPARCS Planning Worksheet as a team, and discuss their findings during conference calls with trainers.

Training Materials & Requirements continued	• **Training Sessions:** Trainings typically include two or three separate interactive learning sessions. Trainings may include clinicians from multiple sites who will have the opportunity to learn from each other. The first training session consists of a two day training attended by at least one clinician and one administrator. It includes a balance of didactic presentations, demonstrations, role-plays, and mindfulness practice. The second training session consists of one day and occurs 4-6 weeks after the start of group. Training and implementation materials include a training/clinician guide and color activity handouts for group members. • **Multi-site consultation calls** with group leaders, supervisors, and administrators occur throughout the duration of the implementation phase.
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** This treatment is appropriate for traumatized adolescents with or without current/ lifetime PTSD, and can be implemented while adolescents are still living in unstable/ stressful environments. This intervention is strength-based. It is based on the assumption that the adolescents' symptoms (behavioral, interpersonal, and affective) represent their best efforts at coping with extreme stress. The treatment facilitates therapists' ability to help group members identify and build upon their strengths. SPARCS is a present-focused intervention, and is not an exposure based model. Although there is no direct exposure component or construction of a trauma narrative, traumas are discussed in the context of how they relate to adolescents' current behavior and to their understanding of their problems and difficulties in the here and now. Group members routinely discuss and process their personal experiences throughout the group. One final advantage of this approach is that it has been specifically designed for use with adolescents, with special consideration to the developmental tasks associated with this age group. As adolescents increasingly strive toward independence and autonomy from adults and caretakers, the influence of their peer group grows, making the group format of this approach especially powerful for this age group. Clinicians report that members often express feelings of validation simply upon hearing the shared stories and histories of other members. As group cohesion builds, members begin to support one another more actively, and will share observations and comments in a way that holds more meaning than when done by the adult co-leaders. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** Intensive clinician training and consultation is required. Some agencies report difficulty retaining a sizeable group of adolescents for the duration of the intervention. **Other qualitative impressions:** Please see the section on "Clinical & Anecdotal Evidence" for a description of clinical impressions observed.

NCTSN The National Child Traumatic Stress Network

GENERAL INFORMATION

SPARCS: Structured Psychotherapy for Adolescents Responding to Chronic Stress

Contact Information	**Name:** Victor Labruna, Ph.D. / Mandy Habib, Psy.D. **Address:** 400 Community Dr., Manhasset, NY 11030 **Phone number:** 516-562-3245 / 516-562-3276 **Email:** vlabruna@nshs.edu / mhabib@nshs.edu
References	DeRosa, R., Habib, M., Pelcovitz, D., Rathus, J., Sonnenklar, J., Ford, J., et al., (2006). *Structured Psychotherapy for Adolescents Responding to Chronic Stress.* Unpublished manual. DeRosa, R. & Pelcovitz, D. (2006). Treating traumatized adolescent mothers: a structured approach. In N. Webb (Ed.), *Working with traumatized youth in child welfare* (pp. 219-245). New York: Guilford Press. DeRosa, R. & Pelcovitz. D. (in press). Igniting SPARCS of change: Structured psychotherapy for adolescents responding to chronic stress. In J. Ford, R. Pat-Horenczyk & D. Brom (Eds.). *Treating traumatized children: risk, resilience and recovery.* New York: Routledge. Ford, J. D. & Russo, E. (2006). Trauma-focused, present-centered, emotional self-regulation approach to integrated treatment for posttraumatic stress and addiction: Trauma Adaptive Recovery Group Education and Therapy (TARGET). *American Journal of Psychotherapy. 60*, 335-355. Layne, C. M., Saltzman, W. R., Pynoos, R. S., & Steinberg, A. M. (2002). *Trauma and Grief Component Therapy.* New York: New York State Office of Mental Health. Lyons, et al. (in press). Evaluation of the implementation of three evidence-based practices to address trauma for children and youth who are wards of the State of Illinois. Miller, A. L., Rathus, J. H. & Linehan, M. M. (2007). *Dialectical Behavior Therapy with suicidal adolescents.* New York, NY: Guilford Press.

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 differs by culture. Further systematic study of alterations in functioning that often occur in the face of chronic interpersonal trauma (not exclusive to PTSD diagnosis) across a number of variables, including culture, is greatly needed in the child trauma literature. While SPARCS assessments do include trauma history and 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. **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.

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?** Evaluation in progress.
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. **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.

Intervention Delivery Method/ Transportability & Outreach continued

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.

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.

Intervention Delivery Method/ Transportability & Outreach continued	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.

TGCT: Trauma and Grief Component Therapy for Adolescents

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** TGCT **Average length/number of sessions:** Individual session length is an average of 50 minutes. (Sessions can be shortened in length to accommodate school class periods. Alternatively, individual sessions can be expanded up to 90 minutes in length, as needed and if time allows.) Depending on the number and types of treatment modules that are implemented, the total number of sessions ranges from 10 to 24. **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** Emphasis is given throughout the intervention (e.g., in psychoeducational exercises, skillbuilding exercises, and group or family-based interventions) to individual differences in responses to trauma or traumatic loss. These differences may arise from cultural, developmental, or exposure-based influences on how children, adolescents, and their families respond to traumatic experiences. Module III consists of a grief component that emphasizes particular sensitivity to cultural, developmental, or religious/spiritually-linked differences in responses to death. **Trauma type** *(primary)*: Community violence **Trauma type** *(secondary)*: Traumatic loss (death) **Additional descriptors** *(not included above)***:** TGCT is a manualized treatment for trauma-exposed or traumatically bereaved older children and adolescents that may be implemented in school, communty mental health, or other service settings. The program has been implemented with a wide range of trauma-exposed and traumatically bereaved older child and adolescent populations, in both the United States and international settings. These populations include youth impacted by community violence, traumatic bereavement, natural and man-made disasters, war/ethnic cleansing, domestic violence, witnessing interpersonal violence, medical trauma, serious accidents, physical assaults, gang violence, and terrorist events.
Target Population	**Age range:** 12 **to** 20 **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** The program has been implemented and evaluated with a broad variety of groups, including war-exposed Bosnian adolescents (comprised of ethnic Muslim, Croatian, and Serbian youths); multi-racial, multi-ethnic middle and high school students exposed to community violence and school shootings in Pasadena, Long Beach, and Santee, Southern California; and among adolescents exposed to the September 11th 2001 terrorist attacks in New York City.

TGCT: Trauma and Grief Component Therapy for Adolescents

Target Population continued	Preliminary versions of the intervention were implemented with children exposed to community violence in an impoverished urban community in Inglewood, California; with socioeconomically disadvantaged youths exposed to gang-related violence in San Fernando, California; and with youths exposed to a massive earthquake in Armenia. **Other cultural characteristics** *(e.g., SES, religion)*: The intervention has been implemented with a variety of socioeconomic and religious/cultural/ethnic groups, as described above. **Language***(s)*: Currently English and Bosnian. The authors are open to translating and adapting the intervention for other cultural groups. **Region** *(e.g., rural, urban)*: The program has been implemented in inner-city, urban, and post-war settings. **Other characteristics** *(not included above)*: The program has been implemented and evaluated in both individual and group-based modalities. A family-focused intervention component is also included in the manual.
Essential Components	**Theoretical basis:** TGCT is based on a developmental psychopathology model that addresses the complexity of traumatic experience, the roles of trauma and loss reminders, the interplay of trauma and grief, the influences of life adversities, the influence of traumatic expectations on current and future behavior, and the importance of restoring developmental progression. TGCT also draws upon cognitive-behavioral theory and social provisions theory. **Key components:** TGCT is a multi-component (modularized) treatment manual and accompanying workbook with detailed instructions for conducting individual or group sessions. The intervention is assessment-driven, with specific treatment modules being selected for implementation based on clients' problems, needs, and strengths. The intervention contains a variety of components: • Initial assessment, case conceptualization, and treatment planning • Psychoeducation • Emotional regulation skills • Addressing youths' and families' traumatic stress experiences and reactions • Promoting adaptive coping (e.g., social support, problem-solving, contending with trauma and loss reminders) • Addressing maladaptive beliefs relating to trauma and loss • Promoting adaptive developmental progression • Addressing grief and loss • Maintaining adaptive routines • Relapse prevention

Essential Components continued	• Ongoing monitoring, surveillance, and evaluation of treatment response • Family/parent sessions offered at key points in treatment • Assessment tools available to measure all major targeted therapeutic outcomes
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** ❒ **Yes** ☒ **No** ❒ **Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)***.** 4 **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** ❒ **Yes** ☒ **No** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***?** ☒ **Yes** ❒ **No** **If YES, please include citation:** Layne, Saltzman, Burlingame, Davies, Popovic, Duraković, et al., 2001 **Has this intervention been presented at scientific meetings?** ☒ **Yes** ❒ **No** **If YES, please include citation***(s)* **from last five presentations:** International Society for Traumatic Stress Studies (ISTSS): Layne, Turner, Deter, Judson, Legerski, Darby & Money, 2004; Layne, Neibauer, Manwaring, Arslanagic, Saltzman & Pynoos, 2003 The National Center for Mental Health Promotion and Youth Violence Prevention: Layne & Saltzman, 2004 Rome Conference on Childhood Trauma: Saltzman, Layne & Pynoos, 2003 American Group Psychotherapy Association: Saltzman, Layne & Pynoos, 2002 **Are there any general writings which describe the components of the intervention or how to administer it?** ☒ **Yes** ❒ **No** **If YES, please include citation:** Saltzman, Layne, Steinberg & Pynoos, 2006 Saltzman, Layne, Steinberg, Arslanagic & Pynoos, 2003 Saltzman, Layne, Steinberg & Pynoos, 2003 Saltzman, Pynoos, Layne, Steinberg & Aisenberg, 2001a **Has the intervention been replicated anywhere?** ☒ **Yes** ❒ **No** **Other countries?** *(please list)* Bosnia & Hercegovina

TGCT: Trauma and Grief Component Therapy for Adolescents

Clinical & Anecdotal Evidence continued	**Other clinical and/or anecdotal evidence** *(not included above)*: A deliberate search for poor or adverse clinical outcomes was undertaken in an independent program evaluation conducted across 10 participating secondary schools in Bosnia. Very few (1 to 2%) poor outcomes were found, either as measured using quantitative measures (PTSD symptoms, depression symptoms) or using qualitative methods (focus groups). In contrast, strong evidence of program benefit was found among the majority of participating students.	
Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Pilot Trials/Feasibility Trials *(w/o control groups)*	**N=**6 (Layne et al. pilot trial) **N=**87 (Layne et al. open trial) **N=**26 (Saltzman et al. open trial) **By gender:** All studies: Combined Boys and Girls **By ethnicity:** Layne et al. pilot trial: Latino and African-American Layne et al. open trial: Bosnian Saltzman et al. open trial: Latino, African American, Caucasian **By other cultural factors:** Layne et al. pilot trial: Urban SES-disadvantaged high school students exposed to severe gang violence Layne et al. open trial: War-exposed youths exposed to severe post-war adversities Saltzman et al. open trial: 11-14 year old SES-disadvantaged youths	Layne, Pynoos & Cardenas, 2001 Layne, Pynoos, Saltzman, Arslanagic, et al., 2001 Saltzman, Pynoos, Layne, Steinberg & Aisenberg, 2001b
Clinical Trials *(w/control groups)*	**By gender:** Boys and girls (individually treated)	1. Implementing CBT for Youth and Families After September 11th: Lessons Learned from the Child and Adolescent Trauma Treatments and Services (CATS) Project. Authorship: CATS Consortium Status: Under review 2. Clinical Outcomes of CBT on Youth Affected by the WTC Disaster Authorship: CATS Consortium Status: Manuscript in preparation

TGCT: Trauma and Grief Component Therapy for Adolescents

Research Evidence continued	Sample Size (N) and Breakdown *(by gender, ethnicity, other cultural factors)*	Citation
Randomized Controlled Trials	**N=**79 **By gender:** Combined boys and girls (treated in groups) **By ethnicity:** War exposed Bosnian secondary school students **By other cultural factors:** Adolescents living amidst severe adversity in post-war Bosnia.	Layne, Saltzman, Poppleton, Burlingame, Pašalić, Duraković, et al., in press Layne, Poppleton, Saltzman, et al., in preparation
Other Research Evidence	**N=**34 **By gender:** Both girls and boys **By ethnicity:** Bosnian Muslim **By other cultural factors:** War-exposed secondary school students	Qualitative Program Evaluation: Cox, Davies, Burlingame, Campbell & Layne, in press

Outcomes

What assessments or measures are used as part of the intervention or for research purposes, if any?

Quantitative Instruments (used for risk screening, clinical interview, triage, monitoring, and/or for program evaluation applications):

- Adolescent Self-Efficacy Scale (Bandura, 1992)
- Depression Self-Report Scale (Birelson, 1981)
- Cognitive Distortions Scale (Briere, 1999)
- Student Self-Rating Scale (Hightower, 1987)
- War Trauma Exposure Inventory (Layne, Djapo & Pynoos, 1999)
- Post-War Trauma Exposure Scale (Layne, Steinberg & Pynoos, 1999a)
- Post-War Adversities Scale (Layne & Djapo, 1999)
- Loss Reminder Screening Inventory (Layne, Savjak, Steinberg & Pynoos, 1999)
- Trauma Reminder Screening Inventory (Layne, Steinberg & Pynoos, 1999b)
- UCLA Grief Inventory (Layne, Pynoos, Savjak & Saltzman, 2000)
- Locus of Control Scale (Mirowsky & Ross, 1991)
- UCLA Reaction Index-Revised (Steinberg, Brymer, Decker & Pynoos, 2004)
- Provision of Social Relations Scale (Turner, Frankel & Levin, 1983)
- Self-Satisfaction Survey (Kochendorfer, 1974)

TGCT: Trauma and Grief Component Therapy for Adolescents

Outcomes continued	• Group Climate Questionnaire (MacKenzie, 1983) • Curative Climate Inventory (Fuhriman, Drescher, Hanson, Henrie & Rynicki, 1986) • Youth Outcome Questionnaire Somatization and Social Problems Subscales (Wells, Burlingame & Lambert, 1999) **If research studies have been conducted, what were the outcomes?** Both published open trials and a randomized controlled trial (in press) indicate significant reductions in PTSD, depression, and complicated grief reactions, and improvements in school behavior. Data from the randomized controlled trial indicate that the percentages of students in the treatment condition who reported significant ($p < .05$) pre- to post-treatment reductions in PTSD symptoms (58% at post-treatment; 81% at 4-month follow-up) compare favorably to those reported in rigorously conducted treatment efficacy trials with adults.
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** Layne, Saltzman, Pynoos & Steinberg, 2002 **How/where is training obtained?** Contact the authors **What is the cost of training?** To be negotiated with the authors/trainers **Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ❒ **No** **If YES, what languages?** Bosnian (to date) **Other training materials &/or requirements** *(not included above)***:** Two-day training with ongoing supervision and consultation, program includes a battery of screening measures, interview protocol, 200 page manual and workbook for participants. The participant workbook is extensive, containing many handouts and exercises that are very popular with clinicians.
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** • Contains initial sessions that address potential stigma for treatment and other barriers to participation • Is available in either individual or group-based modalities • Contains a family/parent-focused intervention component • Contains an extensive grief module that provides extensive grief psychoeducation, focuses on reducing traumatic grief, and promotes adaptive grieving and mourning • Focuses specifically on identifying and remediating trauma- or loss-induced disturbances in developmental progression • Specifically tailored to adolescent issues surrounding trauma and loss

TGCT: Trauma and Grief Component Therapy for Adolescents

Pros & Cons/ Qualitative Impressions continued	• TGCT comes with a variety of assessment instruments that are specifically tailored to support initial assessment, monitoring, and evaluation of clients' responses to treatment. • Guidelines are provided for adapting the program in a culturally and ecologically sensitive manner. TGCT is specifically designed to identify and effectively treat youths whose distress and dysfunction fall within the severely distressed, as well as moderately distressed, ranges. It is thus intended to address the needs of the most severely exposed, as well as moderately exposed, youths. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** Treatment length is variable, depending on the number of modules that are implemented. More distressed youths will likely require longer and more intensive intervention. **Other qualitative impressions:** See qualitative program evaluation, described above.
Contact Information	**Name:** Christopher Layne, Ph.D., or Bill Saltzman, Ph.D. **Address:** UCLA - National Center for Child Traumatic Stress, 11150 W. Olympic Blvd., Suite 650, Los Angeles, CA 90064 **Phone number:** (310) 235-2633, extension 223; fax (310) 235-2612 **Email:** cmlayne@mednet.ucla.edu; wsaltzman@sbcglobal.net
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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)

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.

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).

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.

NCTSN The National Child Traumatic Stress Network

GENERAL INFORMATION

TARGET-A: Trauma Affect Regulation: Guidelines for Education and Therapy for Adolescents and Pre-Adolescents

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** TARGET-A **Average length/number of sessions:** 4-12 **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** • Reducing the stigma associated with mental illness: re-framing extreme emotionality/reactivity (e.g., hyporeactivity-dissociation, numbing; hyperreactivity-anxiety, rage) as manageable alterations in the body's self-protective systems; • Spirituality: the culminating skill in the model is "Making a Contribution," which is designed to help people reflect on how they are living in ways that are consistent with their personal and spiritual values and commitments, and thereby making the world better; • Spiritual reflection and culture-based meaning-making is facilitated by distinguishing between "reactive" and "main" feelings, thoughts, goals, and behavioral choices (i.e., an approach to cognitive re-structuring that is sensitive to cultural beliefs, strengths-based and dialectical rather than pathologizing/stigmatizing and dualistic). **Trauma type** *(primary)*: Physical abuse **Trauma type** *(secondary)*: Domestic violence, emotional abuse, sexual abuse **Additional descriptors** *(not included above)***:** TARGET is a promising and acceptable treatment for children or parents experiencing traumatic stress. The primary focus is on recovery from interpersonal trauma. Clinician Manuals and Participant Guides have been developed. TARGET can be provided in individual, conjoint family, dyadic parent-child, group, residential and school milieu, and case management interventions.
Target Population	**Age range:** 10 **to** 18+ **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** Not specific to any particular group. Adapted for youth in the juvenile justice, school, child protection, and child mental health/child guidance systems. Used with multinational Latino, African, Southeast Asian, and Eastern European immigrant families and with multi-generational Native American, Latino, and African American families in the U.S. and Canada, and in translation in Israel, the Netherlands, France, and Puerto Rico. **Other cultural characteristics** *(e.g., SES, religion)***:** Both urban & rural, primarily used with low SES, very frequently with single parents or with families whose children have limited contact with biological parents (e.g., foster kids, residential placements), and diversity of religious affiliations

TARGET-A: Trauma Affect Regulation: Guidelines for Education and Therapy for Adolescents and Pre-Adolescents

Target Population continued	**Language***(s)***:** Translated into Spanish, Hebrew, Dutch, French **Region** *(e.g., rural, urban)***:** Rural & urban **Other characteristics** *(not included above)***:** Have had input from parents, children, and providers from a wide range of cultural groups in development of TARGET (African American, Latino/Hispanic, Eastern European, SE Asian) regarding how to express concepts in a linguistically and culturally sensitive and meaningful manner.
Essential Components	**Theoretical basis:** Cognitive behavioral, self/relational, systems, narrative **Key components:** Self-regulation, affect regulation, autobiographical and working memory (information processing), interpersonal problem solving, stress management, didactic and nonverbal experiential exercises; the skill set is summarized for easy recall and use by an acronym (i.e., FREEDOM)
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** **❒ Yes ☒ No ❒ Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)***.** 3 **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** **❒ Yes ☒ No** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***? ☒ Yes ❒ No** **If YES, please include citation:** Collecting this information now in juvenile detention centers; see Ford & Russo (2006). **Has this intervention been presented at scientific meetings? ☒ Yes ❒ No** **If YES, please include citation***(s)* **from last five presentations:** International Society for Traumatic Stress Studies (ISTSS): Ford, 2008 American Psychological Association (APA): Ford, 2007 American Psychiatric Association: Ford, 2007 National Institute on Drug Abuse Blending Addiction Science & Practice Meeting: Ford, 2006 National GAINS Center Conference: Rowe, Liddle & Ford, 2006 **Are there any general writings which describe the components of the intervention or how to administer it? ☒ Yes ❒ No** **If YES, please include citation:** Ford & Russo (2006). **Has the intervention been replicated anywhere? ☒ Yes ❒ No**

TARGET-A: Trauma Affect Regulation: Guidelines for Education and Therapy for Adolescents and Pre-Adolescents

Clinical & Anecdotal Evidence continued	**Other countries?** *(please list)* In learning collaboratives throughout the Network; as part of David Pelcovitz & Ruth DeRosa's SPARCS treatment and Richard Kagan's Real Life Heroes model; Israel, France, the Netherlands, Canada, Puerto Rico **Other clinical and/or anecdotal evidence** *(not included above)*: TARGET is being adopted as an educational and treatment model in statewide trauma initiatives in Connecticut and Florida for use in juvenile justice detention centers, probation offices, and residential and community programs, and in inpatient, residential, child guidance clinics, and community outreach mental health and substance abuse treatment programs for youths and families. The U. S. Department of Justice, Office of Juvenile Justice and Delinquency Programs has funded (October 2006-September 2008) a two-year field demonstration study of TARGET in Connecticut juvenile detention facilities.

Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Published Case Studies	**N=**4 **By gender:** males & females **By ethnicity:** Latino, African American	Ford, Chapman, Mack & Pearson, 2006 Ford & Russo, 2006
Pilot Trials/Feasibility Trials *(w/o control groups)*	**N=**24 **By gender:** males & females **By ethnicity:** 40% Latino, 25% Black, 35% White **By other cultural factors:** 33% bilingual	Ford, 2004
Clinical Trials *(w/control groups)*	**N=**248 **By gender:** girls **By ethnicity:** 40% Latina, 30% Black, 30% White **By other cultural factors:** 40+% bilingual	Ford & Hawke, in preparation

Research Evidence continued	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Randomized Controlled Trials	**N=**231 **By gender:** males & females **By ethnicity:** 55% White, 25% Black, 11% Latino, 9% American Indian, Alaskan Native, Asian/Pacific Islander	Frisman, Ford, Lin & Mallon, in press
Randomized Controlled Trials	**N=**32 **By gender:** all female **By ethnicity:** 16% African/ Caribbean American, 59% Latina or Mixed Race, 25% European American; **By other cultural factors:** 45% in residential treatment; 37.5% in DCF guardianship; 37.5% had prior arrest for violent crimes	Ford, Steinberg, Moffitt, Hawke & Zhang, in preparation (research reported at www.nrepp.samhsa.gov)
Randomized Controlled Trials	**N=**145 **By gender:** female **By ethnicity:** 40% Black, 35% Latina, 25% White **By other cultural factors:** low SES, primarily single parents	Randomized clinical trial with mothers with PTSD who are caring for a child <5 yrs old. Ford, Steinberg, Moffitt, & Zhang, in preparation (research reported at www.nrepp.samhsa.gov)

Outcomes

What assessments or measures are used as part of the intervention or for research purposes, if any?

Many measures are used, core measures include Traumatic Events Screening Inventory (TESI; National Center for PTSD, www.ncptsd.org), UCLA PTSD Reaction Index, UCLA Traumatic Grief Inventory, Post-Traumatic Cognition Inventory, Trauma Symptom Checklist for Children, Negative Mood Regulation Scale, Weinberger Adjustment Inventory, Hope Scale, KidCope, PTSD Checklist (for parents), Clinician Administered PTSD Scale, Expectancies for Negative Mood Regulation Scale, Interpretations of PTSD Symptoms Scale, State-Trait Anxiety Inventory; State-Trait Anger Expression Inventory; Beck Depression Inventory of Interpersonal Problems, Parenting Stress Index, Parenting Practices Inventory.

If research studies have been conducted, what were the outcomes?

Pilot open trial with five groups (gender specific, developmentally specific, i.e., ages 10-14 and 15-18) of juvenile justice probation clients showed reductions in PTSD avoidance/numbing, self-related post-traumatic cognitions, negative coping by self- and parent-report, increased hope /self-efficacy, and no deterioration.

- Results of randomized controlled effectiveness study 1: TARGET compared to trauma-informed outpatient addiction treatment indicated that TARGET and trauma-informed usual services were equivalent in achieving reductions in depression, anxiety, post-traumatic stress, post-traumatic cognitions, and substance use, which were sustained at an assessment 12-months following entry to the study, but TARGET was superior to trauma-informed usual care in sustaining participants' self-efficacy related to addiction recovery (Frisman et al., in press; research reported at www.nrepp.samhsa.gov).
- Results of randomized controlled effectiveness study 2: TARGET was associated with reductions post-therapy in self-reported PTSD, anxiety, depression, and anger symptoms, and increased self-efficacy/optimism, and with greater improvement than enhanced treatment as usual (ETAU) on PTSD symptoms (primarily Criterion C avoidance and numbing, and Criterion B intrusive re-experiencing). More (77%) TARGET recipients than ETAU recipients (53%) no longer met diagnostic criteria for PTSD or partial PTSD post-therapy.
- Results of randomized controlled effectiveness study 3: Clinically significant reductions post-therapy in self-reported PTSD, anxiety, depression, and post-traumatic beliefs, and increased emotion regulation, and sustained or greater improvements at 3-month and 6-month follow-up assessments. TARGET was associated with greater improvement than an active comparison therapy, present centered therapy, on PTSD and anxiety symptoms, PTSD-related cognitions, and emotion regulation, and (at follow-up) physical health-related functioning. Research reported at www.nrepp.samhsa.gov.
- Open trial replications with a quasi-experimental control group in five juvenile justice detention facilities indicate that the introduction of TARGET as a milieu and group intervention was associated with reduced disciplinary problems vs. the prior six months. Research reported at www.nrepp.samhsa.gov.

TARGET-A: Trauma Affect Regulation: Guidelines for Education and Therapy for Adolescents and Pre-Adolescents

Implementation Requirements & Readiness	**Space, materials or equipment requirements?** Group or individual counseling or school/ educational space. Creative arts materials for experiential exercises. The TARGET manual and handouts have been copyrighted by the University of Connecticut and must be purchased from the University or its licensees. No equipment required. **Supervision requirements** *(e.g., review of taped sessions)***?** Consultation by a certified TARGET trainer/consultant is required following initial training, and for continued use of the materials. Consultation includes review by the trainer/consultant of taped interventions and supervision sessions. **To ensure successful implementation, support should be obtained from:** In order for successful implementation, support should be obtained from: Advanced Trauma Solutions www.advancedtrauma.com
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** • Chang, Augenbraun, Ford & Cruz, in press • Ford, 2008 • Ford, Chapman, Mack & Pearson, 2006 • Ford & Russo, 2006 • Ford, Russo & Mallon, 2007 • Ford & Saltzman, in press • Frisman, Ford, Lin, Mallon & Chang, in press **How/where is training obtained?** www.advancedtrauma.com, Tom DeVitto, CEO, 203-232-2437 **What is the cost of training?** Trainings are delivered within a package that includes ongoing consultation and quality assurance and license to use copyrighted materials, in order to ensure effective adoption and sustainability with fidelity to the model. Trainings usually are delivered to agencies or systems and costed based on the services required. **Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ❒ **No** **If YES, what languages?** Spanish, Hebrew, Dutch
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** • Provides clinician, case manager or childcare worker and family with way to manage their own and youths' intense reactivity secondary to PTSD hyperarousal and hypervigiliance or hypoarousal associated with PTSD emotional numbing and dissociation, in a practical manner that is not stigmatizing or pathologizing, that increases the sense of self-efficacy and hope, and that is adaptable for a variety of cultural belief systems and practices.

Pros & Cons/ Qualitative Impressions continued	• Can serve as a phase 1 intervention to set the stage for almost any other trauma intervention by helping adults and youths become sufficiently regulated to be able to use the other skills: one youth described this as, "before I learned to use the SOS (a component in TARGET) to turn down my brain's alarm, I was too angry to use my anger management skills; now I'm not as angry and even when I get angry I remember to use my skills." TARGET is compatible with most evidence-based models, and has been used as the first line intervention to prepare clients for other interventions (e.g., anger management, relational therapies, addiction recovery programs, trauma-focused cognitive-behavior therapy) in numerous programs. • Readily adapted to settings where youths or families enter and leave services rapidly (e.g., detention centers or partial hospital programs with average length of stay <14 days) in a modular form that can be completed rapidly (e.g., 4 sessions) and introduced to new clients while continuing to be used with ongoing clients (e.g., in groups with rolling admissions). • TARGET has been adapted as a milieu and staff development intervention in several settings (including introduction in intake and use as the behavior management protocol for residential/detention and community-based risk reduction programs, as a crisis management and de-escalation model for acutely distressed or externalizing youths and post-critical incident intervention for staff, as a parent psychoeducation program, and as a staff clinical consultation group protocol). • TARGET provides a unique sequence of skills designed to address the biological changes caused by stress. • TARGET can be delivered by line staff, educators, and case managers, enabling providers to reduce treatment costs and reach significantly more patients. Other therapies must be delivered by highly trained, costly, and scarce mental health professionals. • TARGET is compatible with conventional 3rd party payor systems. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** TARGET can include trauma memory processing but has been found to work best clinically when used in tandem with Trauma-Focused CBT (pilot clinical testing ongoing at the University of Connecticut Child Trauma Clinic).
Contact Information	**Name:** Thomas DeVitto **Address:** www.advancedtrauma.com **Phone number:** 203-232-2437 **Email:** tdevitto@yahoo.com **Website:** www.advancedtrauma.com

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Ford, J. D. (2004, May). *Parents as mediators of trauma: Trauma intervention for youth and parents.* Keynote speech presented at the 2nd Bi-national Conference on Treating Traumatized Children and Adolescents.

Ford, J. D. (2006, October). Post-traumatic stress disorder and Developmental Trauma Disorder. In L. Huey (Chair). Symposium conducted at the meeting of the National Institute on Drug Abuse Blending Addiction Science & Practice Meeting, Seattle, WA.

Ford, J. D. (2007, August). *Risk, resilience, and recovery in traumatized children.* Presented at the annual meeting of the American Psychological Association, San Francisco, CA.

Ford, J. D. (2008, November). *Trauma Affect Regulation: Guide for Education and Therapy (TARGET) in Juvenile Justice.* Presented at the annual meeting of the International Society for Traumatic Stress Studies, Baltimore, MD.

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Ford, J. D., Steinberg, K., Moffitt, K., Hawke, J. & Zhang, W. (in preparation). A randomized clinical trial of affect regulation psychotherapy for delinquent girls: The Girls' In Recovery from Life Stress (GIRLS) Study. Research reported at www.nrepp.samhsa.gov.

Ford, J. D., Steinberg, K., Moffitt, K. & Zhang, W. (in preparation). A randomized clinical trial of affect regulation and social problem solving psychotherapies for low income mothers with PTSD: The Mothers Overcoming and Managing Stress (MOMS) study. Research reported at www.nrepp.samhsa.gov.

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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."** Training and materials have been specifically adapted with input from individuals of the following backgrounds: low-income, ethnoracial minorities (primarily Latino/Latina and African/Caribbean American), as well as to be gender-sensitive for girls as well as boys, and for gay, lesbian, bisexual, and transgender youth and adults. **Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.** Experiential examples and exercises are used to engage youths and families and are based upon activities, language, and metaphors specific to participants from different cultural groups – primarily to resonate with urban, low-income Latino/Latina, African and Carribean-American youths and parents as well as urban, low-income White youths and parents. Samples of exercises are available. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** Clinicians implementing TARGET acknowledge differences in their background and experiences from those of their youth and family clients at the outset of therapy, and invite youths and parents to talk about any reservations or concerns they may have about the clinician's background and respect for and knowledge of persons of other backgrounds. We commonly learn from youths and parents that their initial reservations based on a clinician of a different ethnoracial or SES background were addressed by the clinician's genuine interest right from the start of therapy or group in learning about their (the youth/family's) experiences, values, beliefs, preferred language, and barriers to engaging in TARGET (such as complicated child care, work, or school schedules; or difficulties in attending sessions due to limited transportation options that may cause them concern about money and safety). These concerns are explicitly asked about throughout TARGET sessions and discussed as opportunities to use the skills and enhance trust, self-efficacy, and a sense of connectedness to community/family by participants.
Language Issues	**How does the treatment address children and families of different language groups?** Spanish as well as English-speaking
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?** The intervention does not focus on symptoms but on enhancing and building upon strengths in functioning and relationships, in order to reduce the stigma associated with formal clinical services that most of the low-income, ethnoracial minority participants in TARGET have experienced or fear. The explanation of trauma and PTSD provided in TARGET specifically was designed to demystify, de-stigmatize, and de-professionalize these concepts while introducing youths and families to complex biological and psychosocial issues involved in trauma and PTSD in a way that increases their ability to be informed consumers of services.

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? If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** All assessment measures used in TARGET have been psychometrically validated with low-income ethnoracial minorities and with females as well as males, including in our own studies. **What, if any, culturally specific issues arise when utilizing these assessment measures?** Despite their psychometric status, we know (from asking participants) that the terms used in many widely used trauma and PTSD measures have variable meanings based on ethnocultural background and gender. Therefore, TARGET clinicians routinely ask youths and families about their understanding of key questions and use this as a vehicle for better understanding the youths and families (e.g., what "unwanted memories" or "feeling that you have no future" specifically mean to each participant).
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** See Ford, Chapman, Hawke & Albert (2007); Ford & Russo (2006); Ford, Russo & Mallon (2007). Also, these issues have been addressed, although not specifically to TARGET, by Ford (2008). **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)***.** For deaf adults and for incarcerated women of color; the teaching protocols and materials have been used successfully with children, adolescents, families, and adults of diverse ethnocultural backgrounds with the guideline that facilitators/therapists using the model must elicit from the clients the specific terms and life examples that best convey the core concepts and make the self-regulation skills consistent with their unique cultural, linguistic, and family norms, values, and experiences. **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 has been no difference in the rates of drop out (typically < 10%) for African/Caribbean-American, Latino/Latina, Asian-American, Native-American, or Caucasian boys, girls, men, or women. See research summaries reported at www.nrepp.samhsa.gov.
Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** Risk of current victimization is assessed throughout TARGET sessions, and the FREEDOM skills specifically are applied to enhancing safety and reducing the likelihood of further traumatization.

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?**
TARGET-FS (Ford & Saltzman, in press) has been developed and piloted with cases in the University of Connecticut Child Trauma Clinic, based on collaboration with the originators of Multidimensional Family Therapy, as well as by therapists in an ongoing NIMH-funded study with low-income families in New Orleans who were affected by Hurricane Katrina (Cynthia Rowe, Ph.D., Principal Investigator). TARGET-FS has been uniformly well-received by families and traumatized youths, and clinical and research outcome data are being collected to quantify its outcomes with clients of diverse ethnocultural backgrounds.

Are there cultural barriers to accessing this treatment *(i.e., treatment length, family involvement, stigma, etc.)***?**
TARGET can be delivered on a brief (4-sessions) basis in settings (e.g., juvenile detention) where limited time is available, and as a milieu intervention by line staff (in juvenile detention, psychiatric residential programs, and therapeutic schools) in order to increase ecological validity and reduce stigma for providers as well as for youths and families. Family involvement is emphasized in all TARGET applications.

Are there logistical barriers to accessing this treatment for specific cultural groups *(i.e., transportation issues, cost of treatment, etc.)***?**
Yes; the adaptations describe above are designed to address the barriers.

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)***?**
Community members and system of care groups have been advisors for TARGET throughout its development and continue to be. This currently includes stakeholders for multicultural and special needs youth and family advocacy (Merva Jackson, AFCAMP; Martha Stone, Center for Children's Advocacy and Speak Up! Coalition for Legal Rights for Youth; Greater Harford Academy of the Arts Looking In Theater youth group; Hector Glynn, Vice President, Village for Families and Children; Robin McHaelen, True Colors Mentoring for Gay, Lesbian, Bisexual, Transgender Youth, Clevens St. Juste, Hartford Sports Mentoring League; John Hattery, Homebuilders Institute; Jeanne Milstein, State Child Advocate), faith communities (the Rev. India Mills and Michael Williams), parents (Merva Jackson, AFCAMP, Theresa Goode, GoodWorks; Heather McDonald, Focus on Recovery United, Sarah Gibson, DCF Safe Homes), military families (JasonDeViva, VA Connecticut Health Care System), foundations (Robert Franks, Connecticut Children's Fund; Glynis Cassis, Casey Family Foundation), healthcare (Margie Hudson, Dept. of Public Health), schools (Kim Stroud, CREC, Winston Johnson, Hartford Public Schools), providers (Janet Williams, DCF Medical Director; Hector Glynn, the Village for Families and Children, Robert Franks, CT TF-CBT Network), juvenile justice (Hon. Curtissa R. Cofield, Community Court; William Carbone and John Chapman, Judicial Branch; Leo Arnone, DCF Juvenile Justice Bureau).

Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** Stereotypes, stigma, power imbalances, "hidden" trauma (per Ken Hardy, Ph.D.) associated with racism and racial and class-based discrimination (see Ford, 2008) are explicitly addressed as sources of trauma and triggers for posttraumatic stress. **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** As in implementing TARGET with youths and families, in supervision the supervisor encourages (and provides a role model for authentic disclosure balanced by professional boundaries) discussion of racial, cultural, gender, sexual identity, and age differences with each supervisee and among supervisees. **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** All TARGET research therapists and implementation sites receive guidance on cultural issues and gender sensitivity in TARGET trainings and ongoing consultation (Marisol Cruz, M.A., lead TARGET trainer in juvenile detention settings is a cultural competence trainer; Rocio Chang, Psy.D., Deborah Augenbraun Psy.D., Julian Ford, and Marisol Cruz have written a chapter in press on multicultural issues in TARGET research therapist). **Has this guidance been provided in the writings on this treatment?** See above references, which are used in training TARGET therapists.
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NCTSN The National Child Traumatic Stress Network

GENERAL INFORMATION

TF-CBT: Trauma-Focused Cognitive Behavioral Therapy

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** TF-CBT **Average length/number of sessions:** Over 80% of traumatized children will show significant improvement with 12-to-16 weeks of treatment (once a week; 60-to-90 minute sessions). **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** TF-CBT has been adapted to address the needs unique to Latino and hearing-impaired/deaf populations, and for children who are experiencing traumatic grief. It is also being adapted for Native American families. **Trauma type** *(primary)*: Sexual abuse, traumatic grief, domestic violence, disasters, terrorism, multiple traumatic events **Trauma type** *(secondary)*: Other types of traumatic events **Additional descriptors** *(not included above)***:** The goal of TF-CBT is to help address the biopsychosocial needs of children, with Posttraumatic Stress Disorder (PTSD) or other problems related to traumatic life experiences, and their parents or primary caregivers. TF-CBT is a model of psychotherapy that combines trauma-sensitive interventions with cognitive behavioral therapy. Children and parents are provided knowledge and skills related to processing the trauma; managing distressing thoughts, feelings, and behaviors; and enhancing safety, parenting skills, and family communication.
Target Population	**Age range:** 3 **to** 18 **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** TF-CBT has been tested in Caucasian and African American children as well as Latino children. The modifications of TF-CBT which have been specifically tested for Latino children and for Childhood Traumatic Grief are described under different treatment model descriptions. TF-CBT is currently being adapted for Native American children and for children in other countries (e.g., Zambia, Pakistan, the Netherlands, Germany, etc.). **Language***(s)***:** The TF-CBT manual is being translated into Dutch and German and being adapted for children of diverse cultural backgrounds as described above. Some of the instruments used to test TF-CBT's efficacy are currently available in Spanish. **Region** *(e.g., rural, urban)***:** TF-CBT has been implemented and tested for children in urban, suburban and rural areas. **Other characteristics** *(not included above)***:** TF-CBT is a clinic-based, individual, short-term treatment that involves individual sessions with the child and parent as well as joint parent-child sessions.

Target Population continued	TF-CBT should be provided to those children who have significant behavioral or emotional problems that are related to traumatic life events, even if they do not meet full diagnostic criteria for PTSD. Treatment results in improvements in PTSD symptoms as well as in depression, anxiety, behavior problems, sexualized behaviors, trauma-related shame, interpersonal trust, and social competence.
Essential Components	**Theoretical basis:** Cognitive-behavioral, family, empowerment **Key components:** PRACTICE Establishing and maintaining therapeutic relationship with child and parent • **P**sycho-education about childhood trauma and PTSD • **P**arenting component including parent management skills • **R**elaxation skills individualized to the child and parent • **A**ffective modulation skills adapted to the child, family and culture • **C**ognitive coping: connecting thoughts, feelings, and behaviors related to the trauma • **T**rauma narrative: assisting the child in sharing a verbal, written, or artistic narrative about the trauma(s) and related experiences, and cognitive and affective processing of the trauma experiences; in vivo exposure and mastery of trauma reminders if appropriate • **C**onjoint parent-child sessions to practice skills and enhance trauma-related discussions • **E**nhancing future personal safety and enhancing optimal developmental trajectory through providing safety and social skills training as needed
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** **❒ Yes ☒ No ❒ Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)***.** 3 **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** **❒ Yes ☒ No** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***? ❒ Yes ☒ No** **If YES, please include citation:** All of our treatment studies include drop out statistics (Cohen & Mannarino, 1996; Cohen & Mannarino, 1998; Cohen, Deblinger, Mannarino & Steer, 2004; Deblinger, Lippmann & Steer, 1996). We also have data on client satisfaction for our treatment studies. See below for these publications.

TF-CBT: Trauma-Focused Cognitive Behavioral Therapy

Clinical & Anecdotal Evidence continued

Has this intervention been presented at scientific meetings? ☒ Yes ❒ No

If YES, please include citation(s) **from last five presentations:**
Numerous citations available upon request.

Are there any general writings which describe the components of the intervention or how to administer it? ☒ Yes ❒ No

If YES, please include citation:

Cohen, Mannarino & Deblinger, 2006

Cohen & Mannarino, 1996

Cohen & Mannarino, 1997

Cohen & Mannarino, 1998

Cohen, Mannarino & Knudsen, 2005

Cohen, Deblinger, Mannarino & Steer, 2004

Deblinger, McLeer & Henry, 1990

Deblinger, Lippmann & Steer, 1996

Deblinger, Steer & Lippman, 1999

Deblinger, Stauffer & Steer, 2001

Deblinger & Heflin, 1996

King, Tonge, Mullen, Myerson, Heyne, Rollings, et al., 2000

Stauffer & Deblinger, 1999

Has the intervention been replicated anywhere? ☒ Yes ❒ No

Other countries? *(please list)* King et al., 2000

Research Evidence	Sample Size (N) and Breakdown *(by gender, ethnicity, other cultural factors)*	Citation
Randomized Controlled Trials	**N=**551 original participants, 453 treatment completers Treatment completers **By gender:** 335 female, 118 male **By ethnicity:** 280 Caucasian, 129 African American, 16 Hispanic American, 15 Biracial, 13 other ethnic background	Cohen & Mannarino, 1996; Cohen & Mannarino, 1998; Cohen et al., 2004, Deblinger et al., 1996, Deblinger et al., 2001

TF-CBT: Trauma-Focused Cognitive Behavioral Therapy

Research Evidence continued	Sample Size (N) and Breakdown *(by gender, ethnicity, other cultural factors)*	Citation
Studies Describing Modifications		See TF-CBT for Childhood Traumatic Grief and Culturally Modified TF-CBT for details
Other Research Evidence: Randomized trial replicating findings by treatment developers	**N=**36 **By gender:** 25 female, 11 male **By ethnicity:** English speaking Australian children	King et al., 2000

Outcomes

What assessments or measures are used as part of the intervention or for research purposes, if any?

- An initial clinical interview with parent and child
- Kiddie-SADS structured interview
- Children's Depression Inventory
- State-Trait Anxiety Inventory for Children
- Child Behavior Checklist
- Child Sexual Behavior Inventory
- Children's Attributions and Perceptions Questionnaire
- Parent's Emotional Reaction Questionnaire
- Parental Support Questionnaire
- Parenting Practices Questionnaire
- Beck Depression Inventory (for parental depression)
- UCLA PTSD Index

If research studies have been conducted, what were the outcomes?

A series of randomized controlled trials have demonstrated the superiority of TF-CBT over nondirective play therapy and supportive therapies in children (ages 3 to 14) who have experienced multiple traumas, and those positive results were maintained over time. TF-CBT has proven to be effective in improving PTSD, depression, anxiety, externalizing behaviors, sexualized behaviors, feelings of shame, and mistrust. The parental component of TF-CBT increases the positive effects of TF-CBT for children by improving parents' own levels of depression, emotional distress about their children's abuse, support of the child, and parenting practices.

TF-CBT: Trauma-Focused Cognitive Behavioral Therapy

Outcomes continued	TF-CBT was evaluated by Northwestern University for children in foster care receiving Systems of Care (SOC) interventions (the highest level of services available prior to requiring placement in residential treatment facility). Children at two agencies received TF-CBT; comparable foster children receiving SOC at other agencies received SOC treatment as usual (TAU). Children receiving TF-CBT experienced significantly less placement disruption and less running away than those receiving SOC TAU. Children receiving TF-CBT also experienced significantly greater improvement in PTSD symptoms on the UCLA PTSD Reaction Index, and significantly greater improvement in emotional and behavioral needs on the CANS (Child and Adolescent Needs and Strengths instrument) than those receiving SOC TAU (Mental Health Services and Policy Program, 2008).
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** Private treatment rooms conducive to child comfort and safety **Supervision requirements** *(e.g., review of taped sessions)***?** Clinical supervisors trained and experienced in TF-CBT. **To ensure successful implementation, support should be obtained from:** • Crime-victims' compensation funds in some states • Licensed practitioners/programs for Medicaid reimbursement • Insurance companies that provide coverage of ancillary parent sessions for the child who is the identified patient
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** Cohen, Mannarino & Deblinger, 2006 **How/where is training obtained?** Through the NCTSN TF-CBT Learning Collaborative, TF-CBT Train the Trainer Program, AACAP, APSAC, ISTSS, or other privately arranged trainings. **What is the cost of training?** Training through the NCTSN Learning Collaborative is at cost of travel only. Other trainings depend on registration costs of individual conferences. Private trainings cost approximately $2000-3000/day per trainer plus expenses. **Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ☐ **No** **If YES, what languages?** The TF-CBT treatment manual is being translated into Dutch and German. **Other training materials &/or requirements** *(not included above)***:** Training sessions are appropriate for supervisors and therapists with a master's degree or higher.

Training Materials & Requirements continued	Therapists and clinical supervisors benefit the most from receiving several sequential types of training, which include: • Reading this fact sheet • Completing TF-CBT*Web* online training course • Reading the program developers' treatment book(s) and related materials • Readiness assessment • Intensive skills based training, one to two days • Ongoing expert consultation from trainers for six months • Advanced TF-CBT training, one to two days
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** TF-CBT currently has strong evidence of efficacy and is flexible in terms of how clinicians can adapt it for different families. It can be provided over a relatively short period of time and can be provided in a variety of different settings (home, school, clinic, hospital, residential setting, etc.). Although ideally parents or caretakers should be included in treatment, we have provided it to children only when parents have been unable or unwilling to participate. Most community therapists have been positive about adopting TF-CBT with ongoing consultation. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** Some therapists are not amenable to using a structured approach to treatment such as TF-CBT which requires the therapist to encourage children to talk about their traumatic experiences, or to a short-term treatment model which encourages the parent rather than the therapist to be the primary agent of change for the child. Such therapists will likely prefer a different approach.
Contact Information	**Name:** Judy Cohen, MD, Alleghany General Hospital, Anthony Mannarino, PhD, Alleghany General Hospital, or Esther Deblinger, PhD, CARES Institute, UMDNJ-School of Osteopathic Mediciine. **Email:** jcohen1@wpahs.org, amannari@wpahs.org, deblines@umdnj.edu **Website:** www.pittsburghchildtrauma.org, www.musc.edu/tfcbt
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Deblinger, E., Stauffer, L. B. & Steer, R. A. (2001). Comparative efficacies of supportive and cognitive behavioral group therapies for young children who have been sexually abused and their non-offending mothers. *Child Maltreatment, 6,* 332-343.

King, N. J., Tonge, B. J., Mullen, P., Myerson, N., Heyne, D., Rollings, S., Martin, R. & Ollendick, T. H. (2000). Treating sexually abused children with posttraumatic stress symptoms: A randomized clinical trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 39,* 1347-1355.

Stauffer, L. B. & Deblinger, E. (1999). *Let's talk about taking care of you: An educational book about body safety.* Hatfield, PA: Hope for Families, Inc. Available from http://www.hope4families.com.

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."** It has been specifically tailored for several individual cultural groups, which have received this treatment, including different religious groups (Muslim, Jehovah's Witnesses, Orthodox Jewish), military families, and has also been provided to ethnically diverse families (Latino, African American, Asian, biracial), and children living in foster families. It has also been used for children in a variety of settings, including home, school, inpatient, residential, refugee camp, rural, urban and suburban; and has been adapted for use in a variety of other countries and cultures, including Zambia, Pakistan, Palestine/Israel, the Netherlands, Germany, Norway, Russia, Indonesia, Sri Lanka and Thailand. **Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.** This treatment includes engagement strategies which specifically ask about the child's and parent's cultural practices, and how these may be contributing to psychological distress related to traumatic experiences. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** McKay et al.'s engagement strategies have been incorporated for use with TF-CBT to engage low-income children impacted by poverty. These are not restricted to any particular culture but were effective in engaging and retaining >90% of more than 400 predominantly poor Latino children impacted by multiple traumatic events who received TF-CBT or Trauma-Grief Components Therapy.
Language Issues	**How does the treatment address children and families of different language groups?** As noted above, the treatment has been used in a variety of different cultures and countries. The treatment manual has been translated into Dutch and is being translated into German and Korean. It is also being used by bilingual paraprofessional providers in resource-poor countries (e.g., Africa), who are helping to culturally modify the treatment. These providers learn the treatment in English and provide it in a variety of African languages. The treatment and assessments have been culturally modified using Bolton's established mixed methods and qualitative/quantitative methods.
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?** As described above, Bolton's mixed methods have been used to culturally adopt assessment measures in Africa (UCLA Index, CDI, CBCL) commonly used to evaluate response to TF-CBT. Normative data have been collected for children who have, versus who have not, experienced a variety of traumatic events in Lusaka, Zambia. This is the most detailed assessment study currently being conducted for TF-CBT.

Symptom Expression continued	**If there are differences in symptom expression, in what ways does the theoretical/ conceptual framework of this treatment address culturally specific symptoms?** Studies thus far in Africa, Norway and Germany and with Latino immigrant children have not indicated cultural differences in symptom expression, but require different wording in some cases to adequately elicit these symptoms from children and caregivers.
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?** Yes, see above.
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** Therapists inquire about the family's culture and how this may impact the child's experience of the trauma (for example, shame, self-blame, delayed disclosure, etc.). Parents are also asked about the impact of culture on their own reaction to the child's traumatic experiences and their vicarious trauma if appropriate. This is written about extensively in the treatment manual (Cohen, Mannarino & Deblinger, 2006) with numerous examples included for each component. **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)***.** Yes, for Latino and Native American children additional components and/or adaptations have been developed by NCTSN Centers. **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 by culture and has not been found in the few studies that have been conducted.
Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** No cultural factors have been found in this regard. **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?** As noted, this treatment has been delivered in a variety of settings (clinic, home, school, residential, foster home, refugee camp, inpatient, etc). A recent randomized controlled trial was conducted for children living in foster homes. These were almost all children of color. Many received home-based treatment.

Intervention Delivery Method/ Transportability & Outreach continued	**Are there cultural barriers to accessing this treatment** *(i.e., treatment length, family involvement, stigma, etc.)***?** Anecdotal evidence (numerous requests for this treatment manual and assistance in implementing it from a variety of international sources since it became publicly available) suggests that recipients have not perceived barriers regarding access or implementation for a broad variety of specific cultural groups. However no data are available in this regard to date. **Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** As noted above, most TF-CBT studies have included representative cultural samples suggesting that there are not logistical or other barriers for any specific cultural groups. **Are these barriers addressed in the intervention and how?** Schools have been involved in initial screening and in some cases in provision of this treatment following community disasters (e.g., 9-11, Hurricane Katrina, international disasters).
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** See information related to TF-CBT. Cultural issues are included in all TF-CBT trainings and in the Train the Trainer program. These issues are also featured prominently in the web-based course TF-CBT*Web*. **Has this guidance been provided in the writings on this treatment?** Yes, cultural sensitivity is identified as one of the core values of the TF-CBT treatment model and this has been written about in the treatment book.
References	Cohen, J.A., Mannarino, A.P. & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: Guilford Press.

NCTSN The National Child Traumatic Stress Network

GENERAL INFORMATION

TG-CBT: Trauma-Focused Cognitive Behavioral Therapy for Child Traumatic Grief

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** TG-CBT **Average length/number of sessions:** 12-16 sessions, 60-90 minutes per session **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** Cultural beliefs and practices related to bereavement are addressed. **Trauma type** *(primary)*: Childhood traumatic grief **Additional descriptors** *(not included above)***:** The goal of this intervention is to improve PTSD, childhood traumatic grief (CTG), and depressive, anxiety, and behavior problems in children with CTG as well as to improve PTSD, depressive, and CTG symptoms in their parents or primary caretakers.
Target Population	**Age range:** 6 **to** 18 **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** TG-CBT has been used in diverse cultural groups and has been empirically evaluated in Caucasian and African American samples. **Language***(s)***:** The TG-CBT manual is being translated into Dutch and German. **Region** *(e.g., rural, urban)***:** TG-CBT has been used in urban, suburban, and rural regions, and is being adapted for use in different countries (e.g., Zambia, Pakistan, Russia, the Netherlands, Germany, etc.).
Essential Components	**Theoretical basis:** TG-CBT is based on the TF-CBT model, which has a cognitive-behavioral, family, and empowerment basis, integrated with grief-focused interventions. **Key components:** Parallel individual child and parent trauma- and grief-focused sessions; joint parent-child sessions, provided over 12-16 sessions (first eight are typically trauma focused and subsequent sessions are typically grief-focused).
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** ❒ **Yes** ☒ **No** ❒ **Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)***.** 5 **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** ❒ **Yes** ☒ **No** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***?** ☒ **Yes** ❒ **No**

TG-CBT: Trauma-Focused Cognitive Behavioral Therapy for Child Traumatic Grief

Clinical & Anecdotal Evidence continued	**If YES, please include citation:** Cohen, Mannarino & Knudsen, 2004; Cohen, Goodman, Mannarino & Brown, 2004; Cohen, Mannarino & Staron, 2006 **Has this intervention been presented at scientific meetings?** ☒ Yes ❒ No **If YES, please include citation**(s) **from last five presentations:** Cohen, Mannarino & Knudsen, 2005 Many others upon request. **Are there any general writings which describe the components of the intervention or how to administer it?** ☒ Yes ❒ No **If YES, please include citation:** Cohen, Mannarino & Deblinger, 2006 **Has the intervention been replicated anywhere?** ☒ Yes ❒ No **Other countries?** *(please list)* It is being used and adapted in Zambia, Russia, Israel, the Netherlands, Germany, and for those affected by the 2004 tsunami and the 2005 earthquake in Pakistan. It is also being used by several other NCTSN sites for child traumatic grief (CTG). It has been used by a number of NYC programs related to CTG secondary to September 11, 2001.

Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Pilot Trials/Feasibility Trials *(w/o control groups)*	**N=**61 **By gender:** 38 female, 23 male **By ethnicity:** 43 Caucasian, 15 African American, 3 Biracial	Cohen, Mannarino & Knudsen, 2004 Cohen, Mannarino & Staron, 2006
Randomized Controlled Trials	**N=**40	Brown, Goodman, Cohen & Mannarino, 2004

Outcomes	**What assessments or measures are used as part of the intervention or for research purposes, if any?** • **Child measures**: Expanded Grief Inventory (EGI); Child PTSD Symptom Scale (CPSS); Mood and Feelings Questionnaire (MFQ); Screen for Children's Anxiety Related Emotional Disorders (SCARED). • **Parent Measures**: PTSD Diagnostic Scale (PDS); Beck Depression Inventory II (BDI-II); UCLA PTSD Index-Parent Version, Child Behavior Checklist (CBCL).

Outcomes continued	**If research studies have been conducted, what were the outcomes?** The above instruments were used to assess outcomes for children and parents. Pilot effectiveness studies which have required clinical levels of CTG have shown that children receiving TG-CBT have experienced significant improvement in CTG, PTSD and other related symptoms, and their participating parents have experienced significant improvement in PTSD symptoms as well. A small randomized controlled trial compared TG-CBT to Child Centered Therapy (CCT) among children whose uniformed service parents died in the September 11th terrorist attacks in New York City. Due to the service requirements of the funding agency, this project did not require clinical levels of CTG in participants. At pre-treatment children did not have clinically significant levels of CTG or other outcome measures and no differences were found between the two treatment groups in outcomes at post-treatment. Mothers participating in this project did have clinically significant levels of PTSD, depression and general psychopathology at pre-treatment, and those mothers who participated with their children in receiving TG-CBT experienced significantly greater improvement in all of these domains than those receiving CCT. Randomized trials of children with clinically significant levels of CTG are needed to further evaluate the efficacy of TG-CBT.
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** Private treatment rooms **Supervision requirements** *(e.g., review of taped sessions)***?** Trained supervisors able to provide supervision following initial training or the availability of ongoing consultation when needed. **To ensure successful implementation, support should be obtained from:** Web-based training (CTG*Web* will be launched in 2008), reading the treatment manual, and consultation from trained consultants or ongoing supervision.
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** Cohen, Mannarino & Deblinger, 2006 The treatment manual has been revised in response to suggestions from multicultural therapists. It is being translated into Dutch and German. **How/where is training obtained?** From NCTSN Learning Collaboratives, Train the Trainer Programs, or from privately arranged trainings. **What is the cost of training?** Training through the NCTSN is available at cost. Otherwise training costs approximately $3000/day per trainer, plus expenses. **Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ❒ **No** **If YES, what languages?** The manual is being translated into Dutch and German. Some instruments are currently available in Spanish.

TG-CBT: Trauma-Focused Cognitive Behavioral Therapy for Child Traumatic Grief

Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** The TG-CBT treatment is based on TF-CBT which has strong efficacy evidence and is being successfully disseminated to other countries and cultures. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** Some therapists may not want to use a structured treatment which encourages children to talk about the specific ways the significant other died. **Other qualitative impressions:** Client satisfaction (child and parent) are high.
Contact Information	**Name:** Judy Cohen, MD, Allegheny General Hospital, Anthony Mannarino, PhD, Alleghany General Hospital, and Elissa Brown, PhD **Address:** Alleghany General Hospital Center for Traumatic Stress in Children and Adolescents, Pittsburgh, PA and St. John's University **Email:** jcohen1@wpahs.org, amannari@wpahs.org, browne@stjohns.edu **Website:** www.pittsburghchildtrauma.org and www.musc.edu/tfcbt
References	Brown, E. J., Goodman, R. F., Cohen, J. A. & Mannarino, A. P. (2004, November). *Randomized controlled treatment outcome study for childhood traumatic grief.* Paper presented at Conceptualization, Measurement and Treatment of Childhood Traumatic Grief Symposium, 20th Annual Meeting of the International Society for Traumatic Stress Studies, New Orleans, LA. Cohen, J. A., Goodman, R. F., Mannarino, A. P. & Brown, E. J. (2004). Treatment of childhood traumatic grief: Contributing to a new emerging condition in the wake of community trauma. *Harvard Review of Psychiatry, 12*, 213-216 Cohen, J. A., Mannarino, A. P. & Knudsen, K. (2004). Treating childhood traumatic grief: A pilot study. *Journal of the American Academy of Child and Adolescent Psychiatry, 43,* 1225-1233. Cohen, J. A., Mannarino, A. P. & Staron, V. (2006). A pilot study of modified cognitive behavioral therapy for childhood traumatic grief (CBT-CTG). *Journal of the American Academy of Child and Adolescent Psychiatry, 45,* 1465-1473.

TG-CBT: Trauma-Focused Cognitive Behavioral Therapy for Child Traumatic Grief

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."** It has been specifically tailored for several individual cultural groups which have received this treatment, including different religious groups (Muslim, Jehovah's Witnesses, Orthodox Jewish), military families, and has also been provided to ethnically diverse families (Latino, African American, Asian, biracial) and children living in foster families. It has also been used for children in a variety of settings, including home, school, inpatient, residential, refugee camp, rural, urban and suburban; and has been adapted for use in a variety of other countries and cultures, including Zambia, Pakistan, Palestine/Israel, the Netherlands, Germany, Norway, Russia, Indonesia, Sri Lanka and Thailand. **Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.** This treatment includes engagement strategies which specifically ask about the child's and parent's cultural practices, the family's and extended family's mourning rituals and practices, whether and in what ways these may vary from the child's and parent's own mourning for the deceased person, and whether and in what ways these may be contributing to psychological or other distress.
Language Issues	**How does the treatment address children and families of different language groups?** As noted above, the treatment has been used in a variety of different cultures and countries. The treatment manual has been translated into Dutch and is being translated into German. It is also being used by bilingual paraprofessional providers in resource poor countries (e.g., Africa) who are helping to culturally modify the treatment. These providers learn the treatment in English and provide it in a variety of African languages. The treatment and assessments are being culturally modified using Bolton's established mixed qualitative/quantitative methods.
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?** As described above, Bolton's mixed methods are being used to culturally adopt assessment measures in Africa (UCLA Index, CDI, CBCL) commonly used to evaluate response to TF-CBT. Normative data are being collected for children who have, versus who have not, experienced a variety of traumatic events in Lusaka, Zambia. This is the most detailed assessment study currently being conducted for TG-CBT.
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** Since grief is universal, yet mourning rituals are culturally prescribed to a great degree, this intervention includes a great degree of emphasis on therapists inquiring about culture and how the child's and parent's own grief and mourning intersects with the extended cultural expectations and practices (with culture defined in the broadest sense). This is written about extensively in the treatment manual (Cohen, Mannarino & Deblinger, 2006) with numerous examples included for each component.

Cultural Adaptations continued	**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 by culture and has not been found in the few studies that have been conducted.
Intervention Delivery Method/ Transportability & Outreach	**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?** As noted, this treatment has been delivered in a variety of settings (clinic, home, school, residential, foster home, refugee camp, inpatient, etc). Only one study has been conducted which included multiple settings (following the 9-11 terrorist attacks in NYC) and this did not evaluate outcome according to setting where treatment was delivered. **Are there cultural barriers to accessing this treatment** *(i.e., treatment length, family involvement, stigma, etc.)***?** Anecdotal evidence (numerous requests for this treatment manual and assistance in implementing it from a variety of international sources since it became publicly available) suggests that recipients have not perceived barriers regarding access or implementation for a broad variety of specific cultural groups. However, no data are available in this regard to date. **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 have been involved in initial screening and in some cases in provision of this treatment following community disasters (e.g., 9-11, Hurricane Katrina, international disasters).
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** See information related to TF-CBT.
References	Cohen, J. A., Mannarino, A. P. & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents.* New York: Guilford Press.

Trauma-Informed Organizational Self-Assessment

GENERAL INFORMATION

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** None at this time **Average length/number of sessions:** Length of implementation will vary from program to program **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** Addresses cultural competence issues organizationally and addresses homeless families' access to services **Trauma type** *(primary)*: Interpersonal complex traumas (i.e., physical, sexual, and emotional abuse and neglect) **Trauma type** *(secondary)*: N/A **Additional descriptors** *(not included above)***:** The Trauma-Informed Self-Assessment is an instrument that is designed to help agencies increase their ability to create a system that supports consumers and children of all cultures who have been impacted by trauma. The self-assessment is comprised of a list of statements describing various aspects of a program that is fully "trauma-informed." By completing the instrument, an agency can determine the degree to which they are "trauma-informed." Based on their findings, they can then design a strategic plan for increasing their capacity to provide trauma-informed services.
Target Population	**Age range:** All **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** All **Other cultural characteristics** *(e.g., SES, religion)***:** All **Language***(s)***:** The instrument is currently only in English. **Region** *(e.g., rural, urban)***:** All **Other characteristics** *(not included above)***:** This instrument can be used in residential programs for women and children, including emergency shelters, domestic violence shelters, and transitional and supportive housing programs.
Essential Components	**Theoretical basis:** The self-assessment is based on foundational operating principles developed through examining research and practice within the trauma and homelessness fields. The principles include the following: • Safety • Engagement • Open communication • Integration • Consumer control, choice, and autonomy • Shared power and governance

Essential Components continued	• Trauma awareness • Cultural competence • Healing **Key components:** The self-assessment is organized into five critical domains that make up a trauma-informed program: atmosphere and environment; policies; assessment and service planning; consumer representation; and staff development. Each domain has a list of statements describing various practices that would make a program trauma-informed.	
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** **❒ Yes ☒ No ❒ Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)***.** There are no published writings at this time. **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** **☒ Yes ❒ No** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***? ❒ Yes ☒ No** **Has this intervention been presented at scientific meetings? ❒ Yes ☒ No** **Are there any general writings which describe the components of the intervention or how to administer it? ❒ Yes ☒ No** **Has the intervention been replicated anywhere? ❒ Yes ☒ No** **Other clinical and/or anecdotal evidence** *(not included above)***:** Literature in the trauma and homelessness fields support the need for trauma-informed systems in order to successfully implement trauma-informed services.	
Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Pilot Trials/Feasibility Trials *(w/o control groups)*		Pilot testing is projected to begin February 2007
Outcomes	**What assessments or measures are used as part of the intervention or for research purposes, if any?** The usefulness of this instrument for creating trauma-informed organizations will be determined by completing pre-intervention and post-intervention site visits by program evaluators that includes staff and consumer focus groups, interviews, and document review.	

Outcomes continued	**If research studies have been conducted, what were the outcomes?** There have not been any research studies at this time.
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** The Trauma-Informed Organizational Self-Assessment **Supervision requirements** *(e.g., review of taped sessions)***?** On-going consultation on and off site. **To ensure successful implementation, support should be obtained from:** The National Center on Family Homelessness
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** The National Center on Family Homelessness **How/where is training obtained?** The National Center on Family Homelessness **What is the cost of training?** There is no cost at this time. **Are intervention materials** *(handouts)* **available in other languages?** ❒ **Yes** ☒ **No** **Other training materials &/or requirements** *(not included above)***:** Programs will receive on-site training, technical assistance, and consultation to complete the self-assessment and develop a strategic plan to provide trauma-informed services.
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** Often shelter programs are unable to provide trauma-informed services as the organizational foundation cannot support them. This is a systemic intervention that targets organizational change that supports the creation of trauma-informed environments and will give programs the ability to provide trauma-informed services. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** This may require a lengthy implementation and may be challenging due to the need to have buy-in from all levels of the organization. This requires a level of organizational readiness and commitment to change in order to implement successfully.
Contact Information	**Name:** The National Center on Family Homelessness, Kathleen Guarino **Address:** 181 Wells Ave., Newton Center, MA 02459 **Phone number:** (617) 964-3834 x24 **Email:** kathleen.guarino@familyhomelessness.org **Website:** www.familyhomelessness.org

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."** The self-assessment is currently tailored for settings that provide residential services to families including emergency shelters, transitional and supportive housing, and domestic violence shelters. **Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.** Throughout the self-assessment there are questions that address the cultural competence of an organization with the operating assumption that there are a wide variety of cultural values and beliefs among the residents served by these programs. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** A foundational principle of the self-assessment is that cultural competence and consumer engagement are essential components to providing a trauma-informed environment. This includes questions that focus on involving consumers in the development of services in the program and in the process of developing goals and identifying their needs.
Language Issues	**How does the treatment address children and families of different language groups?** The self-assessment specifically addresses the need to provide written materials in the language of the residents who are served by the program whenever possible. **If interpreters are used, what is their training in child trauma?** N/A **Any other special considerations regarding language and interpreters?** None
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?** This is not specifically addressed; however, as the self-assessment is grounded in the importance of cultural competence, a variety of questions address the concept of symptom expression and understanding these symptoms from the perspective of the consumer rather than making assumptions about what that symptom may indicate. **If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?** While the self-assessment does not address culturally specific symptoms, the need to understand the cultural background of the consumer and take that into account when understanding symptom expression is highlighted throughout the self-assessment.

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?** The self-assessment can be modified for different settings based on the different cultural needs of the consumers served. There are no clinical assessment measures used for this tool. **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?** N/A
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** This assessment notes that cultural context plays a significant role in the types of trauma that may be experienced by consumers, the risk for continued, chronic trauma, how survivors manage their experiences, and which supports and interventions are most effective. Cultural competence involves the idea that policies, procedures and services are informed by cultural knowledge of the consumers being served and the ways that culture impacts consumer needs and service delivery. Therefore, it is necessary for providers to have an understanding of the diversity of cultures within the consumer population they serve and find clear ways to respect the values and rituals of those cultures. This may include offering people opportunities to engage in various cultural rituals or religious services, cook specific foods, and speak in their language of origin. Particular interventions and supports may be more effective for one racial or ethnic population than another, and it is necessary to consumer success that services are offered in a manner that is flexible and appreciates the consumer's cultural background. This approach helps to create a safe and respectful environment in which survivors can begin to rebuild a sense of self and a connection to their communities. **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)*. The self-assessment can be adapted for different settings as it is designed to be adaptable for the different needs of different settings. For example, the self-assessment has been adapted for a drop-in center for runaway youth. **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?** N/A

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 assessment, given its adaptable nature, can be modified to provide other settings with guidance on how to become trauma-informed. **Are there cultural barriers to accessing this treatment** *(i.e., treatment length, family involvement, stigma, etc.)***?** Organizations may not be ready to engage in the self-assessment process and develop a strategic plan for change. There has to be organizational buy-in from all levels of the organization and the support for change to happen in order for an organization to exhibit readiness to engage in the self-assessment process. **Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** There are no logistical barriers for accessing this self-assessment. **Are these barriers addressed in the intervention and how?** N/A **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)***?** Community-building is addressed in a sub-section of the self-assessment given that it helps to create a sense of safety, respect and mutuality and is necessary to the creation of a trauma-informed system. Community building activities include identifying activities that help strengthen connection to the community both within and outside the program.
Training Issues	N/A

TST: Trauma Systems Therapy

GENERAL INFORMATION

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** TST **Average length/number of sessions:** Length varies by level of severity and phases of treatment administered. The Surviving phase (indicated for most acutely symptomatic children), for example, averages three months in length. A child starting at this phase may be in the program for 12 months with the duration of services reduced based on placement at assessment in later phases. **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** The intervention includes a module 'Ready set go' that specifically addresses treatment barriers. Examples of barriers to be addressed include language barriers and transportation barriers. In addition, this module (which can be viewed as a treatment-engagement module) specifically addresses building a treatment alliance across different cultural perspectives and identifying treatment goals that are consistent with the families' views of what is most important. At the core of TST implementation lays a multidisciplinary team that emphasizes the inclusion of community figures (such as teachers, spiritual leaders, community advocates, and case managers) in the treatment planning. TST has been adapted for use with several populations, including refugee and immigrant groups, substance abusing adolescents, medical trauma and pediatric settings, school based treatments, and residential settings. **Trauma type** *(primary)*: Various **Trauma type** *(secondary)*: Various **Additional descriptors** *(not included above)***:** TST is not limited to one specific trauma type. Children that have participated in the program have experienced a wide range of traumas, such as domestic violence, physical abuse, sexual abuse, exposure to war, and medical trauma. Many of the children who have received TST experienced multiple traumas. In addition, TST specifically addresses social-environmental factors that compound the problems associated with trauma exposure, such as poverty or inappropriate school placements.
Target Population	**Age range:** 6 **to** 19 **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** Ethnic groups treated with TST include refugees and recent immigrants (Somalia, Nigeria, Liberia, Sierra Leone, Uganda, Mexico, Guatemala, Honduras), multigeneration African Americans, multigeneration multinational Latinos, Caucasian. **Other cultural characteristics** *(e.g., SES, religion)***:** Not limited to, but has been used with Low SES, Muslim (e.g., Somalis). **Language***(s)***:** English, Spanish

TST: Trauma Systems Therapy

Target Population continued	**Region** *(e.g., rural, urban)*: TST has been used in both urban & rural settings **Other characteristics** *(not included above)*: TST is targeted at children and adolescents who are having difficulty regulating their emotions as a result of the interaction between the traumatic experience and stressors in the social environment.
Essential Components	**Theoretical basis:** TST was inspired in part by Bronfenbrenner's social-ecological model (Bronfenbrenner, 1979), which acknowledges the complexity of the social environment that surrounds an individual, and how disruptions in one area of the social ecology may create problems in another. Interventions in TST are designed to work in two dimensions: strategies that operate through and in the social environment to promote change, and strategies that enhance the individual's capacity to self-regulate. The TST model involves choosing a series of interventions that correspond to the fit between the traumatized child's own emotional regulation capacities and the ability of the child's social environment and system-of-care to help him or her manage emotions or to protect him or her from threat. **Key components:** Trauma Systems Therapy can be seen as a framework for organizing a series of empirically validated interventions to address the real-world needs of children facing considerable adversity. It is designed to help children and families where there is ongoing stress in the social environment. Traumatic stress and the intervention involve two elements: • a child with difficulty regulating his or her emotional state, and • a system of care that cannot effectively regulate the child's response to his or her social environment. In this program, social context includes family, school, and neighborhood. Services are tailored to the child/family using a 3 X 3 matrix with stability of social environment on one axis and the child's ability to regulate emotions on the other. The program has up to five phases: Surviving, Stabilizing, Enduring, Understanding, Transcending. The phase is chosen depending on the degree to which the child can regulate emotional behavioral responses and whether the social environment is stable, distressed, or threatening. Within each phase there are prescribed treatment modules, many of which have their own demonstrated efficacy. These treatment modules include: • Home and Community Based Services • Services Advocacy • Emotional Regulation Skills Training • Cognitive Processing • Psychopharmacology

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Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** ❒ **Yes** ☒ **No** ❒ **Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)***.** 4 **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** ❒ **Yes** ☒ **No** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***?** ❒ **Yes** ☒ **No** **Has this intervention been presented at scientific meetings?** ☒ **Yes** ❒ **No** **If YES, please include citation***(s)* **from last five presentations:** International Society for Traumatic Stress Studies (ISTSS): Ellis, Saxe & Hansen, 2005 American Psychological Association (APA): Casey, Saxe, Ellis, Rubin & Allee, 2005 Boston University Trauma Conference: Saxe & Ellis, 2005; Saxe, Ellis & Kaplow, 2004 **Are there any general writings which describe the components of the intervention or how to administer it?** ☒ **Yes** ❒ **No** **If YES, please include citation:** Saxe, Ellis & Fogler, 2005 **Has the intervention been replicated anywhere?** ☒ **Yes** ❒ **No** **Other clinical and/or anecdotal evidence** *(not included above)***:** In pilot RCT of TST vs. Care as Usual we found that at 3 month follow-up all 10 TST individuals remained in treatment while only 1 Care as Usual case remained in treatment. This suggests that TST may be more effective than usual care in engaging families in treatment.

Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Pilot Trials/Feasibility Trials *(w/o control groups)*	**N=**110 **By other cultural factors:** Rural and Urban	
Randomized Controlled Trials	**N=**20 **By other cultural factors:** African American, Caucasian and Hispanic clients	
Studies Describing Modifications	**N=**Ongoing open trial of Substance Abuse Adaptation	

TST: Trauma Systems Therapy

Research Evidence continued	Sample Size (N) and Breakdown *(by gender, ethnicity, other cultural factors)*	Citation
Other Research Evidence	**By other cultural factors:** Cognitive Processing module is an adapation of TF-CBT.	

Outcomes	**What assessments or measures are used as part of the intervention or for research purposes, if any?** TSCC, PTSD RI, TST Weekly Check-In (9-point rating scale, adolescent self-report, assessing subjective sense of emotional regulation, behavioral regulation, traumatic reminders, and social environmental strengths/support). **If research studies have been conducted, what were the outcomes?** An open trial with 110 families produced reduction of traumatic stress symptoms and decrease in family and school related problems over three months.
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** In order to implement TST, 4 types of services must be available on the team: skill-based psychotherapy, home and community-based therapy, legal advocacy, and psychopharmacology. These four elements can be assembled creatively out of resources available in a particular community. **Supervision requirements** *(e.g., review of taped sessions)***?** Not required, although treatment fidelity can be monitored through videotaping of team meetings. Typically clinicians receive individual supervision as well as group supervision through a weekly team meeting. **To ensure successful implementation, support should be obtained from:** Because TST requires a system shift for most agencies, support must be obtained from agency leadership.
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** Saxe, Ellis & Kaplow, 2006. Available from Amazon.com, Guilford Press, Barnes and Noble bookstores and other major book sellers. **How/where is training obtained?** Training is currently available through individual agency contracts. **What is the cost of training?** Variable **Are intervention materials** *(handouts)* **available in other languages?** ❒ **Yes** ☒ **No**

Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** This intervention is designed to address some of the 'real world' problems that have typically been barriers to treatment engagement and/or implementation of EBP. For instance, this treatment provides a specific module on treatment engagement that addresses practical barriers and cultural barriers. In addition, this treatment specifically addresses social environmental issues that are contributing to traumatic stress symptomatology, such as living in substandard housing, poverty, and immigration status. A module called Services Advocacy specifically details how to incorporate legal advocacy into treatment in ways that specifically address social environmental issues that are affecting mental health. Thus, this treatment is particularly useful for families who face barriers to treatment engagement, who experience social environmental problems, and who may have experienced more than one traumatic event. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** Treatment is phase-based, thus for acutely symptomatic children treatment may last a long time (e.g., one year). Treatment requires an interdisciplinary team, which agencies will need to assemble through various funding sources. TST was specifically designed to be possible with existing funding sources (e.g., not grant funded, paid for through 3rd party payees or other existing services)–nonetheless, for agencies new to TST they will need to examine existing resources within their community and assemble an interdisciplinary team based on what is available.
Contact Information	**Name:** Glenn Saxe, MD **Address:** Children's Hospital Boston, Department of Psychiatry **Email:** glenn.saxe@childrens.harvard.edu
References	Bronfenbrenner, U. (1979). Contexts of child rearing: Problems and prospects. *American Psychologist, 34,* 844-850. Casey, R., Saxe, G., Ellis, B. H., Rubin, D. & Allee, L. (2005). *Children with medical traumatic stress: Expanding Trauma Systems Therapy.* Presented at the annual meeting of the American Psychological Association Conference, Washington, D.C. Ellis, B. H. (2004, October). *Trauma Systems Therapy for refugees.* Paper presented at the International Conference, Anthropology and Health: Cross-Cultural Aspects of Mental Health and Psychosocial Well-Being in Immigrant/Refugee Adolescents. Hvar, Croatia. Ellis, B. Heidi, Saxe, G. & Hansen, S. (2005, November). *Trauma Systems Therapy: Dissemination and implementation in two settings.* Paper presented at the annual meeting of the International Society for Traumatic Stress Studies, Toronto, Canada. Saxe, G. & Ellis, B. H. (2005, June). *Comprehensive care for traumatized children: Trauma Systems Therapy.* Paper presented at the annual Boston University Trauma Conference, Boston, MA.

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Saxe, G. N., Ellis, B. H. & Fogler, J. (2005). Comprehensive care for traumatized children: An open trial examines Trauma Systems Therapy. *Psychiatric Annals, 35*(5), 443-448.

Saxe, G., Ellis, B. H. & Kaplow, J. (2004, June). *Treating child traumatic stress: Self regulation and the social environment.* Paper presented at annual Boston University Trauma Conference, Psychological Trauma: Maturational Processes and Therapeutic Interventions. Boston, MA.

Saxe, G. N., Ellis, B. H. & Kaplow, J. (2006, October). *Collaborative care for traumatized children and teens: A Trauma Systems Therapy approach.* Guilford Press, NY.

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 treatment has been tailored specifically for refugee populations; it includes a general adaptation for refugee populations and a specific adaptation for Somali refugees. The treatment has also been used in both rural and urban areas. **Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.** Yes. The developers emphasize the importance of understanding different cultural explanatory models of healing and trying to engage both cultural and community strengths and healing pathways that are already present in treatment. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** Yes. Case management is emphasized because it helps with engaging the trust of refugee families. For this population, it is important for treatment providers to be seen as helpful, therefore providing practical assistance is a main component of the treatment.
Language Issues	**How does the treatment address children and families of different language groups?** Interpreters are currently used in this treatment however developers are in the process of moving towards a model of training members of the community to assist in treatment. Developers have partnered with graduate schools of social work in order to promote advanced graduate education and support professional development for refugees. **If interpreters are used, what is their training in child trauma?** None. **Any other special considerations regarding language and interpreters?** Clinicians implementing this treatment in small communities are taught to be mindful of confidentiality issues, to the degree that they can. For instance, clinicians give clients the choice of whether to have an interpreter present; phone interpretation is also offered if clients prefer.
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?** No. **If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?** N/A
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 are no differences in assessment measures used.

Assessment continued	**If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** The assessment relies heavily on clinical judgment. **What, if any, culturally specific issues arise when utilizing these assessment measures?** One of the primary assessment measures used in this treatment is the CANS-TEA clinician report, which allows clinicians to integrate collateral information. Using the CANS-TEA helps to ensure cultural validity.
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** Yes. Cultural issues are discussed throughout the adaptation for refugees as well as in the treatment manual. Special attention is paid to engagement, including cultural explanatory models and engaging cultural strengths. **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)***.** The full intervention has been adapted for refugee populations, in general, and specifically for Somali refugee populations. Treatment developers have also identified a process for adapting this treatment for local communities. A review panel of stakeholders or other individuals within the community is established in order to review the intervention after it has been implemented. This review panel is then used to recommend additional revisions as needed. **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 has not been examined for this treatment; however there is no evidence to suggest that there is differential drop out 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)***?** 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?** The treatment is community-based and has been implemented in a number of different settings. Currently there is data looking at the implementation of this treatment in outpatient settings, in the child welfare system, and in schools. A process has been developed to work with key stakeholders in order to determine how the treatment should be designed to fit best into different systems. **Are there cultural barriers to accessing this treatment** *(i.e., treatment length, family involvement, stigma, etc.)***?** Stigma is always a cultural barrier for mental health treatments. **Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** Any logistical barriers are addressed as part of the treatment. The developers emphasize that it is part of the clinician's role to identify any logistical barriers and address them as part of the treatment process.

Intervention Delivery Method/ Transportability & Outreach continued	**Are these barriers addressed in the intervention and how?** Yes, these barriers are addressed in the intervention. Potential transportation issues are addressed by the community-based or home-based nature of the treatment. The cost of the treatment is generally not a problem for clients also. Families are not charged for treatment as it is reimbursable either through the family's insurance or through Mass Health. **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)***?** Developers have established a process to identify which community members are important to the individuals receiving treatment. To the extent that is relevant, clinicians will liaise with these community members as part of the treatment team.
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** Cultural issues are identified and addressed specifically in the treatment alliance/ treatment engagement section of training, and also infused throughout. **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** This is not specified in the treatment protocol. Developers rely on general good practice to identify and address cultural issues between supervisor and clinician and clinician and client. **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** Not specified—see above. **Has this guidance been provided in the writings on this treatment?** No specific guidance has been provided around training in the writings on this treatment. **Any other special considerations regarding training?** No.