TF-CBT: Trauma-Focused Cognitive Behavioral Therapy

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, TF-CBT is being used in a variety of different cultures and countries. The treatment manual has been translated into Dutch, German, Chinese (Mandarin), Polish, Korean and Japanese, with additional translations in progress. TF-CBT is also being used by bilingual paraprofessionals providers in resource poor countries (e.g. Africa) who have helped to culturally modify the treatment and are providing it in a variety of African languages. The treatment and assessments have been 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 study documented that Zambian children experienced similar trauma symptoms to those in the U.S. Similarly, assessments of youth with complex and multiple traumas in the Democratic Republic of Congo and Cambodia confirm that youth in these settings manifest trauma symptoms similar to those in the U.S.

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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.