NCTSN The National Child Traumatic Stress Network

Cognitive Behavioral Intervention for Trauma in Schools
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".** 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 that we have approached this form of culturally competent practice of CBITS includes: 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. 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 is generally bilingual and/or native speakers. However, we have had all types of providers such as case managers, nurses, parents, 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?** We encourage throughout our trainings that all staff involved with traumatized students should be trauma-informed. We also make the materials available in an array of languages.
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 group. Is 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). • **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?** 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 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 expressively 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. For example, to use tv/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 • **Has this guidance been provided in the writings on this treatment?** • **Any other special considerations regarding training?**