### Engagement

<table>
<thead>
<tr>
<th>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.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
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</table>

### 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

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<tr>
<th>How does the treatment address children and families of different language groups?</th>
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<tr>
<td>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.</td>
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### Symptom Expression

<table>
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<tr>
<th>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?</th>
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<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>
### 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.
### CULTURE-SPECIFIC INFORMATION

| 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-CBTWeb.  
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. |