

CULTURE-SPECIFIC INFORMATION

<p>Engagement</p>	<p>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.”</p> <p>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.</p> <p>Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.</p> <p>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 Caribbean-American youths and parents as well as urban, low-income White youths and parents. Samples of exercises are available.</p> <p>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.</p>
<p>Language Issues</p>	<p>How does the treatment address children and families of different language groups? Spanish as well as English-speaking</p>
<p>Symptom Expression</p>	<p>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?</p> <p>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.</p>

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<p>Assessment</p>	<p>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?</p> <p>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.</p> <p>What, if any, culturally specific issues arise when utilizing these assessment measures?</p> <p>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).</p>
<p>Cultural Adaptations</p>	<p>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).</p> <p>Do culture-specific adaptations exist? Please specify (e.g., components adapted, full intervention adapted).</p> <p>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.</p> <p>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?</p> <p>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.</p>
<p>Intervention Delivery Method/ Transportability & Outreach</p>	<p>If applicable, how does this treatment address specific cultural risk factors (i.e., increased susceptibility to other traumas)?</p> <p>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.</p>

**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, Cleveus 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), health-care (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).

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<p>Training Issues</p>	<p>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.</p> <p>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.</p> <p>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).</p> <p>Has this guidance been provided in the writings on this treatment? See above references, which are used in training TARGET therapists.</p>
<p>References</p>	<p>Ford, J. D. (2008). Trauma, PTSD, and ethnoracial minorities: Toward diversity and cultural practices in principles and practices. <i>Clinical Psychology: Science & Practice, 15</i>, 62-67.</p> <p>Ford, J. D., Chapman, J. F., Hawke, J. & Albert, D. (2007). Trauma among youth in the juvenile justice system: Critical issues and new directions. National Center for Mental Health and Juvenile Justice Research Brief. Retrieved June 6, 2008 from http://www.cwla.org/programs/juvenilejustice/ncmhjjtraumayouth.pdf.</p> <p>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). <i>American Journal of Psychotherapy, 60</i>, 335-355.</p> <p>Ford, J. D., Russo, E. & Mallon, S. (2007). Integrating post-traumatic stress disorder (PTSD) and substance use disorder treatment. <i>Journal of Counseling and Development, 85</i>, 475-489.</p> <p>Ford, J. D. & Saltzman, W. (in press). Family therapy for complex traumatic stress disorders. In C. Courtois & J. D. Ford (Eds.), <i>Complex traumatic stress disorders: An evidence based clinician's guide</i>. New York: Guilford.</p>