Integrative Treatment of Complex Trauma  
Culture-Specific Information

| Engagement | For which specific cultural group(s) (i.e., SES, religion, race, ethnicity, gender, immigrants/refugees, disabled, homeless, LGBTQ, rural/urban areas) is this treatment tailored? If none, please respond "not specifically tailored". 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-based, school-based, 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 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... |
**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 treatment address these differences?** 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.

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 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.
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 group. Is 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, Steinberg, & Pynoos, 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. 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.

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<th>Training Issues</th>
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<td>• <strong>What potential cultural issues are identified and addressed in supervision/training for the intervention?</strong> 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.</td>
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<td>• <strong>If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?</strong> 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).</td>
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<td>• <strong>If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?</strong> Same as above</td>
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<td>• <strong>Has this guidance been provided in the writings on this treatment?</strong> No, but is included in treatment manuals currently being developed.</td>
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<td>• <strong>Any other special considerations regarding training?</strong> Not at this time.</td>
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