

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.”

FCT is not specifically tailored to one population or demographic. As a family systems treatment model, the program is designed to work with all families regardless of makeup, complexity, or cultural differences. Peer review study and practice-based evidence have demonstrated positive clinical outcomes for different cultural groups.

Engagement is the most critical component of FCT training with knowledge-based units, skills-building coaching, and competency-based observation and testing specifically focused on engagement. As a result 90% and higher engagement into treatment rates are the norm for fully implemented licensed FCT agencies.

Additional individual clinical consults are provided for coaching staff in engaging specialty populations, and some FCT licensed agencies are providing specialty training for engaging LGBTQ and other populations such as immigrants, race specific (Asian, Indian and Hispanic), and homeless.

Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.

Yes. One of the main tenets of the model is to tailor treatment to meet the specific needs of each family served.

The subjective Joining and Assessment Activities/Tools of the Family Centered Evaluation components are specifically designed to be participative (family driven), visual and sensory based, fun, and to leave the family with a copy of their completed activities. The family leads the way in the clinician’s understanding of their family functioning.

The goals of the assessment process are to enable the client / family members to be convinced that the clinician “gets” them and for them to feel that the clinician has a true understanding of what it is like to be a member of their family. In addition, this phase enables the use of an objective standardized assessment for determining their history of trauma (using the UCLA PTSD Reaction Index) and the areas of family functioning that are their strengths and concern (using the Family Assessment Device). Although information gathering assists with treatment planning, it is integrated into effective engagement.

In the Initial phase of treatment -specific supervision is focused for the clinician on effective engagement and populations served. Supervision is utilized to problem solve specific strategies to assist the clinician in engaging families. In FCT, engagement is understood as a process germane to all sessions regardless of the phase of treatment.

Are there culture-specific engagement strategies (e.g., addressing trust) that are included in the intervention? Central to the onset of services with each family is engagement. Successful engagement is predicated on a number of known factors, but centers primarily around gaining the family’s trust as demonstrated by the family’s willingness to try the clinician’s suggestions.

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<p>Engagement cont'd</p>	<p>With each family, FCT clinicians are expected to share the belief that ‘<i>every family is different</i>’ and that there is “<i>no such thing as a normal family.</i>” Sharing these beliefs is designed to enable the family to gain trust in the process. In addition, we ask the family to teach us about their culture rather than projecting we have complete knowledge about their culture.</p> <p>There are six FCT guarantees shared at the onset of services with each family that include the promise that ‘<i>we will share with them our perceptions about how/what we have observed</i>’ in their functioning or behaviors.</p> <p>This approach is intended to demonstrate to the family that their functioning or behaviors are both congruent and helping to achieve what they want to happen (goals); or are instead getting in the way of what they want.</p> <p>FCT clinicians are trained to share their thoughts before leaving the family home and request each time for the family to correct the FCT clinician in how his/her/their perceptions might be off base or wrong. This is one example of the many guarantees and approaches used that build trust. Another example is the FCT promise that the FCT clinician will ask where they have misunderstood or are wrong in their perceptions.</p>
<p>Language Issues</p>	<p>How does the treatment address children and families of different language groups?</p> <p>Most FCT licensed agencies employ staff that are reflective of the general population/ community and often multi-lingual or at least able to speak the language of the family that they are assigned. Where an interpreter is needed, such are obtained.</p> <p>If interpreters are used, what is their training in child trauma?</p> <p>Most often the interpreter is trained in MH services; specific knowledge of child trauma varies depending on locations and availability.</p> <p>Any other special considerations regarding language and interpreters?</p> <p>Fortunately, the use of outside interpreters is limited due to the diverse FCT certified staff. Because FCT clinicians are locally employed, their diversity of language is often congruent with the diversity of the local community. Document/component translation can be arranged in practically any language by request to the FCT Foundation. Current fidelity documents/components are available in Spanish and English.</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 FCT model does not have research evidence to support culturally-linked expressions of trauma symptoms. However, FCT clinical experience from providing treatment of diverse populations indicated:</p> <ul style="list-style-type: none"> • Referrals from LGBTQ population have history of self-harm/ self-hurting behaviors including suicidal attempts.

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<p>Symptom Expression cont'd</p>	<ul style="list-style-type: none"> • The caregivers/ parents in our Central America (i.e. El Salvador) families have their own trauma history related to war experiences and are initially extremely secretive, but eventually express their own trauma. In addition, emotional detachment from children and family is also apparent. • Negative stigma related to mental health services, as well as resistance to transparency related to past abuse and trauma, frequently emerge in populations where cultural ownership of such is taboo and a reliance upon church/religion as the cure are expected. • Multigenerational sexual abuse within the family has been expressed as a norm during the assessment process; although it is often involved in our work with Haitian families, no ethnic population-specific correlation has emerged. <p>If there are differences in symptom expression, in what ways does the theoretical/ conceptual framework of this treatment address culturally specific symptoms? \</p> <p>Assessment components within the model are designed to enable the family to tell their story / narrative, including cultural norms and expectations. FCT clinicians are taught and coached to respect the cultural norms and, where appropriate, reflect or participate in them.</p> <p>During treatment, an expectation occurs for enactments (activities that permit the family members to practice new ways of functioning in the area of family functioning that is not working for them). Often this process enables what is clinically defined as <i>alter-ego</i> work, when one family member is given the opportunity to speak on behalf of role play another family member. This process enables effective understanding for the clinician of culturally-specific symptoms and also for the younger generation in the family to do so as well.</p> <p>The Family Giving Project is integral to FCT end of treatment activities allows the family to design, develop, and carry out the project in congruence with their values and cultural norms.</p> <p>The Generalization Phase, approximately the last month of services, allows time for families to plan for the future, enables projections related to stages of life, developmental changes, and cultural benchmarks/rites of passage.</p>
<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? Initial subjective assessment tools are designed to honor cultural norms and share the narrative relative to specific family members (multi-generational and current nuclear family) and how they adhered or conflicted with them. The use of <i>ecomaps</i> permits each family member to define what their world (relationships/activities/interests) looks like. In doing so, the assessment yields information about differences between not only various cultural groups with which we work, but also intergenerational cultural differences within members' own families.</p>

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<p>Assessment cont'd</p>	<p>The <i>Family Life Cycle Assessment</i> integrates the caregiver's/parent's own individual history for different stages of life experienced thus far attuned to the norms of their culture. Exploration of this history leads to their determination of what norms or experiences that they want to replicate (repeat), discard, or create anew in their own family. The standardized assessment of the Family Assessment Device (FAD) has also been normed for some specific populations. The FAD is utilized as an assessment of family functioning in most FCT locations.</p> <p>If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?</p> <p>The Family Assessment Device does permit some baseline determination of primary areas of family functioning that of the most critical concern that become clinically significant for change and goals in treatment.</p> <p>What, if any, culturally specific issues arise when utilizing these assessment measures? The Structural Family Assessment is designed for each family member to share their perspective about various issues and/or members of the family (nuclear and multi-generations). In some cultures, we have observed that children/teens are not generally allowed to express different opinions than the adults and in some family situations even gender related norms regarding participation and information sharing has been limited for females. While we cannot specifically correlate this norm with any specific culture (as this occurs in many families with whom we work across all cultures) we have noticed it as common in many first-generation families with whom we work.</p>
<p>Cultural Adaptations</p>	<p>Are cultural issues specifically addressed in the writing about the treatment? Please specify. Yes, in the context of the intensive family systems staffing process used (<i>MIGS – map/issues/goals/strategies</i>). Integral to the MIGS is a section entitled Use of Self, referring to the clinician's notes about special considerations etc. This section is used to note culturally-specific issues related to treatment for each client/family receiving services.</p> <p>Do culture-specific adaptations exist? Please specify Not formally. In the context of assessments used, supervision coaching regarding modifications to address cultural differences are expected and a norm.</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>Not formally for results across all providers. We do have specific FCT agency subsets of 5 years of annualized data on engagement. These data sets have been tested for group differences in level of engagement. We found no significant correlations relating to race or culture for the last 4 years. In contrast, we found significantly lower/higher levels of engagement among Hispanics during the first year (2012) of data collection (p=.03).</p>

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**Intervention
Delivery Method/
Transportability &
Outreach**

If applicable, how does this treatment address specific cultural risk factors

(i.e., increased susceptibility to other traumas)? The FCT model does not formally cite specific cultural risk factors related to specific populations. However, as an intensive home and community based treatment model, the opportunity to assess, identify, and treat specific risk factors and trauma is unique compared to traditional office-based outpatient services. FCT clinicians, through their experiential yet standardized assessments, have a unique opportunity to witness family dynamics within a home or community settings. This presents an opportunity to identify risk factors that may be contributing to family functioning deficits, primary and secondary trauma factors, as well as strengths and opportunities for the family that have gone under-utilized.

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?

The FCT model is provided in the home as the primary location, making it transportable and adaptable to numerous settings including (but not limited to) urban, rural, and frontier communities. Use of FCT-specific implementation tools are designed to assess strengths and challenges of settings where the FCT model is being utilized.

Are there cultural barriers to accessing this treatment (i.e., treatment length, family involvement, stigma, etc.)?

There are no specific cultural barriers identified in the outcomes. The primary barrier is engagement of the family. Having at least one primary caregiver engaged is essential to effective completion of FCT.

Cultural norms, stigma, mistrust of systems and government in general, along with histories of feeling blamed and outcast, present barriers to engaging caregivers / parents. While we face these same barriers in most referred cases, these concerns present—and have special significance for—illegals, transients, and refugees.

Are there logistical barriers to accessing this treatment for specific cultural groups (i.e., transportation issues, cost of treatment, etc.)?

Not generally, as the service is most often provided in the home. The homeless and transient population presents a logistical barrier and is often related to some cultural groups.

Are these barriers addressed in the intervention and how? Yes – assistance with finding housing and related services. Also, this population requires out-of-the-box thinking in designing and implementing the on call and check in / checkup process, as well as devising places to meet with the family.

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)?

Close coordination with other service providers and schools is integrated into the process early in treatment. Given that the family decides whom they want to participate and/or to be informed beyond the immediate nuclear family, the inclusion of friends, pastors, etc. is frequently a part of the therapeutic process. These members of families’ social networks then become resources for support or emergency contacts.

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Training Issues

What potential cultural issues are identified and addressed in supervision/training for the intervention?

Eye contact, touch, seating arrangements, boundaries, acceptance of food and drink, use of surnames and salutations, understanding social contexts of how the culture views identifying problems, and privacy around family issues are but a few of the factors that present difficulties in engagement and use of the assessments.

Additionally, training is provided to clinicians around how to demonstrate respect and acknowledge the privilege of being allowed to work inside of a family's home. Understanding cultural norms around 'guests' in people's homes is an important training factor to effectively engage families into treatment.

Culture competency and awareness is cited in numerous areas across the training and certification process for FCT clinicians. Clinicians undergo an extensive online and live session training process. Incorporated into the online training portion are specific sections dedicated to cultural differences and awareness. Additionally, the trauma training units for clinicians cite ways in which cultural considerations of trauma may manifest differently among different populations/genders/etc. The trauma training is inclusive of the cross-culture differences highlighting the impact and stresses of trauma; one resource outlined and linked within the training unit is the Healthcare Tool Box.*

If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?

Each supervisor of FCT is required to complete an online competency-based course and demonstrate knowledge during live observation and consultation conferences to achieve the certification in FCT Supervision. . This is a yearlong process and includes training and skill development in the supervisor's role in building a partnership with the clinician. In that FCT sites frequently have supervisors and clinicians of different cultures, effective supervision is dependent upon addressing differences that might impact the openness and honest disclosure of full information. Integral to the multifaceted supervision process (peer and individual) is a FCT cultural norm that problems are okay to share and present the opportunities for personal and professional growth.

Because FCT is designed to work with all families (as defined by the family) the opportunity for great variability in family structures exists from family to family. Clinicians and supervisors must be prepared to approach treatment with families with complex histories and makeup, including, but certainly not limited to, single parents, foster and adoptive parents, mixed race families, grandparents raising grandchildren, same sex couples raising children, and so on. Identification of cultural and societal impact on the family must be addressed in training certification, ongoing clinical supervision, and family case staffing completed monthly by the clinicians with their regional treatment team.

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<p>Training Issues cont'd</p>	<p>If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?</p> <p>FCT supervision is designed to be phase-specific. The joining/assessment phase supervision process includes identifying and strategy development regarding cultural differences between the clinician and the client/family. Documentation of these strategies is included in the supervision form and, where applicable, becomes part of the case staffing form (MIGS).</p> <p>Has this guidance been provided in the writings on this treatment? Yes. The FCT Supervisor training and curriculum is manualized and required for all FCT Supervisors.</p> <p>Any other special considerations regarding training? Most state and/or contract and/or accreditation require specific training in cultural sensitivity and awareness for clinicians, and is handled individually by each FCT licensed agency.</p> <p>Individual supervision between supervisor and supervisee is expected no less than monthly. However, newer or less experienced clinicians are expected to have individual supervision at higher frequencies and many times weekly. These supervisions encompass individual case reviews with the supervisor and cases are presented for goal direction, joining/rapport, progress towards treatment progression, cultural considerations/concerns as it relates to treatment, etc.</p>
<p>References</p>	<ol style="list-style-type: none"> 1. Wheels of Change: the Family Centered specialist's handbook and training manual© / created by William E. Painter, Jr. and Marlo Smith. 2. Family Centered Treatment® Design and Implementation Guide /created by Tim Wood 3. The Definitive Report for Family Centered Treatment® /created by W.E Painter Jr., MS, L 'B' Smith, MS, LMFT, Revised 2014-T.J Wood, MS, LPC 4. http://www.familycenteredtreatment.org 5. McMaster Family Assessment Device (FAD) Epstein, N. B., Baldwin, L. M., Bishop, D. S. (1983). The McMaster family assessment device. Journal of Marital and Family Therapy. 9, (2), 171-180. 6. *https://www.healthcaretoolbox.org/cultural-considerations/culturally-sensitive-trauma-informed-care/12-health-care-toolbox/cultural-considerations.htm