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MORE THAN WHOEVER MADE YOU SUFFER: A CULTURALLY-
INFORMED TRAUMA-FOCUSED INTERVENTION
FOR LATINA ADOLESCENTS

A Dissertation Submitted in Partial Fulfillment
of the Requirements of the Degree of
Doctor of Philosophy

Katherine H. Valadez-Sanchez

College of Education and Behavioral Sciences
Department of School Psychology

July 2016

This Dissertation by: Katherine H. Valadez-Sanchez

Entitled: *More than Whoever Made You Suffer: A Culturally-Informed Trauma-focused Intervention for Latina Adolescents*

has been approved as meeting the requirement for the Degree of Doctor of Philosophy in College of Education and Behavioral Sciences, Department of School Psychology

Accepted by the Doctoral Committee

_____
Robyn S. Hess, Ph.D., Research Advisor

_____
Michelle Athanasiou, Ph.D., Committee Member

_____
Madeline Milian, Ed.D., Committee Member

_____
Whitney Duncan, Ph.D., Faculty Representative

Date of Dissertation Defense _____ .

Accepted by the Graduate School

_____
Linda L. Black, Ed.D.
Associate Provost and Dean
Graduate School and International Admissions

ABSTRACT

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This dissertation study explored how the integration of common Latino cultural values within Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) influenced the treatment outcomes of Latina adolescents with a history of trauma. Latino adolescents and their parents often experience great difficulties in attempting to access effective mental health services that are sensitive to their cultural needs. Therefore, the present study sought to understand the impact of participation in Culturally-Modified Trauma-Focused Treatment (CM-TFT) on working alliance, therapeutic engagement, and overall posttraumatic stress disorder (PTSD) symptomatology. In this mixed methods study, four adolescents and two mothers participated in CM-TFT. A self-report scale to measure PTSD symptomatology, as well as an ethnic identity and a working alliance measure were used with the participating Latina adolescents. Pre- and post-intervention semi-structured interviews were completed and the use of culturally modified components were tracked throughout CM-TFT. Results revealed that all adolescents and mothers who completed CM-TFT tended to experience their working alliance with me as their therapist as strong and cultural modifications made in treatment were reported as playing an important role in this process. All participants observed a decrease in PTSD symptoms and experienced improvements in their academic and school functioning. These findings

contribute to the literature on the impactful influence that cultural modifications have on the working alliance, engagement, and attendance of Latina adolescents in therapy, the importance of parental involvement in trauma-focused therapy, and the how-to factor of modifying trauma-focused interventions for Latina adolescents and their mothers.

ACKNOWLEDGEMENTS

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CHAPTER I

INTRODUCTION

Latino youth tend to experience higher rates of traumatic events than other ethnic

groups, including greater rates of sexual assault and harassment, family abduction,

physical assault, and witnessing greater domestic violence than non-Latino White

adolescents (de Arellano, Kmett Danielson, & Felton, 2012). Exposure to traumatic

events is linked to several detrimental psychological consequences, including anxiety and

depressive disorders, suicide attempts, substance abuse, externalizing behavior problems,

and posttraumatic stress disorder (PTSD). Unfortunately, trauma-exposed Latino

adolescents are four times more likely to meet criteria for PTSD than White adolescents

(Kilpatrick et al., 2003). With treatment, the symptoms of PTSD can be greatly reduced.

However, as noted by Kazdin, it has been estimated that between 50% to 75% of children

and adolescents referred to treatment fail to initiate or successfully complete their

treatment (as cited in Robbins, Turner, Alexander, & Perez, 2003).

The low rate of accessing counseling support services among Latino youth is even

more discouraging. Despite the higher rate of mental health needs, it is well-known that

Latino immigrant and non-immigrant children experience greater difficulties accessing

effective mental health services (Beehler, Birman, & Campbell, 2012). Rates of dropping

out of therapy are also especially high for this population, possibly because it is

problematic for them to access services that are culturally sensitive. In their study with

Latino families, Yeh et al. (2002) revealed that 10% to 15% of these families reported

difficulties finding mental health providers who incorporated their beliefs and culture into

therapy. Consequently, it has been hypothesized that treatment providers who are

perceived as culturally insensitive negatively affect client engagement and response to

treatment (de Arellano et al., 2012). Unfortunately, it has also been difficult to research

the effectiveness of culturally-informed treatment approaches with Latino youth because

despite an apparent willingness to participate in treatment research, many barriers exist

that inhibit the ability of youth and their families to stay in treatment such as fear and

distrust of the research process, lack of transportation and child care, and conflicts with

work and family responsibilities (Reidney, Orpinas, & Davis, 2012). In order to increase

the retention and engagement rates of Latino youth and families who seek mental health

services, it is imperative that more research efforts are invested in the exploration of

factors that help to keep these youth in therapy, specifically the therapeutic alliance

between therapists and Latino clients.

Theoretical Orientation

One of the overarching theoretical orientations underlying this study is Bordin's

(1979) theoretical conceptualization of the working alliance. This theoretical

conceptualization has its roots in psychoanalytic theory, though Bordin developed the

model to fit all other types of therapies. Specifically, Bordin referred to the working

alliance as including three main features: an agreement on goals; an assignment of task or

series of tasks; and the development of bonds between the therapist and the client. As

such, the strength of this alliance has been posited to have a strong direct relationship to

therapeutic outcomes in both adult and adolescent populations (Bordin, 1979; Russell,

Shirk, & Jungbluth, 2008; Shirk, Karver, & Brown, 2011). In fact, a meta-analysis by

Shirk et al. (2011) of individual youth alliance-outcomes revealed that alliance is an important predictor of treatment outcomes in both child and adolescent therapy and the effect size is comparable to that obtained in the adult literature.

Effective psychotherapy is rooted in the belief that matching the explanation of said symptoms and matching therapeutic components with the culture of the client will promote engagement and positive therapeutic outcomes (Benish, Quintana, & Wampold, 2011; Frank & Frank, 1993; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002; Wampold, 2007). Therefore, many practitioners have started to explore methods for culturally modifying their treatments to better match the needs of their culturally and linguistically diverse clients. The cultural modification of treatment to improve the congruence between treatment and the worldviews, values, and context in which ethnic minorities live (Benish et al., 2011; Bernal, Jimenez-Chafey, & Domenech Rodriguez, 2009) is one way in which therapeutic outcomes can be enhanced. As Benish et al., (2011) explained, illness is an experience that is shaped by the culture and context in which the client lives and it manifests itself in varying ways through physiological and psychological symptoms.

Misunderstanding or even overlooking the systematic integration of cultural modifications has been observed to result in early termination of treatment and reduce therapeutic outcomes in adult and youth populations (Paniagua, 2005). For example, working with adolescent clients brings forth a variety of issues that increase the likelihood for early termination of treatment. Developmental issues related to mistrust of authority and/or adult figures, adolescents minimizing the need for treatment and struggling with behavioral problems have been found to increase the likelihood of early

termination of treatment (Bordin, 1979; Russell et al., 2008). When youth have experienced trauma, these defenses may be especially resistant and interfere with the course of treatment. Therefore, a strong working alliance coupled with culturally-sensitive treatment is likely to reduce these challenges when working with traumatized youth. In sum, providing culturally-modified therapy is theorized to increase the working alliance between therapist and client. In order to advance the field of culturally-sensitive, trauma-focused services for Latino youth and their families, a deeper exploration of how trauma affects children and youth is presented.

<div align="center">

**Trauma Experiences in Children
and Youth**

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The immediate and long term consequences of witnessing or experiencing a traumatic event are multifaceted and impact children differently depending on a number of factors such as stress-resistant genetic makeups, developmental level, length of trauma, effectiveness of coping styles, and the strength of existing physical, emotional, and social support systems (Cohen, Mannarino, & Deblinger, 2012). *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5;* American Psychiatric Association [APA], 2013) indicates that immediate responses to trauma may include feeling fearful or terrified, being in shock, feeling helpless, and having physiological reactions like a racing heart beat and a decreased ability to concentrate. Those symptoms that persist will likely manifest in intrusive reactions such as nightmares and distressing memories, hyperarousal reactions such as hypervigilance and poor concentration, and avoidance and withdrawal reactions such as avoiding trauma reminders/triggers and emotional numbing (APA, 2013).

**Trauma in Latino Immigrant and
Non-Immigrant Youth**

Latino immigrant and non-immigrant youth are at an increased risk of experiencing single or multiple traumatic events (de Arellano et al., 2012). For instance, Latino youth may be more likely to live in high-poverty areas where exposure to community violence is more likely, single-parent families and substance-use may be prevalent, and anti-immigrant sentiments make discrimination and hate-crimes more probable (Bernal & Saez-Santiago, 2006). Further, exposure to violence prior to, during, or after migration (e.g., fleeing civil wars and/or dictatorships, lack of access to food and hydration sources while walking in a desert, and hiding from federal officials because of undocumented status) also increases the likelihood of experiencing a traumatic event. In fact, a study of 1,004 immigrant school children in Los Angeles reported that around 80% of the sample had witnessed a violent event, 49% had experienced violent victimizations in the past year, and 32% had clinical levels of PTSD (Jaycox et al., 2002). Both prior to and while living in the United States, immigrant Latino youth are likely to experience high levels of stress and trauma and experience many barriers to accessing mental health support. This high level of need underscores the importance of having effective treatments that will meet the needs of these youth.

Evidence-based Interventions

Empirically-supported treatments (ESI), also known as evidence-based interventions (EBI), are therapeutic approaches that have been extensively researched and studied and thus demonstrated to improve psychological outcomes based on empirical evidence (Kratochwill & Shernoff, 2004). These interventions have been regarded as the gold standard for identifying interventions that have rigorous scientific evidence

supporting for their effectiveness (Ingraham & Oka, 2002). As such, practitioners in the field are increasingly expected to use EBIs for treatment of various psychological or educational problems given the demand to deliver research-based treatments to children and families. Several EBIs have been developed for traumatized youth and of those, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen, Mannarino, & Deblinger; 2006) has the most empirical research to support its use.

The goal of an EBI is to provide a systematic, research-based approach to treatment of certain disorders or problems. On the other hand, researchers and clinicians have long known that the individualization of therapeutic services will likely yield the best treatment outcomes. Since EBIs are largely derived from Western cultural values and beliefs (Griner & Smith, 2006) and researched with non-minority populations, it is imperative to strike a delicate balance between culturally-sensitive practice and maintaining the integrity of EBIs. Available research on the efficacy and effectiveness of EBIs with Latino adolescents has been scarce (de Arellano et al., 2005) and adaptations to current accepted therapies are warranted to make them culturally sensitive. Bernal et al. (2009) described cultural adaptations as "the systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (p. 362).

Latino youth are less likely to receive any type of evidence-based services due to lack of health insurance, different help-seeking behaviors, stigma around mental health services, and lack of education around when and where to seek mental health services (Kataoka et al., 2002). However, even if they were able to overcome these barriers, it is

unlikely that the treatment would be culturally sensitive to the needs of youth and their families. There are few available programs specific to Latino youth and a lack of experienced mental health professionals who are capable of addressing diverse needs (Feldman, Trupin, Walker, & Hansen, 2013). Given the high level of exposure and trauma experienced by this population, it is important to examine and disseminate culturally sensitive trauma-focused assessment and treatment to address their needs.

Although research points to the importance of further exploration on symptom presentation and severity, the type of treatment preferred by families, and engagement and retention in therapy, studies addressing these areas have been insufficient and have provided mixed results regarding these factors. Hence, The Workgroup on Adapting Latino Services (2008), a project created by the Chadwick Center for Children and Families, which is part of the National Child Traumatic Stress Network (NCTSN), called for further research in these specific areas in order to further inform the field in adapting EBIs for use with Latino youth and their families. Bernal and Saez-Santiago (2006) argued that "In the absence of reliable information on the efficacy and effectiveness of mental health treatments for ethnic minorities, there is a need for research that can contribute to the knowledge base of what works and how it works" (p. 125).

**Culturally-Modified Trauma-Focused
Treatment (CM-TFT)**

Currently, Trauma-Focused Cognitive Behavioral Theory (TF-CBT) is the single most researched intervention for addressing trauma-related symptoms in children and adolescents (Fitzgerald & Cohen, 2012). It has been shown to effectively decrease PTSD symptoms in several research studies (Fitzgerald & Cohen, 2012). The TF-CBT model was created for children 3-18 years old who are experiencing primary PTSD symptoms

such as difficulties regulating affective states (e.g., anxiety, anger, depression), behavioral difficulties (e.g., avoidance of trauma triggers, problematic social interactions, lack of behavioral control), biological difficulties (e.g., somatic complaints), cognitive symptoms (e.g., distorted cognitions about self or others), social difficulties (e.g., affiliating with deviant or defiant peers, isolating self from others), or school difficulties (e.g., problems with concentration or hyperactivity; Fitzgerald & Cohen, 2012).

As such, TF-CBT pulls from a variety of theories to address the varied symptoms. For example, TF-CBT utilizes aspects of cognitive behavioral, attachment, humanistic, psychodynamic as well as psychophysiology theories (Fitzgerald & Cohen, 2012). The TF-CBT model has nine different components that address the symptoms described above. These components are: (a) Psychoeducation and Parenting skills; (b) Relaxation skills; (c) Affective modulation skills; (d) Cognitive coping and processing skills; (e) Trauma narration; (f) In-vivo mastery of trauma reminders (if indicated); (g) Conjoint child-caregiver sessions; and (h) Enhancing future safety and planning for the future. These core TF-CBT components are provided to parents and children separately with a few conjoint sessions that tend to occur toward the end of treatment. These components are typically given in the above order, as one skill builds on the previously learned skill, though the therapist has the flexibility to review previously learned skills throughout the treatment.

Culturally-modified Trauma-Focused Therapy (CM-TFT) is a version of TF-CBT that was modified to be utilized with the Latino population. The culturally modified components for Latino families are interwoven throughout the entire intervention by ascertaining which cultural values are relevant to these families and then using these

components to increase engagement, attendance, and facilitate a decrease in symptoms. Rivera (2008) outlined a variety of constructs that can be strategically used throughout treatment with Latino participants as indicated by each client. These constructs included: *machismo*; *marianismo* (i.e., refers to the Virgin Mary, indicating that girls should look at her as a role model and stay virgins until marriage); *familismo* (i.e., refers to the importance of family and interdependence between family members); *personalismo* (i.e., refers to acting in a warm, interactive manner rather than in a neutral, professional manner and providing some self-disclosure); fatalism (i.e., seeing events as being within their fate and out of their hands); *dichos y cuentos* (i.e., Spanish proverbs and folktales); and spirituality. For example, the cultural value of *familismo* can be incorporated by inviting extended family members to share information for the assessment portion of the treatment. By doing this, the therapist is sending the message that the focus of treatment is on the family as much as it is on the individual client. As a result, family members may feel more welcomed to participate in the treatment process. In this study, cultural constructs are further explored in order to understand the process of individualizing cultural modifications to each family.

**Working Alliance as a Vehicle to Increased
Adolescent Attendance**

Working with adolescent clients brings many challenges to the field of psychotherapy. Not only are they less likely to self-refer for treatment--and in turn, less motivated to participate in therapy (Shirk et al., 2011)--but they often minimize the need for treatment or the extent of their psychological problems. Further, developmental issues related to mistrust of authority and/or adult figures and possible behavioral problems may further complicate engagement in therapy and decrease the likelihood of successful

treatment completion (Bordin, 1979; Russell et al., 2008). Therefore, it has been hypothesized that a strong therapeutic relationship is more critical in child than adult therapy (Shirk et al., 2011; Shirk & Saiz, 1992), and has been posited as one of the most critical predictors of therapeutic outcomes. Unfortunately, child and adolescent working alliance studies have been largely excluded from the literature when compared to the large pool of working alliance studies that focus on adult populations (Shirk & Farver, 2003). In the interest of decreasing treatment dropout and increasing therapeutic engagement, research in the field of adolescent therapeutic alliance has begun to surface, with special focus on process predictors of therapeutic outcomes (Shirk & Karver, 2003). Southam-Gerow and Kendall (1996) found that a positive therapeutic relationship is viewed as extremely important to children and youth enrolled in Cognitive Behavioral Therapy (CBT). More recently, a study among depressed adolescents receiving CBT manualized therapy showed that the ratings of alliance predicted change in depressive symptoms and therapist-rated alliance predicted continuation in therapy (Shirk, Gudmundsen, Crisp Kaplinski, & McMakin, 2008). Thus, even when using an EBI, a positive therapeutic relationship is critical for enhancing outcomes and engagement among adolescents.

Therapists working with traumatized adolescents often find that engaging them in therapy is challenging for a number of reasons. One specific challenge is persuading them to participate in a treatment where talking about their trauma is core to obtaining positive outcomes. Often times, traumatized children and adolescents may experience an increased distrust and reduced confidence in their parents' and other adults' ability to protect them from danger (Ormhaug, Jense, Wentzel-Larsen, & Shirk, 2014). Further,

they may not trust the resources provided to them and may feel more hesitant to actively participate in therapy. In working with Latino youth who may struggle with seeking and receiving mental health services, Kataoka et al. (2002) found that it was important to explore and understand how measuring working alliance multiple times over the course of therapy could act as a vehicle to increased attendance and engagement in EBIs.

Problem Statement

Despite the documented effectiveness of TF-CBT with children and adolescents from the majority culture of the United States, there has not been enough attention given to the impact that culture has on the likelihood of seeking treatment and from whom, as well as treatment outcomes among Latino populations (Harmon, Langley, & Ginsburg, 2006). Because of the documented level of mental health needs due to trauma among this population, targeted research is needed to understand how culturally adapting EBIs might encourage Latino adolescents, as well as their families, to become more actively engaged in therapy and, in turn, derive better outcomes from treatment. Currently, although many practitioners in the field believe that it is important and beneficial to culturally adapt mental health interventions to accommodate clients' needs, they also believe that there is little empirical evidence that suggests doing so (Griner & Smith, 2006). Neglecting to systematically integrate important cultural modifications can result in early termination of treatment and reduce the full therapeutic effect of the intervention (Paniagua, 2005).

As Griner and Smith (2006) stated, "mental health practitioners have a moral and ethical responsibility to provide effective interventions to all clients by explicitly accounting for cultural contexts and cultural values relevant to clients' well-being (p. 531). Similarly, Gelso and Fretz (2001) stated that:

> Numerous researchers agree that the single most important reason both for the underutilization of mental health services by ethnic minority clients and for the high dropout rates is the inability of psychotherapists and counselors to provide culturally sensitive/responsive therapy for the ethnic minority client. (p. 153)

It is of paramount importance to understand that counseling and psychotherapy theories and interventions have been developed predominantly from the cultural beliefs of upper and middle-class European-Americans (Griner & Smith, 2006) and they continue to reflect these values, which may be incompatible with those of some ethnic minorities (Sue, 1998). For example, collectivistic values and contextual variables (e.g., lower socioeconomic status, social issues such as racism and discrimination) may be ignored or even devalued if clinicians are not culturally competent to understand their meaning and worth. Most importantly, misunderstanding these variables may give the perception that services are insensitive to the clients' needs (Zane, Enomoto, & Chen, 1994).

Rationale for Study

The exploration of how cultural modifications of evidence-based trauma treatments impacted retention and therapeutic working alliance between therapists and Latino adolescents were important for a number of reasons. Understanding how relevant cultural and contextual variables serve as protective or risk factors for Latino adolescents may help practitioners understand how to use these variables within a strength-based approach. In turn, knowledge of and integration of cultural factors may advance the working alliance between Latino adolescents and their therapists. By incorporating the use of working alliance measures the development of this relationship can be used to inform both therapeutic and research purposes. Finally, because caregivers are involved in some aspects of CM-TFT, their perceptions of this model were also important to assess

as these findings may contribute to the literature on culturally-responsive family-centered therapy.

Although TF-CBT is the single most researched intervention for addressing trauma-related symptoms in children and adolescents (Fitzgerald & Cohen, 2012), little is known about how traumatized Latino immigrant and U.S. born adolescents perceive TF-CBT, as well as what aspects of the culturally-modified treatment they find helpful for increasing their attendance and engagement in treatment. Only one study by Dittmann and Jensen (2013) was found that explored these experiences through qualitative methodology. However, the participants received traditional TF-CBT and their ethnicities were not disclosed, the cultural modifications of the treatment were not tracked, and the participants' parents were not interviewed. Given the lack of qualitative research exploring the experiences of Latino immigrant and non-immigrant adolescents and their families in CM-TFT, this study filled an important gap in the literature by providing an exploration of the interplay between cultural modifications, retention, and working alliance.

Mixed methodology was used to explore how integration of common Latino cultural values influenced working alliance, therapeutic engagement, and treatment outcomes among Latina adolescents with a history of trauma. This study incorporated the concept of pragmatism which reflects the idea that multiple quantitative and qualitative paradigms can be collected to form a complementary knowledge-base that aids in holistically understanding a certain phenomenon. Within the combination of quantitative and qualitative data, a previously undetected phenomenon may be discovered and the "what works" factor can be better explained (Geist & Lahman, 2008). Much of the

existing literature on TF-CBT with minority populations is quantitative in nature.

Utilizing mixed-methodology can strengthen the weaknesses that cloud the results of the

purely quantitative research designs, thus shedding a new light onto the process of

adapting EBIs for use with Latino adolescents and their families.

Purpose of the Study

In this study, I used CM-TFT with a small group of Latina adolescents who had

experienced trauma. Both process and outcome variables were monitored through

quantitative and qualitative measures. My goal was to understand how to improve

retention and engagement in trauma therapy among Latina adolescents and their families.

Through qualitative methodology, the incorporation of culturally modified elements of

this therapeutic approach was explored. Particular attention was given to understanding

how these individualized cultural modifications of TF-CBT (i.e., CM-TFT) influenced

retention and engagement in therapy. A measure of working alliance was used to assess

therapeutic alliance between myself (as therapist) and the Latina adolescent (as client).

Additional secondary outcomes (e.g., school attendance and performance) were also

explored in an effort to develop a broad understanding of the adolescent's experience in

CM-TFT.

Research Questions

The research questions for this study were as follows:

Q1   How do the Latina adolescent participants who receive CM-TFT treatment make meaning of their experience?

    a.   What do the adolescent participants who receive CM-TFT perceive as beneficial or detrimental to their treatment?

    b.   What role do Latino constructs play in the process of engagement in the CM-TFT intervention?

    c.   What role do Latino constructs play in the process of increasing attendance in the CM-TFT treatment?

Q2   How do the caregivers of the Latina adolescent participants who receive components of CM-TFT describe their experience with the intervention?

Q3   How does the ethnic identity of the Latina adolescent participants, as measured by the Multigroup Ethnic Identity Measure-Short, and CM-TFT strategies interact throughout the therapy process?

Q4   How do the Latina adolescent participants receiving CM-TFT rate their level of therapeutic alliance with their therapist on the Working Alliance Inventory-Short across the different measurement points?

Q5   Do the adolescent participants who receive the CM-TFT intervention experience a decrease in PTSD symptoms as compared to their pre-intervention number of symptoms?

Q6   Do adolescents receiving the CM-TFT treatment in a school setting demonstrate increases in school behaviors suggesting improved functioning (e.g., increased school attendance, improved academics, and fewer behavioral referrals)?

Definition of Terms

Acculturation. Acculturation is a process that immigrants experience after coming into contact with two or more cultures (Berry, Phinney, Sam, & Vedder, 2006) and results in their identities, attitudes, cultural values and beliefs being influenced by the host country's cultural values.

Acculturation gaps. Acculturation gaps occur when parents and their children acculturate at different rates to the host country's culture.

Alliance. The term alliance refers to the client-therapist relationship and three different dimensions that facilitate change and predict outcomes: bonds, tasks, and goals (Bordin, 1979; Russell et al., 2008; Shirk et al., 2011). Alliance between the therapist and the client in this study was assessed with the *Working Alliance Inventory-Short* (*WAI-S*; Hatcher & Gillaspy, 2006).

Alternative school. Alternative schools are usually viewed as individualized educational opportunities designed to meet the needs of students at-risk for school failure (Foley & Pang, 2006). However, there are different types of alternative programs, some that emphasize on programmatic themes for academic content (e.g., charter and magnet schools) while others emphasize behavior and curriculum modification. For this study, an alternative school refers to students who are academically and behaviorally at-risk.

Caregiver. This term refers to the person that the adolescent chooses to participate in the TF-CBT treatment.

Culturally-Modified Trauma-Focused Treatment (CM-TFT). This is the acronym for the culturally-modified version of Trauma-focused Cognitive Behavioral Therapy. Bernal et al. (2009) described cultural adaptations as "the systematic modification of an evidenced-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (p. 362). Cultural modifications are made to the mainstream TF-CBT intervention in order to increase engagement, attendance, and facilitate a decrease in symptoms.

Culture. Canino and Guarnaccia (1997) defined culture as a social construction that structures human thought, emotion, and interactions and provides guidelines for dealing with challenging life events, including illnesses. Canino and Roberts (2001) echoed this definition, asserting that culture is continuously changed throughout an individual's life by social processes and interactions such as migration and acculturation, and is the outcome of an individual's life experiences combined with group values, norms, and experiences.

Ethnic identity. This construct refers to one's sense of belonging to a certain ethnic group, including values, language, and shared traditions (Phinney & Ong, 2007). Ethnic identity has been largely researched by studying a person's commitment to an ethnic group, studying their cultural behaviors and attitudes toward an ethnic group, and examining the degree to which they seek information and experiences related to a specific ethnic group (Phinney & Ong, 2007). Ethnic identity was assessed in this study through qualitative interviews as well as the *Multigroup Ethnic Identity Measure, Short* (*MEIM-S*; Phinney & Ong, 2007).

Evidence-based intervention. This term refers to treatments or interventions that have been extensively studied and shown to improve educational or psychological outcomes through robust, comprehensive scientific evidence demonstrating efficacy and effectiveness (Kratochwill & Shernoff, 2004).

Families. This term refers to parents, guardians, grandparents, siblings, aunts, uncles, cousins, godparents, and other individuals regarding as family members and playing a significant role in the adolescent's life.

Latino or Latina. The term Latina refers to females and Latino refers to males or the entire group. These terms refer to any person who was born in the United States or abroad who are of Latin American descent. This population's background can be traced back to Mexico, Central America, South America, Cuba, Puerto Rico, or the Dominican Republic.

Trauma. According to the *DSM-5* (American Psychiatric Association, 2013), trauma refers to the exposure to actual or threatened death, serious injury, or sexual violence by directly (e.g., having the event happen to them) or indirectly experiencing the

traumatic event (e.g., learning that a traumatic event happened to a loved one) and these can happen one time or repeatedly over a period of time. Trauma symptoms and events were assessed in this study with *The University of California at Los Angeles Posttraumatic Stress Disorder Reaction Index* (PTSD-RI; Steinberg & Brymer, 2008; Steinberg, Brymer, Decker, & Pynoos, 2004).

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). This trauma-focused conjoint child and parent intervention was developed to effectively decrease primary PTSD symptoms in children 3-18 years old. The model pulls from a variety of theories such as aspects of cognitive behavioral, attachment, humanistic, psychodynamic as well as psychophysiology theories (Fitzgerald & Cohen, 2012) in order to alleviate PTSD symptoms. As a family-centered intervention, this model promotes the engagement of both children and significant family members to decrease PTSD symptoms and promote generalization of symptom change. The main objectives of this intervention are to process thoughts and feelings related to the traumatic event(s), manage and resolve distressing thoughts, feelings, and behaviors related to the event, increase healthy coping skills and communication within the family, learn effective parenting strategies, and help the traumatized child regain a sense of safety and control over their lives.

Delimitations

Given that I was the primary researcher and therapist in this study, my influence was naturally present when facilitating CM-TFT. Therefore, my biases, previous experiences, and overall therapeutic assumptions were present in all aspects of the study. In order to maintain awareness of my own influences on the therapeutic and research process, I kept detailed field notes tracking my progress and assumptions as therapy

unfolded. Additional information regarding my researcher stance is provided in Chapter III.

The Latina adolescent students who participated in this study attended an alternative high school in a Western state of the United States, which may limit the transferability of these findings to other school settings. Additionally, as a result of providing therapy in a school setting without consistent access to office space, therapy sessions were held in a variety of settings, including the school gym, school courtyard, nurse's office, and the adolescent's home. Despite this disadvantage, the setting in which therapy was provided was not thought to significantly affect treatment outcomes of this study.

CHAPTER II

REVIEW OF LITERATURE

There are many sources of trauma in children's lives and none is quite as disturbing as the high incidence of childhood maltreatment. In 2012, approximately 3.18 million children in the United States were subject to at least one Child Protective Services (CPS) report and more than 60% of these reports were considered serious enough to warrant an open investigation. Of these CPS reports, 78.3% constituted cases of neglect; 18.3% to physical abuse; 9.3% to sexual abuse; 8.5% were psychologically maltreated cases; and nearly 15% of these cases constituted two or more maltreatment types (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2012). While reporting and communication systems have improved, there are a number of childhood traumatic experiences that are not captured by CPS. For example, exposure to domestic and/or community violence, the traumatic loss of a family member, and pre-, trans-, and post-migration events such as lack of access to food and hydration sources and fleeing violent civil wars all constitute examples of possible traumatic events. Whether the child experienced single or multiple traumatic experiences, these events are likely to incur devastating effects in the lives of children, families, and their communities.

The goals of this comprehensive literature review are manifold. I present the relevant foundational research to the current study, including a definition of trauma, child and adolescent traumatic experiences, their effects on mental health and social emotional

development, and resilience factors that reduce these effects. The construct of trauma is further explored by paying special attention to the literature related to the adolescent population and the domains of impairment that they may experience as a result of trauma. Evidence-based interventions (EBI) for trauma are covered, with special focus given to modified interventions appropriate for use with Latino populations. Specifically, I describe the advantages of disseminating culturally-modified EBIs in many settings, including schools, where many Latino students receive their mental health interventions and support.

A full understanding of trauma must address the sociocultural context of the individual. Latino immigrant adolescents are more likely to experience a unique variety of traumatic events. Further developmental issues that are inherent to adolescence can make interventions challenging for practitioners and developing a strong working alliance is critical to increased intervention success with Latino adolescents. A deeper focus is given to working alliance as a means to increased attendance and active participation on the part of the adolescent client, leading to decreased symptomatology and improved functioning.

<div align="center">**Trauma in Children and Adolescents**</div>

Many children and adolescents experience various events in their life that are considered stressful and overwhelming. Parental divorce, the death of a loved one, and migrating to a new country all bring varying degrees of stress that may exceed an individual's coping mechanisms. However, the distinctive features that distinguish traumatic experiences from stressful life events are that the perceived traumatic event must threaten the injury, death, or the physical integrity of the child or others around

them and cause horror, terror, or profound helplessness when it occurs (American Psychological Association Presidential Task force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents, 2008; Kilpatrick, Resnick, & Acierno, 2009). When such features are encountered, a variety of biological and environmental factors may either protect or make the child more vulnerable for developing psychological disorders.

**Vulnerability and Resiliency in Children
and Adolescents**

The onset and maintenance of a psychological disorder depends largely on the biological and environmental factors present before, during, and after a traumatic experience. Known as pretraumatic, peritraumatic, and posttraumatic factors (APA, 2013; Friedman, Resick, Bryant, & Brewin, 2011), these are aspects of a child's self and environment that predict prognosis after a trauma. Pretraumatic factors include the child's prior emotional problems (e.g., prior traumatic exposure as well as prior externalizing and internalizing disorders), environment (e.g., low socioeconomic status and education, childhood adversity such as family dysfunction and unhelpful coping strategies, and minority racial/ethnic status), and genetic and physiological makeups (e.g., younger age at the time of the trauma). Peritraumatic factors are related to the environment in which the trauma occurred and include the severity of the trauma (e.g., the greater the trauma, the greater the likelihood of developing psychological disorders), perceived life threat, injuries encountered, and interpersonal violence experienced. Finally, posttraumatic factors include temperament-related traits such as negative appraisals and inappropriate coping strategies, and environmental factors such as subsequent exposure to trauma reminders; number of difficult life events after the trauma; and other trauma-related losses such as financial instability and social rejection (APA, 2013). While there is no

exact combination of factors that predict the onset of clinical disorders, the more risk factors a child possesses, the greater the likelihood of severe acute or ongoing psychological symptoms (Friedman et al., 2011).

In explaining the onset and maintenance of psychological disorders, Ingram and Price (2010) defined the concept of vulnerability as an endogenous trait, rooted in biological and psychological processes, which is attenuated or intensified by certain environmental experiences. Conversely, the term "risk" has been defined differently from vulnerability in that risk refers to factors that are associated or correlated with a greater likelihood of developing a disorder (e.g., living in a chaotic and stressful environment), but are not considered to be innate to the individual. Taken together, children and adolescents may be at-risk for developing psychopathology if they live in a violent and unsafe neighborhood and this risk has greater likelihood of being actualized if they also possess the vulnerability factors associated with onset of the disorder (e.g., negative thinking processes, family history of anxiety disorders, genetic predisposition; Koenen, Amstadter, & Nugent, 2009).

Reactions to traumas vary and depend largely on a child's or adolescent's ability to access and appropriately utilize their protective factors. For younger children, their reactions to traumas tend to depend on their parents' reactions to the same trauma more so than adolescents (Laor, Wolmer, & Cohen, 2001). In general, if the child's parents cope well with the trauma, their children tend to model those same coping strategies and fare better than children whose parents struggle to cope with a specific trauma (Cohen, Mannarino, & Deblinger, 2012). However, traumas that start earlier in life may affect the child's developmental trajectory even more so than if the trauma had occurred later in life

(Cohen, Mannarino, & Deblinger, 2012). Perry (2009) explained that the brain develops in a bottom up fashion, from least complex (i.e., brainstem) to the most complex areas (i.e., limbic, cortical). Because different brain areas have their own timeline for development, processes that occur at earlier periods of the child's development may be more sensitive to disruptive, traumatic experiences, and in turn affect the organization and development of the more complex parts of the brain (Cicchetti & Toth, 1995; Wamser-Nanney & Vandenberg, 2013). Hence, the same traumatic experience will likely impact a 1-year-old differently than an 8-year-old.

Most children and adolescents' reactions to traumatic events affect their typical functioning by reducing concentration and attention, facilitating the development of new fears, changing their sleep patterns, and increasing somatic complaints. However, most will soon return to their pretrauma levels of functioning (Cohen, Mannarino, & Deblinger, 2012; Friedman et al., 2011; Kilpatrick et al., 2009; Koenen et al., 2009; Newman, 2002). Other children and adolescents who do not have access to protective internal and environmental buffers may go on to develop symptoms of posttraumatic stress disorder (PTSD). With the newest edition of the DSM-5, PTSD was divided into two parts based on the age of the individual. For the purposes of this study, focus will be given to PTSD symptomatology of children ages 6 and older.

**Posttraumatic Stress Disorder in
Children and Adolescents**

According to the *DSM-5* (APA, 2013), children and adolescents must have had exposure to actual or threatened death, serious injury, or sexual violence by directly (e.g., having the event happen to them) or indirectly experiencing the traumatic event (e.g., learning that a traumatic event happened to a loved one) and these can happen one time

or repeatedly over a period of time (APA, 2013). There are four distinctive features of

PTSD: intrusion symptoms; persistent avoidance of internal and external reminders of the

traumatic event; negative alterations in cognitions and mood that are related to the

traumatic event; and marked alterations in arousal and hyperactivity.

Intrusion symptoms. Intrusion symptoms involve the persistent, unintentional,

and invasive nature of distressing memories, dreams, and/or dissociative reactions of the

traumatic event (APA, 2013; Friedman et al., 2011). These intrusions are often triggered

by internal or external cues that resemble the traumatic event and can be accompanied

with physiological reactions such as a racing heart. Developmentally, some traumatized

children and adolescents' brains try to generate intense, wishful thoughts about being

protected and safe when the traumatic event happened. The brain reacts to these thoughts

by creating intense intrusion symptoms (Pynoos et al., 2009). These thoughts of being

protected and safe are often known as "action plan" initiatives by the hippocampus,

where memory and learning take place (Pynoos et al., 2009). For example, intrusive

memories, prolonged intense psychological distress, and flashbacks all reference

preoccupation with the traumatic thoughts. These symptoms could be explained as the

brain's maladaptive attempts at trying to build preventive and protective interventions

(Pynoos et al., 2009) as a survival mechanism. In turn, children and adolescents may

begin to develop learned maladaptive reactions toward trauma triggers (e.g., avoiding

people, places, things, or situations that remotely remind the child of the traumatic

experience), increased anxiety, and disturbed sleep patterns, which negatively affect

academic and social contexts. Intrusion symptoms can occur in the form of dreams,

flashbacks, dissociative reactions, and/or prolonged intense distress at sensory reminders of the traumatic event.

Avoidance symptoms. This category of symptoms involves the constant avoidance of stimuli associated with the traumatic event(s) such as painful thoughts, memories, and/or feelings related to the traumatic event. This category might also include avoiding aspects of one's environment that act as reminders of the traumatic event (e.g., people, settings, conversations, activities; APA, 2013). In an effort to protect themselves from further traumatic experiences and negative feelings, children and adolescents may begin to develop behaviors that lead to more difficulties (Cohen et al., 2006). For example, an adolescent who experienced date rape by a school peer may begin to avoid going to a specific class, to be truant at school, and may even develop school refusal problems. In the case of domestic violence traumas, the child's parents may become the child's trauma reminders and efforts to avoid them may prove to be nearly impossible, adding to the individual's stress. Pynoos et al. (2009) argued that children and adolescents often do not have the freedom to avoid people or situations as much as adults (e.g., parents, school) and their avoidance-behaviors begin to represent incident-specific fears (e.g., children who are victims of domestic violence may fear being around their parents and this may not manifest until they are old enough to leave their home). Pynoos et al. further recommended the need for a better characterization of this PTSD feature because incident-specific fear may not be understood by many as rooted in avoidance.

The avoidance of painful feelings is another hallmark of this category. In some adolescents, self-injury such as cutting, burning, or other forms of self-harm may begin as a result of wanting to avoid feeling numb or feeling overwhelming pain (Cohen et al.,

2006; Pynoos et al., 2009). School-age children often times turn to substance abuse as a maladaptive strategy to avoid trauma reminders and to cope with negative self-image. Further, some children and adolescents may choose to avoid age-appropriate relationships as they do not feel comfortable because they perceive themselves as different from their peers. If no intervention is provided, this category of symptoms may transform into other psychological disorders, such as generalized anxiety disorder (Cohen et al., 2006).

      Negative alterations in cognitions and mood. Traumatic events often alter children's and adolescents' cognitions and emotions about themselves and the world around them (e.g., "I can't ever trust anyone," "The world is dangerous; there's nothing I can do about it;" Friedman et al., 2011; Meiser-Stedman, Yule, Smith, Glucksman, & Dalgleish, 2005). In this PTSD category, children and adolescents show symptoms of struggling to understand the cause and consequences of a traumatic event and often blame themselves or others for their trauma. Searching for an explanation for why something so horrifying would happen to them, their cognitions begin to distort and possibly lead to persistent negative emotional states, significant decreases in participation in once enjoyable activities, feelings of detachment from others, and/or experiences of dissociative amnesia (APA, 2013; Wamser-Nanney & Vandenberg, 2013). Developmentally, children and adolescents' egocentric view of the world may lead them to place blame on themselves for experienced traumas that were clearly not their fault. This misplaced self-blame often results in suicidality, cognitive distortions, guilt, and shame.

Marked alterations in arousal and reactivity. Often regarded as biologically-based processes (Pynoos et al., 2009), this category of symptoms involves affective dysregulation which often results in angry outbursts with little or no provocation; hypervigilance; sleep disturbances; heightened startle responses; and thrill-seeking impulses that often result in self-destructive behaviors (APA, 2013; Cohen et al., 2006; Friedman et al., 2011; Schwab-Stone et al., 1999). Alterations in arousal and reactivity are often times different in males and females, with females exhibiting higher rates of internalizing symptoms and males exhibiting higher rates of externalizing symptoms (Miller & Resick, 2007). Severely and chronically traumatized children who experience interpersonal-types of traumas (e.g., child abuse or domestic violence) often experience affective dysregulation to a greater extent than children who experience nonintentional traumas (e.g., car accident or natural disaster; Wamser-Nanney & Vandenberg, 2013). Furthermore, children who experience chronic interpersonal abuse often do not receive the consistent nurturing, care, and affection that most children with one-time traumas receive. The lack of reciprocal affection and invalidated anger, sadness, and fear emotions likely lead to missed opportunities for learning how to appropriately regulate intense emotions.

Adolescents with Complex Trauma

While many adolescents experience one-time traumatic events, some children (especially adolescents) experience repeated or ongoing episodes of traumatic life events that interfere with various aspects of their functioning (Cohen et al., 2006; Cook et al., 2005) to a greater extent than just experiencing symptoms of PTSD (Wamser-Nanney & Vandenberg, 2013). The term complex trauma, developed by Herman (1992), surfaced

out of the literature on adult and child victims who had experienced prolonged abuse. Both researchers and clinicians found the diagnosis of PTSD to lack the much more complicated symptomatology of many patients. By definition, individuals with complex trauma struggle with multiple impairments beyond those accounted for by a standard PTSD diagnosis. Specifically, these individuals may experience disrupted attachments (e.g., problems with boundaries, social isolation); physiological problems (e.g., somatization), affect dysregulation (e.g., difficulty labeling and expressing feelings); dissociation (e.g., amnesia, depersonalization); behavioral discontrol (e.g., poor impulse control and aggression); problems with cognitive tasks (e.g., focusing and completing tasks, planning and organizing); and/or problems with self-concept (e.g., body image problems and shame and guilt; Cook, Blaustein, Spinazzola, & van der Kolk, 2003; Cook et al., 2005; Miller & Resnik, 2007). Hence, it is not the number of traumatic events that define complex trauma but rather the multiplicity of domains that are impaired as a result of traumatic events.

The noted domains affected by complex trauma are often the result of prolonged interpersonal abuse that starts at an early age such as experiencing childhood sexual abuse, witnessing domestic violence, and for some refugee populations, witnessing the day to day violence that are a part of refugee camps (Cook et al., 2005; Wamser-Nanney & Vandenberg, 2013). Complex trauma is often the result of multiple factors that mediate the impact of traumatic events, such as parental support, level of distress, retraumatization as a result of multiple traumas, and the child's attributions and perceptions about the traumatic event (Cohen et al., 2006).

One of the hallmarks of complex trauma is affective dysregulation and extreme reactivity to events in the environment (van der Kolk, 2005). In many instances, adolescents presenting with complex trauma experience emotional and behavioral dysregulation which may present in aggressive behaviors toward others who they perceive as being critical. In this example, the adolescent's affective dysregulation may go as far as assaulting the teacher or other students in the classroom. Due to the early start and chronic nature of the trauma, many adolescents' brain structures do not develop typically and are deprived of consistent, healthy environmental experiences necessary for healthy functioning. Thus, abilities such as analytical capacity, executive functioning, and self-regulation and modulation may be grossly impaired (Cook et al., 2005). Unfortunately, most interventions available for adolescents with PTSD have not been systematically studied with complex trauma populations. Consequently, adolescents with a history of complex trauma often have the most difficulty with intervention adherence, active engagement, and intervention completion. Regardless of the level of complexity in the trauma symptoms, it is imperative that interventions be multifaceted in order to effectively address the many different aspects and presentations of PTSD.

Interventions for Adolescent Trauma

Research on the interventions of PTSD in adolescents is at its early stages as compared to the advanced knowledge and practice in treating PTSD in adult populations (Black, Woodworth, Tremblay, & Carpenter, 2012). Among the most commonly used interventions for adolescents are variations of cognitive behavioral therapy (CBT) which has robust empirical evidence when compared to psychodynamic and medication treatments (Feeny, Foa, Treadwell, & March, 2004; Black et al., 2012). In 2012, Gillies,

Taylor, Gray, O'Brien, and D'Abrew compared the effectiveness of commonly used psychological therapies such as CBT, exposure-based therapy, narrative therapy, supportive counseling, family-based therapy, and Eye-Movement Desensitization Reprocessing (EMDR) for treating children and adolescents diagnosed with PTSD. The authors concluded that CBT had the most solid evidence of effectiveness when treating PTSD in this population. However, they also noted that there was not enough research comparing CBT with the other therapies and consequently, they could not establish the effectiveness of one therapy over another in this specific meta-analysis (Gillies et al., 2012).

In CBT, the therapist is interested in challenging and changing the pattern of negativistic and unhelpful thoughts and behaviors with the intent of lessening or eliminating the presenting psychological symptoms. Aspects of this therapeutic approach tend to be incorporated into most of the commonly used treatments for youth who have experienced trauma. In their comprehensive review of trauma-informed interventions for adolescents 12-18 years, Black et al. (2012) discovered that the most commonly used interventions included: Multimodal Trauma Treatment (MMTT; March, Amaya-Jackson, Murray & Schulte, 1998); Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT; Cohen et al., 2006); Stanford Cue-Centered Therapy (SCCT; Carrion & Hull, 2010); Seeking Safety (Najavits, Gallop, & Weiss, 2006); and Trauma Affect Regulation: A Guide for Education and Therapy (TARGET; Advanced Trauma Solutions, 2001-2010). As noted, most of these approaches include elements that are consistent with a CBT approach, with TF-CBT being one of the most commonly used treatments because of the evidence base for this specific therapy.

Evidence-based Interventions for
Trauma: Trauma-Focused
Cognitive Behavioral
Therapy

Evidence-based interventions (EBI) are interventions that have been extensively studied and shown to improve educational or psychological outcomes through robust, comprehensive scientific evidence demonstrating efficacy and effectiveness (Kratochwill & Shernoff, 2004). Practitioners are expected to use EBIs to provide a systematic, research-based approach to intervention of certain disorders or problems. The need and demand for EBIs has grown over the years as the accountability movements continue to spread. However, despite this increased expectation for use of empirically supported practices, fewer than 10% of clinicians are likely to use an EBI as part of their practice (Cusworth Walker, Trupin, & Hansen, 2013).

While many trauma-informed interventions are routinely used across adolescent populations in different settings (e.g., residential treatment, correctional youth facilities), TF-CBT is one of the few EBIs for treating trauma in children and adolescents. This therapeutic approach has been recognized by several groups of experts and federal agencies as being both effective and efficacious for youth (e.g., Chadwick Center for Children & Families, 2009; Child Welfare Information Gateway, 2012; The National Child Traumatic Stress Network; Substance Abuse and Mental Health Services Administration [SAMHSA] National Registry of Evidence-Based Programs and Practices; and The California Evidence-Based Clearinghouse for Child Welfare). In fact, TF-CBT was the most studied and endorsed interventions used to address trauma in adolescent populations (Black et al., 2012) and these authors strongly encouraged the use of this therapy to help reduce trauma-specific symptoms among children and adolescents.

Originally created for children and adolescents who had been sexually abused (Deblinger & Heflin, 1996), today TF-CBT is used to treat PTSD and traumatic grief symptoms resulting from a variety of traumatic events including chronic exposure to domestic and community violence and one-time events such as car accidents or natural disasters (Fitzgerald & Cohen, 2012). It has been shown to effectively decrease PTSD symptoms in at least 10 controlled trials, 2 quasiexperimental trials, and open non-control trials (Fitzgerald & Cohen, 2012). Additionally, in a series of TF-CBT trials with child victims of sexual abuse, TF-CBT was shown to be superior in comparison to other interventions that were not trauma-specific (e.g., nondirective, supportive therapies, child-centered therapies) or waitlist control (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen & Mannarino, 1996, 1998; Deblinger, Lippmann, & Steer, 1996). Furthermore, this approach has been successfully used with youth experiencing complex trauma symptoms (Fitzgerald & Cohen, 2012). However, the majority of TF-CBT trials have been with youth who have experienced contact sexual abuse.

Trauma-Focused Cognitive Behavioral Therapy has a strong research base with children and adolescents from ages 3 to 18 years old experiencing clinical levels of PTSD as well as those who experience subclinical, but distressing symptoms of the disorder. Specifically, the model was created to address primary PTSD symptoms such as difficulties regulating affective states (e.g., anxiety, anger, depression), behavioral difficulties (e.g., avoidance of trauma triggers, problematic social interactions, lack of behavioral control), biological difficulties (e.g., somatic complaints), cognitive symptoms (e.g., distorted cognitions about self or others), social difficulties (e.g., affiliating with deviant or defiant peers, isolating self from others), or school difficulties (e.g., problems

with concentration or hyperactivity; Cohen et al., 2006; Fitzgerald & Cohen, 2012).

Additionally, brief, parallel weekly caregiver sessions are held to introduce the same

issues addressed in the child sessions in order to habilitate parents with the skills

necessary to support the continued growth of their children throughout treatment.

In order to address the multiple symptoms of trauma, TF-CBT is grounded in

several theories. For example, TF-CBT utilizes aspects of cognitive behavioral,

attachment, humanistic, psychodynamic as well as psychophysiology theories that

explain how trauma affects the mind and body (Fitzgerald & Cohen, 2012). The TF-CBT

model has nine different components that address the symptoms noted. These

components are denoted by the acronym PRACTICE and are as follows: (a)

Psychoeducation, (b) Parenting skills, (c) Relaxation skills, (d) Affective modulation

skills, (e) Cognitive coping and processing skills, (f) Trauma narration, (g) In-vivo

mastery of trauma reminders (if indicated), (h) Conjoint child-caregiver sessions, and (i)

Enhancing safety planning for the future. These nine core TF-CBT components are

provided to parents and adolescents separately (parents meet for at least 15 minutes face-

to-face or over the phone while adolescents attend 50-minute sessions) and the conjoint

sessions tend to occur toward the end of the intervention. Typically, the components are

given in the above order, as one skill builds on a previously learned skill. However,

therapists can use their clinical judgment to review previously learned skills and

determine when one phase of the treatment is complete and when the next should be

introduced.

A major component of TF-CBT is the psychoeducational component which

involves both the caregiver and the child. The main goals of this component are to

educate about and normalize the symptoms of trauma. Specifically, the therapist seeks to reinforce the accurate thoughts that the caregiver and child have about the traumatic event and outline the steps of the intervention. Furthermore, instilling a sense of hope and assuring the child and the caregiver that TF-CBT has been shown to be highly effective is extremely important, as it provides them with a sense of relief and hope for the future (Cohen et al., 2006). Psychoeducation can take the form of an informational sheet with facts and prevalence rates of the trauma, flashcards with frequently asked questions that adolescents might have about the trauma, and books that describe the experiences of adolescents with traumas.

Many children who experience a traumatic event display behavioral difficulties that are hard to handle for many caregivers. These behavioral difficulties may inhibit the healing process as behaviors such as angry outbursts or avoidance may inadvertently be reinforced (e.g., child is removed from a fear-evoking situation), making the responses stronger and more difficult to manage. Hence, TF-CBT incorporates a parenting skills component to educate and train caregivers on skills to optimize the healing process of the child (Cohen et al., 2006; Cohen, Mannarino, Kliethermes, & Murray, 2012). Most importantly, the parenting skills component helps the parent understand how the trauma and the problem behaviors are interrelated by helping the caregiver feel more empathetic toward the child. Parenting skills learned include the use of praise, selective attention, effective time-out procedures, and contingency reinforcement schedules.

To reduce the physiological symptoms of stress and PTSD (e.g., racing heart, startle response, muscle tension, and hypervigilance) TF-CBT incorporates a relaxation training component. In this component, adolescents and their parents are taught coping

skills such as focused breathing, guided imagery, progressive muscle relaxation, meditation, and other activities that the adolescent and/or parent find relaxing already (e.g., aerobic activities such as playing football or cycling; listening to music; arts and crafts; Cohen et al., 2006).

The affective expression and modulation component of TF-CBT is helpful for adolescents who struggle with intense, painful feelings and do not know how to regulate them. In essence, this component targets the negative alterations in mood symptoms of PTSD (APA, 2013) and helps adolescents build their feelings vocabulary, learn techniques to help them modulate their emotions in different settings, and to feel a heightened sense of control over their affective states. Skills that help the child identify and express feelings, interrupt unwanted thoughts (thought stopping), as well as positive imagery and self-talk are learned.

Because many caregivers and adolescents employ inaccurate and unhelpful thoughts to cope with their traumatic experiences, the cognitive coping and processing component was created to encourage them to challenge and correct these cognitions. This process is called cognitive coping, and it is based on the work of Beck (1995). In essence, adolescents and their parents learn how to make sense of their traumatic experiences by learning coping skills that make them aware of their automatic thoughts and how these are connected to their feelings and behaviors. For example, one such technique is the cognitive triangle, in which caregivers and adolescents outline and analyze scenarios and determine how to challenge and change inaccurate and/or unhelpful thoughts (Cohen et al., 2006; Cohen, Mannarino, & Deblinger, 2012).

The creation of a trauma narrative and cognitive coping and processing (also referred to as gradual exposure) are the next components of TF-CBT. Originally developed by Deblinger, McLeer, and Henry (1990), it is conceptualized as an exposure procedure that promotes repeated reading, writing, and elaboration of the traumatic experience in order to desensitize the adolescent to the trauma reminders (Cohen et al., 2006). Therefore, the psychological and physiological reactions related to the traumatic event decrease as the exposure procedure continues. As a result, the individual's need to avoid the trauma reminders decreases because the psychological and physiological triggers associated with it are not as salient. In-vivo mastery of trauma reminders is an optional component of TF-CBT that is used when narrative techniques alone are not sufficient to desensitize the adolescent to certain trauma reminders (e.g., continued school refusal because of a serious victimization incident). As the therapist and the adolescent work to create the trauma narrative, details of the traumatic experience are recorded in some creative fashion (e.g., writing lyrics; writing chapters of a book; drawings) and inaccurate thoughts and troubling feelings associated with each detail are re-constructed by utilizing the cognitive coping and affective modulation skills learned in the previous TF-CBT components (Cohen et al., 2006).

In order to review educational information, share the trauma narrative, and promote more open and healthy communication between the caregiver and the adolescent, TF-CBT employs a conjoint child-parent session component. In this component, the adolescent is expected to share their finished trauma narrative while the caregiver actively listens to and is supportive of the adolescent. Both parties are prepared by practicing and engaging in role-plays to make them emotionally ready for these

conjoint sessions (Cohen et al., 2006). Therapists use their clinical judgment to determine how many conjoint sessions are needed and whether the caregiver is emotionally ready to be supportive and respectful of the adolescent's narrative. Finally, the enhancing future safety and development component is incorporated as a way to teach adolescents and their caregivers the skills to increase their self-efficacy and preparedness and decrease the likelihood of future victimization (Cohen et al., 2006). These sessions often involve the development of a safety plan and use of personal safety skills (e.g., in the case of community violence, the creation of a map to and from school that delineates safe and unsafe areas to walk, phone numbers of people the adolescent can call in case of an emergency, and strict curfew rules).

In the current study, a culturally-modified version of TF-CBT was used with Latina adolescents and their caregivers. In order to set the stage for why culturally-modification of interventions is necessary for Latino populations, a closer exploration of culturally-sensitive practice is provided. The next section is meant to help the reader understand this concept and illustrate how some EBIs can be transformed into culturally-sensitive interventions.

The Process of Cultural Adaptations of Evidence-based Interventions

As stated earlier, the need and demand for EBIs has grown over the past 15 years as professional organizations have sought to increase the effectiveness and accountability for their work. However, despite this increased emphasis, fewer than 10% of clinicians are likely to use an EBI as part of their practice (Cusworth Walker et al., 2013). Cusworth Walker et al. (2013) asserted that one of the reasons for the underutilization of EBIs is their perceived lack of cultural sensitivity. As Griner and Smith (2006) stated, most EBIs

were largely derived from Western cultural values and beliefs and may represent a cultural mismatch with clients of different cultures. In order to maintain fidelity to the implementation of EBIs, it is imperative to understand how to strike a delicate balance between culturally-sensitive practice and maintaining the integrity of EBIs.

McKleroy et al. (2006) described cultural adaptation of interventions as "the modification of key characteristics, elements, and methods of delivery while maintaining the core elements and theory of the intervention" (p. 379). Similarly, Bernal et al. (2009) described cultural adaptations of EBIs as "the systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (p. 362). As such, these cultural adaptations are multifaceted in nature and require the exploration of a variety of dimensions before, during, and after therapy. For example, the Ecological Validity and Culturally Sensitive Framework created by Bernal, Bonilla, and Bellido (1995) was created to achieve cultural sensitivity in intervention research. This model promotes the examination of the following eight dimensions: (a) language (culturally appropriate use of language); (b) person (role of ethnic/racial variables between the therapist and the client); (c) metaphors (symbols and concepts of the client); (d) content (knowledge of the client's culture such as values, traditions, social and political variables, etc.); (e) concepts (intervention components consonant with the client's culture and context such as dependence vs. interdependence); (f) goals (support of positive and adaptive values already existing within the client's culture); (g) methods (cultural adaptation of the methods in the intervention such as use of language as formal or informal, reframing of drug abuse, and use of *cuento* [folk tales] therapy); and (h)

context (consideration of economic and social context when assessing the client such as acculturative stress, phase of migration, developmental age, and social supports).

The Ecological Validity and Culturally Sensitive Framework has been applied in a few studies to guide cultural modifications to EBIs (Matos, Torres, Santiago, Jurado, & Rodriguez, 2006; Nicholas, Arntz, Hirsch, & Schmiedigen, 2009; Rossello & Bernal, 1999) and it provides a helpful process for understanding how culturally-modified interventions can be developed. For example, Nicholas et al. (2009) utilized the Ecological Validity and Culturally Sensitive Framework to culturally-modify an intervention manual and protocol for use with Haitian-American adolescents. A team of clinicians and researchers facilitated multiple focus groups with clinical and non-clinical adolescent groups and gathered their opinions about the manifestation of depression symptoms among Haitian adolescents, their perceptions of how depression develops; and their ideas about how the symptoms should be treated. Additionally, the adolescents were asked about perceptions of barriers to mental health treatment, challenges mental health professionals may face with this population, and they were asked to evaluate each component of the intervention using the eight elements of the Ecological Validity and Culturally Sensitive Framework. In sum, the Ecological Validity and Culturally Sensitive Framework calls for ongoing acquisition of information from the targeted population to develop and revise the cultural adaptations of interventions.

One example of a culturally-modified intervention is the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) Program. The CBITS intervention is based on the TF-CBT model and is designed to reduce symptoms of PTSD, depression, and behavioral problems with students in 5th to 12th grade. This intervention has been

modified for use with ethnically diverse children and adolescents by collaborating with community organizations (e.g., community stakeholders, faith-based organizations, school personnel, liaisons with cultural knowledge and expertise, and parents of ethnically-diverse children and adolescents) in program development, planning, and delivery (Ngo et al., 2008). For example, Ngo et al. (2008) conducted planning meetings with parents, community leaders, and lay health workers and listened to the needs of the community prior to implementing the CBITS program. The authors used what they learned at these planning meetings to adapt how they introduced the concept of trauma and trauma intervention in the school and they tailored the intervention for African-American, Latino, and Native American children. For example, clinicians included culturally-relevant people, materials, and concepts within the program to increase engagement and clinical utility. In one instance, CBITS clinicians have encouraged some Native American groups to burn sweet grass during relaxation exercises.

The CBITS program represents one example of the process of adapting an intervention to meet the unique needs of ethnically diverse children, adolescents, and their families. As noted, the process of culturally-tailoring an intervention is multifaceted in nature, and requires the exploration of a variety of dimensions before, during, and after therapy. Trauma-Focused Cognitive Behavioral Therapy has undergone a similar process and it is presented next.

Culturally-Modified Trauma-Focused Treatment (CM-TFT)

Culturally-Modified Trauma-Focused Treatment (CM-TFT) is a culturally modified version of TF-CBT that was developed specifically for the Latino population. This version of TF-CBT was culturally-modified by utilizing the theoretical (Ecological

Validity and Culturally Sensitive Framework created by Bernal et al., 1995) and practical

quantitative and qualitative research on trauma-focused interventions with Latinos (de

Arellano et al., 2012). As de Arellano et al. (2012) described, CM-TFT was developed by

facilitating multiple focus groups with Latino caregivers from different geographic

regions of the United States and representing various nationalities, socioeconomic

statuses, and immigration statuses. Providers who serve Latino families were also

included in these focus groups, with the goal of determining the acceptability of various

cultural values and beliefs that are considered important to Latinos. These cultural values

and beliefs were then further refined to increase cultural relevance and effectiveness.

Once refined, the cultural values and beliefs were field tested with a variety of Latino

families by interweaving them throughout the entire intervention according to which

cultural values and beliefs were most relevant to the families. These cultural

modifications were used to increase engagement, attendance, and facilitate a decrease in

symptoms.

   The following cultural values were gathered from the multiple focus groups

facilitated by de Arellano who then incorporated them into CM-TFT. As introduced in

Chapter I of this dissertation, these constructs included: *machismo*; *marianismo*;

familismo; *personalismo*; *fatalism*, *dichos y cuentos*; and spirituality. These values were

used according to the needs and culture of the family. For example, the cultural value of

familismo could be incorporated by inviting extended family members to share

information for the assessment portion of the intervention. By doing so, the therapist

could send the message that the focus of intervention was on the family as much as it was

on the individual client. As a result, family members may feel more welcomed to participate in the intervention process.

While the CM-TFT intervention has already been culturally-modified for use with Latino groups, this does not mark the end of the cultural-modifications. Instead, the use of culturally-sensitive assessment strategies coupled with cultural competence on the part of the therapist is still needed to further inform the treatment process. In this study, cultural constructs were further explored in order to understand the process of individualizing cultural modifications to each family.

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**Mental Health and Acculturation of
Immigrant Populations**

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The dynamic acculturative process of immigrant adolescents and their families has far-reaching implications on their adjustment and mental health outcomes in the United States. In 2010, the foreign-born U.S. population totaled 13% (U.S. Census Bureau, 2012) and 24% of the total U.S. population under the age of 18 had at least one immigrant parent (Batalova & Terrazas, 2010). This population faces unique social challenges such as exposure to traumatic experiences as part of their pre-migration experiences (Smokowski, Rose, & Bacallao, 2008), and continued exposure to high risk environments because of lack of access to proper health care, unemployment, living in poverty, crowded housing conditions, discrimination, and exclusionary federal legislation mandates, especially those for undocumented immigrants (Center for Health and Health Care in the Schools, 2011). The challenges that immigrant adolescents may face within the schools include high dropout rates, lack of access to high quality instruction, decreased school resources, and overall lack of programming and experienced mental health professionals who are trained to effectively address their needs (Feldman et al.,

2013). Consequently, many immigrant families are continuously confronted with great difficulties that hinder their positive adjustment to a new life and overall positive mental health.

Certain groups of Latino immigrant and non-immigrant youth are at an increased risk of experiencing single or multiple traumatic events (de Arellano et al., 2012). Some factors that increase the likelihood of experiencing a traumatic event include living in high-poverty areas where exposure to community violence is more likely, being a part of single-parent families or families where substance-use may be prevalent, and living in neighborhoods with increased anti-immigrant attitudes that make discrimination and hate-crimes more probable (Bernal & Saez-Santiago, 2006). Exposure to violence prior to, during, and/or after migration also increases the likelihood of traumatic events. Using a sample of 1,004 recently immigrated (e.g., within the previous 3 years) children in Grades 3-8, Jaycox et al. (2002) sought to understand exposure to violence, emotional distress in the form of PTSD and depressive symptoms, and patterns between these two variables. Almost half (48%) of the sample had immigrated from Mexico, 15% from El Salvador, 10% from Guatemala, and 14% from unspecified countries in Central and South America. Non-Spanish speaking countries such as Korea, Russia, and Armenia made up the remaining 12% of the sample. Using the Life Events Scale as a measure for community violence exposure, the authors found that about 49% of the children sampled had experienced a violent victimization and 80% reported witnessing violent events in the previous year. Moreover, 32% of the children sampled scored in the clinical range on the Child PTSD Symptom Scale (Foa, Cashman, Jaycox, & Perry, 1997) and the authors found strong correlations between violence exposure and all three clusters of PTSD

symptoms (using DSM-IV-TR PTSD criteria) as well as depressive symptoms. This study was the one of the first to empirically document the relationship between high rates of violent exposure and PTSD and depressive symptoms.

The Influence of Culture on Mental Health

Prior to starting a discussion about acculturation and mental health of immigrant adolescents, it is imperative that a working definition of culture be provided as so many potential definitions exist in the literature. Canino and Guarnaccia (1997) defined culture as a social construction that structures human thought, emotion, and interactions and provides guidelines for dealing with challenging life events, including illnesses. Canino and Roberts (2001) echoed this definition, asserting that culture is continuously changed throughout an individual's life by social processes and interactions such as migration and acculturation, and is the outcome of an individual's life experiences combined with group values, norms, and experiences.

Lopez, Kopelowicz, and Canive (2002) asserted that many definitions of culture misrepresent it as "static or fixed . . . generalized value orientations or behaviors" (p. 63). On the contrary, culture is an ever changing aggregation of beliefs, values, attitudes, predispositions, and norms held in every community and encompassing every individual in society (Pescosolido, 2007). Consistent with these different definitions, culture is one of many factors that determine how individuals experience mental illness, seek treatment, and adhere to and follow recommendations for the treatment. In sum, these definitions of culture were chosen for this study because of the emphasis placed on the continuous and dynamic nature of this construct. As it applies to recently migrated Latino adolescents

and their families, this emphasis is important to understand as it relates to developmental aspects of adolescents and the acculturation process of this unique population.

Understanding adolescents in a culturally-sensitive manner requires exploring their own and their family's culture, levels of acculturation, and how these variables impact their perceptions of the world (Fontes, 2005). Culture impacts the way in which adolescents are affected by trauma and this is especially true for immigrant families who have been traumatized as a result of the migration experience. The result of intergenerational traumatic experiences can affect the way in which families cope with their adolescents' trauma and the way in which they react toward people offering treatment to them (Chadwick Center for Children and Families, 2009). Harmon et al. (2006) argued that culture impacts the beliefs a family has regarding the etiology and origin of the disorder, why and when a family seeks treatment, whom they trust for their services, and even which treatments are acceptable to use.

Culture may also serve as a protective and strength factor for the family. For example, some Latino groups hold the cultural value of *familismo* (e.g., familism) very strongly. This worldview may be manifested in a shared sense of responsibility for caring for children, providing financial and emotional support to family and close friends, and sacrificing for the welfare of the group (Santiago-Rivera et al., 2002). To illustrate, Frauenglass, Routh, Pantin, and Mason (1997) found that a strong sense of familismo was associated with lower levels of substance use (e.g., tobacco, marijuana, and alcohol use) among Latino adolescents. Lopez et al. (2004) found that expression of warmth in Mexican American families, but not European-Americans, was a protective factor against relapse. In some, holding and utilizing this knowledge was a key to building a stronger

alliance with the family and increasing the likelihood of continued engagement in the intervention.

Culture influences the way in which symptoms develop, present, and are reported (Cohen et al., 2006). For example, the core value of familismo that some Latino groups may hold emphasizes seeking help within the family and discourages them from seeking help outside of the family (de Arellano et al., 2012). Culturally-competent clinicians are aware of and ready to modify their ways of offering an intervention to accommodate for these cultural differences. Another example may be in the way in which a Latino family views the etiology of an adolescent's symptoms. Often, there is a focus on the physical origins of symptoms such as the stomachache that may come with anxiety rather than the emotion of fear. If the therapist insists on pursuing the psychological origins of the symptoms, she may begin to be at odds with the family and it is unlikely that the family will adhere to intervention recommendations. Further, the client and therapist are unlikely to build a strong alliance or feel satisfied with the intervention. Understanding the ways in which a clinician can utilize culture within a strength-based approach delineates the construct of cultural competency (Chadwick Center for Children and Families, 2009).

Exploring the ways in which trauma disorders are viewed and developed in other cultures is important to consider. In particular, the ethnocultural variations across the different factors of trauma disorders (e.g., onset, manifestation, course, and outcome; Marsella, 2010) deserves a deeper exploration. The very definition of trauma and its related manifestations demands acknowledgement of the existence of Western assumptions about trauma and PTSD and its rootedness in the medical model of the disorder (Marsella, 2010). As it stands today, the biopsychosocial response to traumatic

events (e.g., the brain, central nervous system, and other hormonal processes being

activated and responding through the fight, flight, or freeze response) and the

neurobiological responses to repeated traumatic memories appears to be universal

(Marsella, 2010; Van Rooyen & Nqweni, 2012). However, non-universal elements have

been identified in the literature, such as the degree to which a person denotes an event as

traumatic (e.g., the criteria of "exposure to actual or threatened death" delineated in the

DSM 5 may not apply to cultures that perceive the destruction of religious symbols and

buildings as traumatic events; Terheggen, Stroebe, and Kleber, 2001). Also, the ways in

which avoidance and numbing behaviors are manifested is also culturally and socially

mediated, as some societies living under chronic stress and trauma cannot avoid and

hence, learn to function in the environments they live in. Tearfund (2007) notes that

every culture provides its members with a variety of verbal and non-verbal behaviors

with which to express distress and suffering and some behaviors differ significantly from

Westernized behaviors (e.g., emotional expression, help seeking behaviors). Overlooking

these culturally-influenced distress languages may contribute to the misunderstanding of

trauma symptoms across cultures.

In many cultural groups, the experience of PTSD symptoms are categorized into

specific local cultural symptoms (e.g., *ataque de nervios* ["attack of nerves"] is

characterized by intense emotional upset including anxiety, anger, grief, and can be

accompanied by screaming and shouting uncontrollably and attacks of crying and

trembling; APA, 2013). In their 2011 article, Hinton and Lewis-Fernandez noted that

there is some evidence that the DSM-IV-TR PTSD category was valid cross-culturally as

this group of symptoms occurred among many diverse cultural groups. However, the

experience and expression of PTSD symptoms is not identical across cultures. For example, increased reporting of avoidance, numbing, and somatic symptoms exist in some cultural groups. Hence, an understanding of how symptom expression varies across cultures is imperative to understanding an individual's experience with the disorder.

In recognition of this different meaning and expression given to trauma, "mental health practitioners have a moral and ethical responsibility to provide effective interventions to all clients by explicitly accounting for cultural contexts and cultural values relevant to clients' well-being" (Griner & Smith, 2006; p. 531). Cultural insensitivity on the part of the therapist and/or mental health agencies have been posited as the single most important reason for underutilization of services by culturally and linguistically diverse (CLD) clients. Higher dropout rates are often the result of the therapist's inability to incorporate culturally sensitive practices within therapy (Gelso & Fretz, 2001). Because counseling and psychotherapy theories and interventions have been largely developed from the cultural beliefs of upper and middle-class European-Americans (Griner & Smith, 2006), these cultural beliefs and values may not be compatible with some ethnic minorities (Sue, 1998). Misunderstanding these culture-driven variables may give the perception that services are insensitive to the clients' needs (Santiago-Rivera, 2002; Sue, Zane, Nagayama Hall, & Berger, 2009; Zane et al., 1994).

**Acculturation Process and
Mental Health**

The process of positive adjustment is mediated by a construct called acculturation. Acculturation is a process that immigrants experience after coming into contact with two or more cultures (Berry et al., 2006). As immigrant adolescents and their families experience this process, their identities, attitudes, cultural values and beliefs become

influenced by the cultural values of the host country. Their eventual cultural adjustment into the host country depends on a variety of psychological and sociocultural factors that may facilitate or hinder their ability to function with daily life demands (Berry et al., 2006). Psychological factors may include individuals' sense of personal and cultural identity, mental health status, and their belief that they can achieve personal satisfaction in their host country. Sociocultural factors may include individuals' ability to cope with external factors, as shown by their capacity to solve problems related to school, family, and society (Berry, 1997). Marin (1992), a pioneer in the study of acculturation among Latinos, described the process of acculturation as:

> A process of attitudinal and behavioral change undergone . . . by individuals who reside in multicultural societies (e.g., the United States, Israel, Canada, and Spain), or who come in contact with a new culture due to colonization, invasion, or other political changes. (p. 236)

An important factor in understanding the process of acculturation is the host country's multicultural ideology (Berry, 1997). Berry explained that when host countries are accepting of cultural diversity and embrace it as an opportunity to share values and resources, a more positive adjustment is likely to occur. In contrast, host countries may seek to devalue cultural diversity by embracing assimilation programs that enforce the dominant culture's values and ideals, which may segregate and even marginalize certain cultural groups. Perceived discrimination, a probable outcome of the host country's assimilation strategies, has been shown to be negatively related to positive adaptation (Berry et al., 2006). Moreover, while adapting to the cultural, linguistic, and academic demands of the host country, factors such as family separation and risk for psychopathology (e.g., history of significant trauma) may further hinder their positive adjustment. As related to trauma-focused interventions, employing strategies that create a

sense of acceptance by embracing aspects of an adolescent's culture are likely to yield more positive mental health adjustment in Latino immigrant adolescents and their families.

Acculturative stress stems from an individual's problematic adjustment to the host country. Specifically, these problems may arise from incongruent cultural values, difficulties mastering the language, discrimination (Yeh, 2003), mental health problems, and a clash between the individual's systems. For example, some immigrants who flee their country because of ethnic discrimination and violence (e.g., indigenous Guatemalans) may find themselves being discriminated against in their new neighborhoods and/or schools. The social losses (e.g., social networks, family ties, social status), and environmental stressors (e.g., financial and housing difficulties, intergenerational conflict) that frequently occur as adolescents migrate to a different country further contribute to the experience of acculturative stress (Cabrera, Villarruel & Fitzgerald, 2011).

Acculturative stress among immigrant adolescents has been linked with a variety of mental health risks. For example, meta-analysis of studies related to suicide rates among adolescents revealed higher rates of suicidal ideation and attempts for Latino youth than for either European Americans or African Americans (Canino & Roberts, 2001). Canino and Roberts (2001) explained that higher familial conflict, discrimination experiences, fewer life opportunities, and difficulties mastering the English language exacerbate the likelihood of suicide in this population. Acculturative stress, especially experiencing discrimination, has also been linked with higher rates of depression in Mexican American adolescents, and United States-born adolescents of Cuban, Mexican,

and Nicaraguan origin (Cabrera et al., 2011). Clearly, acculturative stress among immigrant adolescents can take a significant toll in the mental health wellbeing of this population.

In their discussion of differential rates of suicidal behaviors, Canino and Roberts (2001) warned about generalizing study findings to all Latino groups, as this would be conceptually and practically inappropriate. Specifically, the pressures, social formations, and historical reasons for migration give each Latino group a different dimensionality that makes them unique from each other. Each of these aspects affects the way in which Latino groups are viewed and treated in the United States and may shape the way in which their social emotional struggles present. Therefore, attending to inter- and intracultural differences among Latino subgroups provides a richer and more meaningful understanding of their unique experiences. This point calls for the further individualization of interventions that have already been culturally-modified.

Another aspect of acculturative stress involves fear of deportation due to the undocumented status of many immigrant families. The deportation of undocumented immigrant families has left many of them torn apart without warning. Cabrera et al (2011) stated that the current United States immigration system leaves many vulnerable immigrant adolescents orphaned and placed under the custody of familiar or unfamiliar individuals who may not know how to act in the best interest of this group. Unfortunately, many of these adolescents become runaways or "youth in street" (p. 5). The existing mental health statistics for this population estimate that about 30% of these adolescents experience major depressive symptoms, 46% have attempted suicide, and 27% to 36 % reported that they struggled with PTSD symptoms (Cabrera et al., 2011).

Another variable at play in immigrant adolescents' adjustment in the United States are parent-child acculturation gaps, which occur when parents and their adolescents acculturate at different rates to the culture of the host country. Acculturation gaps have been found to increase familial stress and parent-child conflict (Smokowski et al., 2008; Stevens & Vollebergh, 2008; Szapocnik & Kurtines, 1993) and have been regarded as a risk-factor for mental health problems. As it relates to trauma, parent-child acculturation gaps can increase the level of stress that the traumatized youth experiences if the parent and child view the same traumatic event differently (de Arellano & Kmett Danielson, 2008). For example, a father who holds marianismo as a cultural value may believe that his sexually abused adolescent daughter is not pure anymore due to her lost virginity; a Latino adolescent suffering from anxiety may feel embarrassed of being seen with his less-acculturated parents or heard speaking his native language. In both of these examples, the clinical symptoms are exacerbated by acculturative issues that can be missed if the therapist is not aware of the level of acculturation of the parent and the adolescent (Harmon et al., 2006).

As immigrant adolescents experience the process of acculturation, they will begin to form their multidimensional ethnic identity, which was first defined by Tajfel (1981) as "that part of an individual's self-concept which derives from his knowledge of his membership of a social group (or groups) together with the value and emotional significance attached to that membership" (p. 255). As implied by this definition, ethnic identity is multifaceted and differs according to the developmental level of the individual. As related to mental health, it is important to understand how the experiences of adolescents prior to and after migrating to the United States affect the way their ethnic

identity forms. By understanding how acculturation and adjustment problems inform the development of ethnic identity, we can better understand this cultural aspect of mental health problems in this population. Additionally, understanding the ethnic identity of adolescents affected by trauma may better inform a more culturally-sensitive intervention approach.

Ethnic Identity and Mental Health

Adolescence marks a sensitive period for identity development (Umaña-Taylor, Diversi, & Fine, 2002) and it has long been considered a cornerstone to psychological well-being (Smith & Silva, 2011; Umaña-Taylor et al., 2002; Umaña-Taylor, Gonzalez-Backen, & Guimond, 2009). In this stage, adolescents tend to explore, establish, and eventually commit to a certain personal and social identity (Erikson, 1968; Kiang, Witkow, Baldelomar, & Fuligni, 2010). The development of ethnic identity, which is one aspect of identity formation, was defined by Phinney (2000) as "a central defining characteristic of many individuals, particularly those who are members of minority . . . groups" (p. 256). As adolescents become more aware of whom they are in relation to their social groups, the process of identity development leads them to explore their family's ethnic and cultural origins (Phinney, 2003). Research suggests that in minority populations, ethnic identity formation appears more challenging due to being identified with a less powerful group, confronted with negative stereotypes, and discrimination (Umaña-Taylor et al., 2002) among others. Since ethnic identity is important to the development of self-esteem, sense of belonging, optimism, academic motivation, and positive adjustment (Roberts et al., 1999; Umaña-Taylor et al., 2002), the concept of

ethnic identity is important to understand when creating and implementing a culturally-informed trauma-focused intervention with Latino adolescents.

Several ethnic identity models have been created to understand how immigrants live in their new intercultural settings. The work by Phinney (1990) and Berry (1997) has resulted in the emergence of a bidimensional conceptualization of acculturation. Mainly, this bidimensional model emphasizes the degree to which individuals maintain their original cultural identities and the degree to which they adopt the culture of their host country as their own. This bidimensional approach provides four different ethnic identities that convey how the individual may be acculturating to their host country. *Assimilation* occurs when individuals become interested in adopting the host country's culture and not in maintaining their original cultural identity. *Separation* occurs when individuals do not wish to adopt the host country's culture but instead maintain their original cultural identity. *Marginalization* occurs when the individuals do not wish to maintain their original cultural identity or adopt the host country's culture. Finally, *integration* (i.e., biculturalism) occurs when both cultures are maintained and individuals become psychologically and sociologically involved within the host country (Berry et al., 2006).

Although much of the research on acculturation styles and adaptability of immigrants has occurred with adult immigrant populations, Berry and colleagues (2006) have studied this area with adolescents 13 to 18 years old. Their sample pool included 7,997 youths from 26 different cultural backgrounds who lived in 15 different countries. The authors concluded that youth who fit the integration/bicultural style tended to adapt more positively than any other acculturation style, as evidenced by their healthier

psychological and sociocultural adaptation. This finding was found to be consistent with the existing literature on adult acculturation and adaptation (Berry, 1997). While youth in the integration style experienced more positive adaptation, 22% of their sample fit the diffuse style, which is characterized by lacking a sense of purpose in life and being socially isolated (Berry et al., 2006). In their study, those who fit the diffuse profile indicated that they experienced higher levels of discrimination and had shorter length of residence in the host country. Hence, the authors concluded that experiencing discrimination may be involved in rejecting close involvement with the host country as well as their original culture, and this outcome is influenced by the individual's length of residence. Taken together, these findings could be used to promote mental health initiatives that encourage immigrant youths and their families (especially those who have been in the host country for less than three years) to maintain and integrate their original ethnic culture with the host country's traditions. The integration of the two (i.e., biculturalism) is likely to promote a sense of belongingness and meaning in both cultures and decrease the sense of alienation and hostility from either culture (Berry et al., 2006).

A consistent finding in the literature is the positive relationship between biculturalism and self-esteem across different ethnicities. In their acculturation study of 1,119 Latino high school students, Carvajal, Hanson, Romero, and Coyle (2002) found that the students fitting the bicultural group tended to display more positive mental health outcomes than students who aligned with the marginalized ethnic identity. In other words, adolescents who integrate their culture of origin with the culture of the host country tend to display greater self-esteem, stronger social skills, and psychological well-

being. All of these factors contribute to resiliency against psychological vulnerability, including PTSD.

Understanding the acculturative process of Latino adolescents and their families as well as the importance of individualized culturally-informed interventions is a critical step toward cultural competence. However, possessing this knowledge may not be enough to increase the therapeutic engagement and attendance of adolescent Latinos. As Shirk et al. (2011) argued, working with and successfully retaining adolescents in intervention was challenging for a number of reasons including that they were less likely to self-refer for treatment--and in turn less motivated to participate in therapy. In fact they often minimize the need for intervention or the extent of their psychological problems; their developmental stage brings forth issues related to mistrust of authority and/or adult figures; and they may struggle with behavioral problems that increase the complexity of the intervention. All of these barriers unique to the adolescent years can make engagement in therapy more challenging and decrease the likelihood of successful intervention completion (Bordin, 1979; Russell et al., 2008). Therefore, a strong therapeutic relationship has been hypothesized as more critical in child than adult therapy (Shirk & Saiz, 1992), and has been posited as one of the most critical predictors of therapeutic outcomes.

Working Alliance as a Vehicle for
Increased Engagement and
Attendance

One of the challenges that arise when working with adolescents who have been traumatized is actively engaging them in therapy. For example, persuading them to participate in an intervention where talking about and processing their trauma is core to

obtaining positive outcomes is often challenging. Often times, this unique population may experience an increased distrust and reduced confidence in their parents' and other adults' ability to protect them from danger (Eltz, Shirk, & Sarlin, 1995) because they failed to do so when the trauma occurred. Further, they may not trust the resources provided to them and may be more hesitant to actively participate in therapy due in part to an increased sense of hopelessness and increased interpersonal problems including having difficulty developing and maintaining healthy relationships. It has been hypothesized, then, that experience of maltreatment negatively influences the formation of an alliance and compromises the effectiveness of intervention (Eltz et al., 1995). In working with Latino youth who may already struggle with seeking and receiving mental health services, Kataoka et al. (2002) suggested that it was important to understand how measuring working alliance multiple times over the course of therapy could act as a vehicle to increased attendance and engagement in EBIs.

In his 1979 article on the theoretical conceptualization of the working alliance, Bordin posited that the working alliance between the person seeking change and the person acting as the change agent was "one of the keys, if not the *key* to the change process" (p. 252). While this theoretical conceptualization had its roots in psychoanalytic theory, Bordin (1979) developed the model to fit all other types of therapies by finding the commonalities between them and extrapolating three prevalent factors: mutual agreement on the *goals* of therapy; *tasks* to be carried out by the client and the therapist that were seen as relevant and efficacious; and a *bond* of trust, acceptance, and confidence between the client and the therapist (Bordin, 1979; Horvath & Luborsky, 1993). The strength of this alliance has been shown to have a strong direct relationship to

therapeutic outcomes in the adult, child, and adolescent literature (Bordin, 1979; Russell et al., 2008; Shirk et al., 2011).

Shirk et al. (2011) conducted one of the first rigorous meta-analyses of individual therapy youth alliance-outcomes. Findings of this meta-analysis revealed that alliance was an important predictor of intervention outcome in both child and adolescent therapy and the effect sizes were comparable to those found in the adult literature. Furthermore, the authors found a stronger association between alliance and outcomes in behavioral more so than non-behavioral therapies. This was surprising since some behavioral interventions have focused on specific technical procedures rather than the alliance. The authors recommended for therapists to monitor alliance over the course of treatment.

Lambert and Shimokawa (2011) conducted a meta-analysis of studies that included client feedback methods (such as monitoring the working alliance). Findings of this meta-analysis revealed that rates of client deterioration were cut in half and rates of positive responding increased with the clients who received treatment when client feedback methods were utilized. Furthermore, the authors found that the most positive responding occurred for clients who were at-risk for negative outcomes early in therapy and for the therapists who provided information to the client about the therapeutic relationship, motivation for treatment, social support system, and negative life events. The authors recommended that clinicians employ real-time client feedback to compensate for the therapists' limited ability to accurately recognize client worsening in therapy.

It is well-known that the client-therapist relationship is very important for treatment outcome in child and adult therapy. For example, in a follow-up study with 36 adolescents who had participated in a manualized CBT intervention specific to anxiety

disorders 3.35 years prior, Southam-Gerow and Kendall (1996) sought to find whether previous intervention outcomes were maintained and what components of the intervention were remembered most by the adolescents. Apart from largely maintaining the gains they made during the intervention, findings showed that 47% of the children found the therapeutic relationship as the most important part of their intervention. The authors concluded that their findings support the notion that, similar to adult studies, the therapeutic relationship is perceived as a valuable component of intervention even when using a manualized intervention.

As it related to specific groups of adolescents, Eltz et al. (1995) hypothesized that experience of maltreatment would negatively influence the formation of an alliance and compromise the effectiveness of an intervention. Their sample included 38 inpatient adolescents between the ages of 12 and 18 years. This sample was predominantly White (83%) and all adolescents were treated by therapists who were psychodynamic in their theoretical orientation. The authors found that the development of a therapeutic alliance predicted intervention success and that it was particularly important with adolescents with a history of abuse. Specifically, maltreatment, multiplicity of maltreatment, and type of perpetrator maltreatment were associated with initial alliance difficulties. Moreover, adolescents with higher levels of interpersonal problems and lower interpersonal expectations showed increased difficulties in alliance formation over time. In sum, the formation of a strong therapeutic alliance between maltreated adolescents and their therapists is particularly important. Indeed, the awareness of therapists on these issues throughout therapy is imperative as they attempt to actively address obstacles to the development of a positive alliance.

More recently, Shirk et al. (2008) studied the construct of therapeutic alliance with a sample of depressed adolescents receiving a CBT manualized intervention. Their sample included 54 adolescents, of whom 12 were Hispanic, between the ages of 14-18. Using the Therapeutic Alliance Scale for Adolescents (Shirk & Saiz, 1992), the authors measured the perceived therapeutic alliance of both the adolescent and the therapist, after the third session. In this study, adolescent-reported alliance (as evidenced by self-report and interview) predicted change in depressive symptoms and therapist-rated alliance predicted continuation in therapy, even after controlling for the number of sessions completed. Thus, even when using an EBI, a positive therapeutic relationship is critical for enhancing outcomes and engagement among adolescents. The authors recommended that future research be invested in understanding what factors of the alliance promote or sustain involvement with certain CBT tasks such as homework completion and other active ingredients.

Although it is well-known that the adolescent-therapist alliance is a significant predictor of intervention outcomes, it is surprising that there is a lack of research examining the process variables that are at play during the formation of an alliance (e.g., pre-intervention variables that may make intervention dropout even more likely). Moreover, the research that exists on specific groups of adolescents, such as Latino groups with PTSD symptoms, is even more limited. Therefore, Levin, Henderson, and Ehrenreich-May (2012) attempted to narrow this gap in their study of interpersonal predictors of early working alliance in a manualized CBT intervention with adolescents who were diagnosed with anxiety and depression disorders.

In their sample of 31 adolescents (61.3% Latino, aged 12 to 17 years), Levin et al. (2012) utilized the client and therapist forms of the Working Alliance Inventory-Short form (Tracey & Kokotovic, 1989) three weeks into the intervention. They also used self-report measures of social support, attachment security, and social functioning in their current family and peer relationships prior to the start of the intervention. Findings showed that adolescents tended to rate the alliance more positively than therapists (average of 6 or above on a 7-point scale) and the authors suggested this was likely due to fewer points of reference (only three sessions) from which to judge the quality of the alliance. Moreover, adolescents who perceived their relationships with the caregivers as secure and positive tended to report more positive alliances with their therapists. Overall, these findings suggested that allowing adolescents to rate their alliance more than once during therapy may provide a more accurate picture of the alliance. Furthermore, adolescents with weak social support systems and relationships with others may predispose them to therapeutic alliance problems. With regard to adolescents with symptoms of PTSD, these findings were critical in terms of understanding strategies to recognize, evaluate, and develop a strong alliance and strategies to use with vulnerable client populations.

Norcross and Wampold (2011) provided conclusions and recommendations from the Task Force on Evidence-based Therapy Relationships after having reviewed more than a dozen meta-analyses exploring the field of therapeutic relationships. Among several, some of the practice and research recommendations were: (a) to encourage practitioners to routinely monitor their client's responses to the therapeutic relationship and treatment; (b) to concurrently use evidence-based therapy relationships and

evidence-based treatments that are adapted to the specific characteristics of the client; (c) to encourage therapists to refrain from assuming that they know how their clients are perceiving the therapeutic relationship and treatment, because these assumptions are often times incorrect; and (d) to progress beyond correlational design studies and instead focus on exploring the relationships between patient qualities, clinician behaviors, and treatment outcome.

Conclusion

In summary, this comprehensive review of the literature revealed various gaps in the field of trauma-focused treatments for Latino adolescents. First, it revealed that there is a great need to explore and understand the sociocultural contexts of Latino adolescents and their families in order to fully grasp the call for more targeted research to identify and address their unique treatment needs. Because certain groups of Latino adolescents have been more likely to experience a variety of traumatic events, more practice-based research is needed in the area of cultural adaptations of EBIs. Increased research on how culturally-informed evidence-based trauma treatments have impacted retention and therapeutic working alliance might encourage them as well as their families to become more actively engaged in therapy. In turn, they may derive better outcomes from their mental health interventions.

CHAPTER III

METHODOLOGY

Overview

This study represented an exploration of the interplay between cultural

modifications, working alliance, therapy attendance and completion, as well as

perceptions of the therapeutic process.. Mixed methodology was utilized in this study to

explore how the integration of Latino cultural values throughout treatment influences

working alliance, therapeutic engagement, and treatment outcomes among adolescents

with a history of trauma. Both process and outcome variables were monitored through

quantitative and qualitative measures with the goal of understanding how individualized

cultural modifications made to TF-CBT used with Latina populations influenced

retention and engagement in therapy.

Mixed Methods

In this study, I utilized a mixed-methods multicase design to explore the

experiences of Latina adolescent high school students and their caregivers as they

participated in CM-TFT. Creswell and Plano Clark (2011) defined mixed methodology as

follows:

> Mixed methods research is a research design with philosophical assumptions as
> well as methods of inquiry. As a methodology, it involves philosophical
> assumptions that guide the direction of the collection and analysis of data and the
> mixture of qualitative and quantitative approaches in many phases in the research
> process. As a method, it focuses on collecting, analyzing, and mixing both

quantitative and qualitative data in a single study or series of studies. Its central premise is that the use of quantitative and qualitative approaches in combination provides a better understanding of research problems than either approach alone. (p. 5)

Through the work of Greene, Caracelli, and Graham (1989), five reasons emerged for choosing mixed-methods designs: (a) triangulation, (b) complementarity, (c) development, (d) initiation, and (e) expansion. Triangulation refers to the convergence of results from different data collection methods (quantitative and qualitative methods); complementarity explains the enhancement and illustration of constructs through the results of different data collection methods; development describes the use of one method of data collection to inform the use of the other method of data collection; initiation refers to the discovery of new perspectives and ideas as a result of using a different method to answer previously unanswerable questions; and expansion refers to the extension of the breadth and range of knowledge by using different methods for different knowledge bases (Creswell & Plano Clark, 2011). In this study, all five of these elements were integrated into the general framework of the study and helped to guide data collection and analysis procedures.

The construct of pragmatism was also especially useful in this study. Pragmatism is the idea that multiple quantitative and qualitative paradigms can be collected to form a complementary knowledge-base that aids in holistically understanding a certain phenomenon. Within the combination of quantitative and qualitative data, a previously undetected phenomenon may be discovered and the "what works" factor can be better explained (Geist & Lahman, 2008). Through the use of mixed-methods and with special focus on pragmatism, I sought to balance the weaknesses that cloud the results of the purely quantitative research designs often used in the existing TF-CBT literature and

shine light onto the process of culturally modifying and implementing an EBI (i.e., TF-CBT) with Latina high school students and their caregivers (in this case, their mothers). Besides balancing out the weaknesses of purely quantitative or qualitative designs, mixed-methods studies are useful in answering seemingly unanswerable research questions through the collection of data that can answer both open-ended and close-ended research questions. These data may take the form of numeric ratings on instruments or measurement scales, individual or focus group interviews, observations, and artifacts (Geist & Lahman, 2008).

Design Rationale

A mixed methods multicase design was selected as the preferred methodology for this study because it was thought that qualitative data alone would not provide a sufficient depth of understanding of the student and the mother's experiences with CM-TFT. The depth of these experiences was enhanced through the use of case study research, which is esteemed for its ability to describe complex action, perception, and interpretation (Merriam, 2009). The knowledge gathered from these case studies was naturally more concrete and contextual. The rich descriptions presented in this study were gathered from multiple bounded systems (i.e., Latina adolescent and their mothers who have struggled with PTSD symptoms) whose life experiences are embedded within the context in which they occurred. More specifically, a particularistic approach was used in this study (Merriam, 2009), in which I focused on a specific sample of participants to provide more insight into practical problems with Latina adolescents, their mothers, and the use of EBIs to treat trauma. In order to expand the knowledge of the usefulness of culturally modifying EBIs with Latina adolescent populations, it was imperative to gather

data from a collection of cases from which compelling and evocative interpretation could be made. Most importantly, the inclusion of multiple rather than single case studies enhances the external validity of the findings (Merriam, 2009).

Creswell and Plano Clark (2011) described six different mixed-methods designs that facilitate the priority, collection, and analysis of the data gathered: (a) convergent parallel design; (b) explanatory sequential design; (c) exploratory sequential design; (d) embedded design; (e) transformative design; (f) and the multiphase design. Due to the primarily qualitative orientation of this study, an embedded mixed-methods case study approach fits best with the multicase design because quantitative strands of data (e.g., PTSD rating scale, working alliance measure, ethnic identity measure, traumatic immigration events, as well as attendance and informal grade records) were collected prior to, during, and after the intervention to answer secondary research questions and augment the meaning of the primary qualitative data collected. In essence, both of these sources of data provided a more complete and meaningful picture of the Latina adolescents prior to, during, and after intervention. One of the assumptions of embedded designs is that a single type of data set is not sufficient to answer the research questions and that the different types of research questions require different types of data (Creswell & Plano Clark, 2011). In this study, the exploratory nature of how Latina adolescents and their mothers experience the intervention set the stage for a qualitative approach. The confirmatory nature of whether Latina adolescents treated with CM-TFT experienced a decrease in PTSD symptoms warranted quantitative methods as well. A blend of quantitative and qualitative data were used to assess the process of therapy; working alliance ratings and therapist journaling were integrated to observe the potential interplay

between cultural modifications and client engagement. Hence, the use of this embedded design provided the necessary framework and logic that guided me through the process of data collection and analysis to ensure that my results were rigorous, persuasive, and of high quality.

Researcher Stance

As I was the primary instrument of intervention delivery, information collection, and data analysis in this study, it is necessary for me to provide information about myself and my social context in relation to the participants of this study. In doing so, readers are better able to understand how my social background and upbringing may have influenced the ways in which I utilized my culture and upbringing in therapy, the lens through which I viewed the participants, and the framework from which I analyzed and made meaning from these data.

As a Venezuelan immigrant, I have been interested in diversity issues since I arrived to the United States at the age of 13. Having a first-hand experience of the loss of friendship, family, and cultural ties that happen as a result of immigration has put me in the unique and powerful position to understand, empathize, and advocate for families with similar situations. For example, as a Venezuelan, cultural values such as *personalismo* and *familismo* are second-nature to me and are therefore easy for me to integrate inside and outside of therapy. However, I also recognized that many aspects of my upbringing are different between me and the participants such as differences in socioeconomic status, education, acculturation, and nationality. These contextual variables offer rich and extensive value to understanding the systems in which the participants functioned and avenues to effective intervention. In these cases, it was

imperative for me to acknowledge that while I am familiar with certain aspects of some Latino groups, each and every case brought forth unique experiences, values, and perspectives that were different from my own. Using my clinical supervision time to bring forth said issues was fundamental to recognize the interactions that occurred as a result of cultural differences and to adapt the way in which I approached interventions with them.

Once in graduate school for my PhD in school psychology, my interests for the delivery and cultural modification of EBIs to reach underserved populations, particularly the Latino community, reached a deeper personal and professional level. I have worked with traumatized Latino adolescents and through this work I have become keenly aware of the multitude of barriers that many of these families face when seeking mental health treatments. These experiences prompted me to become trained in TF-CBT and play an active role in researching how to make best practices more culturally sensitive and deliver interventions that are likely to make a significant and lasting impact in the lives of Latino adolescents, their families, and the larger community.

Methods

Context and Participants

In this study, four Latina participants were recruited from Andres Bello High School (this is a pseudonym chosen to protect the identity of the participants and school). According to data provided by the 2012 U.S. Census Bureau, the city in which Andres Bello High School is located has a population of 45,913 residents. During the time frame of this study, the ethnic composition of the school district was 83% Latino and the district was considered to be high-poverty school because 23% of students were living below the

poverty line. Additionally, there was a 31% mobility rate and about 10% of students were considered homeless. Further, an estimated 17% of adults living within this district's boundaries had less than a ninth-grade education and 40% had not earned a high school diploma. Finally, graduation rates for this district were below state averages at 52% and there was a 25% teacher turnover rate.

Andres Bello High School's student population was approximately 77.9% Latino, 19.5% White, and 2.7% African American. This school is a standards based alternative school located at an intersection of a busy and crowded street with a police station located next to the building. At the time of the study, this school contracted with a school-based mental health therapist four days of the week who was not trained in TF-CBT. This site was chosen for this study because of the large Latino population within this school, the high needs of the student body, the high risk community in which the adolescents and their families lived, and the lack of evidence-based trauma-focused treatments being offered. Additionally, I had developed a working relationship with the staff after completing a one-year externship. This close relationship enabled me to obtain buy-in from school administrators and staff.

A unique purposeful sampling method (Merriam, 2009) was used to select the Latina adolescent participants of this study. This type of sampling method was used because adolescent participants needed to meet specific criteria in order to be included in this study. Participants of this study included four Latina students (one was first generation, two were second generation, and one was third generation) who were between the ages of 16 to 18 years old with a history of exposure to at least one traumatic

experience such as exposure to domestic and community violence, sexual abuse, immigration-related traumatic events, among others.

In order to qualify for inclusion into this study, Latina adolescent participants also had to have experienced distressing symptoms of PTSD without necessarily meeting the full criteria for PTSD. Specifically, all participants had to have reported symptoms of PTSD with at least one symptom from criteria B (intrusion), C (avoidance), D (negative alterations in cognitions and mood), and E (marked alterations in arousal and reactivity). However, participants who presented with more than five symptoms in less than four criteria clusters (e.g., two symptoms in criteria B, 1 symptom in criteria C, 1 symptom in criteria D, but 0 symptoms in Criteria E), were also included in the study. In addition to DSM-5 criteria, instrumentation was used to help make this determination (see below). Due to the limited amount of case management resources, adolescents and caregivers who had active psychotic symptoms, developmental disabilities, and/or active substance abuse problems were excluded from this study.

All Latina adolescents that were recruited for this study were given the choice to include at least one caregiver in the intervention as well as the study. If the adolescent refused to include a caregiver, this decision was honored and no caregiver was included. In the current study, two out of the four participants agreed to include a caregiver in the treatment and both of the caregivers were mothers. No incentives were provided to any of the participants. A brief introduction to each of the participants (with pseudonyms) is provided below.

Ana and Laura. Ana (17 years old) and her mother, Laura, were participants of the current study. Ana was in the 12th grade at Andres Bello High School. Ana was born

in the United States (second generation immigrant) and spoke English and Spanish fluently. Her mother, Laura, was born in Mexico and also spoke English and Spanish fluently.

Gaby and Karina. Gaby (17 years old) and her mother, Karina, were also participants of the current study. Gaby was born in the United States (third generation immigrant) and spoke English fluently; she understood Spanish but could not speak it fluently. Her mother, Karina, was born in the United States and spoke English and Spanish fluently.

Valeria. Valeria (18 years old) chose to participate in the treatment on her own, despite living with her mother and siblings. Valeria was in the 12th grade at Andres Bello High School. She was born in the United States (second generation immigrant) while both her mother and father were born in Mexico. Valeria spoke English fluently and while she understood Spanish, she struggled to speak it fluently.

Ruby. Ruby (18 years old) chose to participate in the treatment on her own, despite living with her mother and siblings. Ruby was in the 12th grade at Andres Bellow High School. She was born in Mexico (first generation immigrant) and immigrated to the United States when she was five years old. She is considered to be undocumented as her parents entered the U.S. illegally and could not apply for legal residence. Ruby spoke English and Spanish fluently.

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Data Collection

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Instrumentation: Quantitative Data

Several self-report measures were administered to each participant after assent from the adolescent and consent from the caregiver was obtained. These self-report

measures assessed trauma exposure, PTSD symptoms, ethnic identity, and level of

working alliance between me and these Latina participant clients. The responses to the

self-report measures – described in the next section – served as a springboard to follow-

up questions about the adolescent's experiences with PTSD symptoms, immigration

experience, and ethnic identity (refer to the "Instrumentation: Qualitative data" section

for a complete description of the qualitative uses of these measures). Table 1 provides a

clear depiction of each self-report measure and the timing in which each of them were

administered.

Table 1

Timing of Self-report and Qualitative Measures

Type of data	Pre-intervention	During intervention	Post-intervention
Quantitative	PSTD-RI Immigration Events MEIM-S		PTSD-RI
Qualitative	Two-part semi-structured interview	Tracking use of culturally modified components	Post-intervention interview
Quantitative and Qualitative	Demographic data	WAI-S	

Demographic survey. A series of demographic questions were asked regarding

the adolescents' gender, age, grade level, ethnicity, and number of years in the United

States (if the participant identified as an immigrant), and reason for migration.

Additionally, two questions regarding substance abuse and psychotic symptoms were

asked to determine exclusion criteria. This questionnaire was available to all adolescents

in English and Spanish. For a sample of the demographics survey, refer to Appendix A.

The University of California at Los Angeles Posttraumatic Stress Disorder Reaction Index (PTSD-RI). The University of California at Los Angeles Posttraumatic Stress Disorder Reaction Index for DSM-5 (PTSD-RI DSM-5; Pynoos & Steinberg, 2013) was used to measure exposure to traumatic events and PTSD symptomatology pre and post- intervention. This scale is a paper-and-pencil screening measure that assesses an individual's exposure to 18 types of traumatic events and assesses DSM-5 PTSD diagnostic criteria, although it is not intended to establish a definitive PTSD diagnosis. The earlier version of this scale (PTSD-RI-DSM-IV; Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998) has been one of the most widely used instruments to assess PTSD symptoms in a range of children and adolescents across trauma types, sex, age ranges, and cultures (Beehler et al., 2012; Steinberg et al., 2004; Steinberg et al., 2013). For example, Goenjian et al. (2001) used the PTSD-RI for DSM-IV with a sample of 158 Nicaraguan adolescents after Hurricane Mitch. Test-retest reliability was assessed by testing seven adolescents initially and again after seven days, which yielded a correlation coefficient of 0.93. In Steinberg et al.'s (2013) study of the underlying factor structure of the PTSD-RI for DSM-IV, internal reliability for the total scores were quite strong (.88 to .90) for males and females in a large sample of Caucasian, African American, and Hispanic children and adolescents. The authors estimated a 6-28 day test-retest reliability of .84. Because the PTSD-RI for DSM-5 scale is quite new, there have been no published studies to date that use this scale. However, it was still considered appropriate to use this scale given the strong psychometric properties of its earlier version.

In this study, the Adolescent version of the PTSD-RI was used because it assessed exposure to traumatic events and PTSD symptomatology in adolescents ages 13-17.

Despite the age difference, this measure was given to the two 18 year old adolescent participants as it was deemed appropriate because they were still living with their parents and attending high school. The PTSD-RI is divided into three parts: First, adolescents are asked whether something scary or violent has ever happened to them and they are prompted to provide a brief description of the event. Next, adolescents are asked "yes" (has happened) or "no" (has never happened) questions about various traumatic events that they may have experienced in their lifetime. For this study, all adolescents must have checked *yes* to at least one item on this list to be included.

Once adolescents had identified at least one traumatic event, they were asked which traumatic event was most bothersome to them now and they were also asked to provide more detail about the event (e.g., length of time since event and brief description of what happened, if different from the one they specified earlier). Next, they were asked to rate how frequently they experienced a variety of PTSD symptoms in the past month on a Likert scale from 0-4 where 0 is *none*, 1 is *little*, 2 is *some*, 3 is *much*, and 4 is *most*. Finally, adolescents were asked a series of questions that assessed whether the symptoms endorsed caused distress or functional impairment. The scoring software for the PTSD-RI for DSM-5 was used to score each scale to calculate the DSM-5 Criterion B, C, D, and E subscale scores as well as overall PTSD score. As long as participants were experiencing some distressing symptoms of PTSD, they were included in the study. The PTSD-RI scale was administered to all adolescent participants, pre- and post- intervention. All participants chose to use the English version of this scale.

Immigration events. The questions included on this instrument were developed by de Arellano and Kemitt Danielson (2008) as a culturally sensitive way to measure

stressful immigration events. At the time of this study, this scale had only been used

qualitatively, and there were no existing data on the psychometric properties (M. Torres,

personal communication, March 18, 2014). In this study, this instrument was only used

with the Latina adolescents who indicated that they had immigrated to the United States,

to assess the types of trauma (if any) that might have occurred while in transit to the

United States. Traditional measures, such as the PTSD-RI do not capture these types of

potential events and therefore, this scale was used to supplement data from the PTSD-RI

given the unique population (i.e., immigrants) who were participants for this study. The

traumatic experiences the adolescent may have experienced prior to and after

immigrating to the United States are not measured by this scale, but the PTSD-RI scale

was able to capture these traumatic events. Taken together, the experiences noted on both

instruments were used as a means to understand adolescents' PTSD experience across

different contexts. Lastly, the Latina adolescents were given the choice of using these

events during the construction of the trauma narrative. This measure was available to the

adolescents in English and Spanish. As the only immigrant in this study, Ruby completed

the measure in English. For the immigration events instrument, refer to Appendix B.

Multigroup Ethnic Identity Measure-Short (MEIM-S). The Multigroup Ethnic

Identity Measure-Short (Roberts et al., 1999) was developed from a diverse sample of

417 high school students, of whom 89 were Latino. The MEIM is grounded in social and

ego identity theories (Erikson, 1968; Marcia, 1980; Tajfel, 1981;Waterman, 1985) and

has been regarded as one of the most widely used ethnic identity measures in

multicultural research due to its wide applicability and utility across many racial/ethnic

groups in the United States (Ponterotto, Gretchen, Utsey, Stracuzzi, & Saya, 2003; Yoon,

2011). Roberts et al. (1999) utilized the MEIM-S scale with an ethnically diverse sample of 5,423 adolescents (about 18% identified as Central American and Mexican American) between 12 and 14 years of age. In that sample, the reported Cronbach's alpha for the total score was .84.

The MEIM-S, a shortened form of the MEIM, was developed to measure two aspects of ethnic identity in adolescents and young adults ages 12 and older: ethnic identity search; and affirmation, belonging, and commitment (Roberts et al., 1999). It consists of 12 items and respondents of this measure are instructed to rate each item on a 5-point Likert-type scale ranging from 1 (*Strongly Agree*) to 5 (*Strongly Disagree*). A slight modification was made to this measure by putting the anchors of the scale on a table, next to each item, for easier scoring. While there is not a cutoff score for this scale, higher scores represent greater exploration or commitment (Phinney & Ong, 2007). For this study, this scale was scored by using the mean of the 12 items to obtain an overall score. The score range was between 1 and 5, with 1 representing a weak endorsement of ethnic exploration and commitment, and 5 representing a strong degree of ethnic identity. Prior to administering this instrument, respondents were asked an open-ended question that elicited their ethnic self-label. The instrument ends with a list of appropriate ethnic groups that adolescents can check to indicate their own and their caregivers' ethnic backgrounds.

The exploration subscale (items 1, 2, 4, 8 and 10) refers to behaviors and attitudes that reflect ethnic identity exploration such as exploring, learning about, and becoming involved in one's ethnic group (Roberts et al., 1999). This subscale contains items such as "I participate in cultural practices of my own group, such as special food, music, or

customs." The affirmation/belonging subscale (items 3, 5, 6, 7, 9, 11, and 12) refers to the sense of belonging, attachment, or personal investment combined with pride and positive feelings about one's ethnic group (Roberts et al., 1999). This subscale contains items such as "I am happy that I am a member of the group I belong to." To review the MEIM-S, refer to Appendix C.

The MEIM-S was available to participants in English and Spanish. Both versions were obtained from and used with permission from the developers of the measure. Because the English version of this measure did not have the ethnic backgrounds "Mexican" and "Mexican-American" listed, these were added to the measure. There were no reliability data for the Spanish version of this measure at the time of the study. However, it was believed that it was still appropriate to use this measure given the strong psychometric properties of the English version.

Working Alliance Inventory-Short (WAI-S). The Working Alliance Inventory-Short (WAI-S; Tracey & Kokotovic, 1989) is a 12-item, self-report therapist and client instrument grounded in Bordin's (1979) theoretical conceptualization of the working alliance. The original instrument, the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) has been widely used with adolescent populations (Hintikka, Laukkanen, Marttunen, & Lehtonen, 2006). The WAI has received the most empirical attention (Corbiere, Bisson, Lauzon, & Ricard, 2006) out of several working alliance measures currently used in the field (e.g., California Psychotherapy Alliance Scales [Gaston & Marmar, 1991], Therapeutic Alliance Scale for Adolescents [Faw, Hogue, Johnson, Diamond, & Liddle, 2005]) and it has been modified and used to fit the language and development of Latino adolescents in previous studies (Florsheim,

Shotorbani, Guest-Warnick, Barratt, & Hwang, 2000; Santisteban & Mena, 2009). It has

been used with a variety of populations (adults, children, couples), with different session

lengths, and has been translated into 18 different languages (Horvath, 1994).

The WAI has been updated to shorten the original 36-item instrument into a

briefer 12-item instrument, the Working Alliance Inventory-Short (WAI-S; Tracey &

Kokotovic, 1989), which has been found to have greater reliability with the same

populations the WAI was originally developed with (Tracey & Kokotovic, 1989). Given

that the WAI-S factor structure was similar to the full WAI, there is support for the

validity of the WAI-S (Busseri & Tyler, 2003). The scale was created to measure three

components of the working alliance: tasks, goals, and bond. Levin et al. (2012) used the

WAI-S with a sample of 31 adolescents, 19 of whom were Latino. The WAI-S was used

once during the course of intervention and it showed excellent total score internal

reliability for both the adolescent and therapist report (.89 and .91, respectively). In the

current study, this measure was given to the adolescents every 3 weeks to capture

whether perceived working alliance with myself as therapist changed over the course of

the intervention. Although the WAI-S is usually given only once during the intervention,

I followed the recommendation of Kataoka et al. (2002) to use the instrument multiple

times over the course of the intervention as a vehicle to understand and inform how to

increase attendance and engagement in therapy.

The Tasks subscale (items 1, 2, 8, and 12) refers to the mutual agreement about

the tasks of therapy. Specifically, this scale measures whether the therapist and the client

believe that the tasks performed in therapy are efficacious and relevant, and whether both

take responsibility for performing these tasks. This subscale contains items such as "As a

result of these sessions I am clearer as to how I might be able to change". The Goals subscale (items 4, 6, 10, and 11) refers to the mutual agreement about the goals of therapy that are the target of intervention. This subscale contains items such as "We have established a good understanding of the kind of changes that would be good for me". Finally, the Bond subscale (items 3, 5, 7, and 9) refers to the bond between the client and the therapist and it includes measures of positive attachment such as mutual trust, acceptance, and confidence (Hovarth, 1989). This scale has two negatively worded items (4 and 10) that are reversed when scored. The Bond subscale contains items such as "I feel that _____ appreciates me." For items including a blank line, respondents are instructed mentally substitute their therapist's name for "_____." To review the WAI-S, refer to Appendix D.

Adolescents were instructed to rate their experience of therapy by circling a 7-point Likert-type scale: 1-*Never,* 2-*Rarely,* 3-*Occasionally,* 4-*Sometimes,* 5-*Often,* 6-*Very Often,* and 7-*Always.* A slight modification was made to this measure by putting the anchors on a table, next to each item, for easier scoring. Given that the WAI-S is not a standardized measure, it does not have cut off scores or specific interpretations for overall scores. In this study, overall scores ranged from a low of 73 to a high of 84 (out of a total of 84), with higher scores reflecting a greater degree of perceived working alliance. All three WAI-S scales (tasks, goals, and bond) were graphed and visually analyzed for each participant (see "Procedures" section for a complete description). As noted, both the English and Spanish versions were available for participants. However, all participants chose to complete it in English.

Instrumentation: Qualitative Data

Qualitative data were collected prior to the start of the intervention, during, and after intervention completion from both the adolescent participant and their participating caregivers. A description of each method of qualitative data collection is presented below.

Semi-structured intake interview. I conducted semi-structured intake interviews to ask follow-up questions from the self-report measures (PTSD-RI, Immigration Events, and MEIM-S) and to provide feedback to clients regarding the results of their PTSD-RI. Regarding the responses to the self-report measures, these served as a springboard to deeper follow-up questions about the adolescent's experience with PTSD symptoms, immigration experience, and ethnic identity. For example, some of the follow-up questions that were asked for the PTSD-RI scale were: "In the PTSD-RI scale, you noted that you've experienced the following item some of the time: 'I do risky or unsafe things that could really hurt me or someone else.' What risky or unsafe things did you think about as you were answering this question?" and "In the PTSD-RI scale, you noted that you've experienced the following item most of the time: 'I try to stay away from people, places, or things that remind me about what happened.' Tell me more about what you do to stay away from people, places, or things that remind you of what happened." These follow-up questions helped to build a comprehensive history of participants' trauma symptoms.

The responses to the MEIM-S were used as one indicator of how much the TF-CBT model could be culturally modified and in what ways. These responses were utilized to develop a framework from which to understand the ethnic dimensions of the

adolescent and her caregiver. Some potential questions that were asked were: "In the MEIM-S scale, you agreed with the following statement: 'I have often done things that will help me understand my ethnic background better'. What are some examples of these things?" and "In the MEIM-S scale, you disagreed with the following statement: 'I feel a strong attachment toward my own ethnic group.' Tell me more about why you disagreed with this statement."

The feedback session--the second part of the semi-structured interview--is a component of the TF-CBT intervention and its purpose is to share information regarding the results of the PTSD-RI self-report measure. Specifically, the goal of this feedback session is to educate the adolescent and her caregiver about the etiology of PTSD (e.g., the adaptive and maladaptive functions of PTSD, factual information about the disorder), provide answers to commonly asked questions, and share information about the adolescent's specific trauma. All of this information is given in the context of the adolescent's results of the PTSD-RI, by explaining each symptom and how TF-CBT addresses each. In this study, this feedback session lasted approximately 30 to 60 minutes. For a sample script of this feedback session, refer to Appendix E.

Tracking use of culturally-modified components. Through the use of field notes/memos and supervision sessions, I tracked my use of culturally-modified components with each participant. At the end of each session, I wrote detailed and descriptive S.C.O.A.P. (Summary, Culture, Observations, Assessment of overall functioning and academics, and Plan) notes to illustrate the ways in which culturally-informed strategies were incorporated into the session and the reasons why they were incorporated. In addition, these notes stated how the adolescent and/or caregiver seemed

to react toward this cultural modification. These notes were used during the post-intervention interview as a way to explore with the adolescent and/or her caregiver how they perceived the incorporation of cultural constructs used during therapy.

Semi-structured post-intervention interview. At the end of the intervention, all adolescents and their caregivers were asked to participate in post-intervention interviews. Interviews were conducted by me because it was hypothesized that adolescents would feel more comfortable and open to talk about their trauma and their experience in therapy with someone who had built rapport and trust with them (refer to Appendix F for post-intervention interview questions). It was recognized that a potential drawback would be the participants' willingness to share negative feedback with me.

The purpose of these post-intervention interviews was to gain an understanding of the adolescents' and caregivers' experience with the intervention model provided to them and the content of these interviews were used to answer each of the research questions. Specifically, the post-interview questions targeted levels of satisfaction with the intervention, the extent to which the culturally-modified intervention had any effect on their intervention attendance and working alliance with me, and how they perceived themselves post- intervention. A few of the questions that were asked were: "During therapy, I used what I learned about you and your culture to make your therapy more individual for you (followed by showing them excerpts that illustrated when I used their cultural values). How do you think that using these helped you stay in therapy?" and "If you could pick one word or phrase to describe yourself before and after having gone through this therapy, what would they be? Why?"

Procedure

Institutional Review Board Approval

An application for the university and school district's Institutional Review Board (IRB) was submitted and obtained prior to proceeding with the study (see Appendix G). Once approval from both IRBs was obtained, recruitment of participants was initiated.

Recruitment. Participants from Andres Bello High School were recruited through the school personnel (e.g., teachers, school counselor, child advocate/school psychologist, and principal) because this school did not have a formal mental health team established. The school-based therapist was also informed of the study, serving as an additional referral source. Additionally, informal conversations about the study and the intervention were held with the parent liaison and the English Language Development (ELD) teachers to provide more outreach to students and parents.

Screening for inclusion criteria. Once information about potential participants was received from each referral source, I sent the referral source a 4-question (see Appendix H) screener to determine whether the adolescent had experienced a traumatic event. This screener was sent through email. Next, I contacted the prospective caregivers and gave them information about the study and gained preliminary permission to contact their adolescent to determine if she would be interested in being a part of this study and to receive services. I explained to each student participant why they were referred to me, provided an overview of the study such as the structure of the TF-CBT model, the expected number of intervention sessions (12-18), and the criteria that needed to be met in order to qualify for participation. If the student accepted, the caregiver was contacted

again and both were invited to participate in the treatment unless the adolescent explicitly

refused to include a caregiver.

If the student did not want her caregiver to be involved, I explained that although

I would keep our conversations private (e.g., no details of our therapeutic sessions unless

mandated reporting was indicated), I would nevertheless provide caregivers with updates

on session dates, times, and progress. Although I invited the participants to choose any

close relative, instead of a parent or in addition to the parent, to take on the caregiver role

during the intervention, none of them chose to include any other relative in their

treatment other than their mothers.

Permission for the student's participation was obtained using the appropriate

forms from the UNC IRB (consent and assent forms). All consent and assent forms were

available in English and Spanish. No other forms were required by the district beyond the

consent and assent forms required by UNC. Once all these signed forms were returned to

me, I met with each participant, either at her school or in another private location as

preferred. During this meeting, I explained limits to confidentiality and administered the

demographic information and PTSD-RI self-report measures to determine if the

individual met criteria for inclusion into this study. If the answers to these questions met

inclusion criteria, I administered the rest of the self-report measures to the student

(Immigration Events and MEIM-S). All recruited participants met inclusion criteria.

Semi-structured interview: Follow-up questions and feedback session. After

the instruments were administered, they were quickly analyzed to screen for inclusion

criteria. Next, the first part of the semi-structured intake interview took place (i.e.,

follow-up questions from the PTSD-RI, Immigration Events, and MEIM-S measures).

After all necessary information to obtain a complete history of the trauma and traumatic symptoms was gathered, the adolescent and I made a future appointment for the second part of the semi-structured intake interview (i.e., feedback session for the results of the PTSD-RI). This feedback session lasted approximately 30 to 60 minutes. All adolescents preferred the use of English as the primary language during sessions except for Ruby who preferred to use both English and Spanish.

The participants were asked about barriers to participating consistently in the intervention such as transportation or school responsibilities. In instances where there were identified barriers, the adolescent and I brainstormed ways in which these barriers could be minimized (e.g., meeting after school after an exam day, meeting at their home during school breaks). Permission to pull students out of their classrooms was obtained through the participating school district's IRB. All attempts were made to pull students during their advisory or elective class periods in order to minimize academic disruptions. In order to increase attendance, if the adolescent was unable to attend the school for their weekly sessions (e.g., absence or truancy), I offered the option of holding the session at their homes or another community setting with private meeting rooms that would maintain confidentiality (e.g., library with private study rooms). While the majority of the therapy sessions were held at the school, three participants (Gaby, Valeria, and Ruby) allowed me to hold some therapy sessions in their homes.

Once both parts of the semi-structured intake interview were finished, I set up weekly appointments with the adolescents (and participating caregivers for parallel therapy sessions). Therapy retention strategies included phone reminders one or two days before the meeting and reminder cards after each session. As noted, every three sessions,

adolescent participants completed the WAI-S during the last five minutes of therapy in order to inform therapy and incorporate strategies to improve the working alliance throughout the therapy process.

      Intervention: Culturally Modified Trauma-Focused Treatment. Following the semi-structured intake interview, adolescents and their caregivers began receiving the intervention once a week (adolescents met for approximately 50 minutes and caregivers met face to face or via telephone for 15 minutes or longer) lasting approximately 16 to 23 weeks. The nine different TF-CBT components as described in Chapter II were followed. Culturally-modified components were interwoven throughout the intervention, as indicated, to increase engagement, attendance, and facilitate a decrease in symptoms. de Arellano et al. (2012) incorporated the following cultural values into CM-TFT: *familismo, personalismo, respeto* and *simpatía, marianismo, machismo, espiritualismo,* fatalism*,* and folk beliefs*,* and *dichos* and *cuentos*. However, as noted previously, my inclusion of cultural values into the intervention were not exclusive to this list. The cultural insight gathered from the self-report measures, semi-structured intake interviews, and weekly sessions also were used in order to further culturally modify the intervention.

      I followed the TF-CBT model with integrated cultural modifications by following existing guidelines (Cohen et al., 2006; Cohen, Mannarino, & Deblinger, 2012) on how to implement the model provided to me during a two-day training I attended to learn this model. Additionally, I was supervised every other week for one hour by Dr. Evelin Gomez, a certified supervisor for TF-CBT who is employed by the Kempe Center in Denver, CO (for supervision contract, see Appendix I). Dr. Gomez identifies herself as bilingual in English and Spanish and bicultural. She supervised my general

implementation of the TF-CBT model as outlined and she also helped in integrating

cultural modifications into the intervention model. Additionally, in order to maximize the

amount of supervision provided to me, I attended five group supervision conference calls

with Dr. Kimberly Shipman from the Kempe Center as part of the TF-CBT training I

attended in September of 2013. Although a trauma narrative is a critical component of

TF-CBT and all participants (except Ruby) completed one, these were not included in

this narrative because of the sensitive nature of the participants' detailed stories and to

protect their confidentiality and that of their families.

Post-intervention semi-structured interviews. As noted, at the conclusion of the

intervention, all adolescents and their caregivers were asked to participate in separate

post- intervention interviews that lasted between 40 and 60 minutes. These interviews

were conducted by me because it was recognized that the client participants may not have

trusted an unknown interviewer to listen to their stories about their therapy experience.

The purpose of these post-intervention interviews was to gather additional understanding

of the adolescents' and caregivers' experiences with the individualized intervention

model provided to them. Specifically, the post-interview questions targeted levels of

satisfaction with the intervention, the extent to which the culturally modified intervention

had any effect on their attendance and working alliance with me, and how they perceived

themselves post- intervention.

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Data Analysis

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Prior to describing the data analysis process of this study, it is important to

acknowledge that given that I was the primary researcher and therapist in this study, my

influence was naturally present when facilitating the intervention. Therefore, my biases,

previous experiences, and overall therapeutic assumptions were present in all aspects of the study and likely had some influence in the ways in which participants responded to my therapeutic approach and responded to the self-report measures. I maintained awareness of my own influences on the therapeutic and research process by detailing field notes and tracking my overall process and assumptions, as described below.

Quantitative Data

The use of a multicase study allowed for the descriptive nature of the dependent variable in order to infer functional relationships between the independent and the dependent variable. For example, data from pre-intervention PTSD-RI scale was compared to the post-intervention PTSD-RI scale data in order to determine whether CM-TFT worked in decreasing PTSD symptomatology. This information was used in a descriptive manner because it was unlikely that any type of statistical analysis could be completed due to small sample size.

This step answered the following research question:

Q5   Do adolescent participants who receive the CM-TFT intervention experience a decrease in PTSD symptoms as compared to their pre-intervention number of symptoms?

Quantitative/Qualitative Data

Working alliance is a complex construct and as such was measured with a blend of quantitative and qualitative data. For example, the WAI-S was administered to the Latina adolescents every three weeks and the three scales (i.e., Bond, Tasks, and Goals) plus the total score was scored, graphed, and visually analyzed as it was collected. The following research question was answered by the noted strategies:

Q4　　How do the Latina adolescent participants receiving CM-TFT rate their level of therapeutic alliance with their therapist on the Working Alliance Inventory-Short across the different measurement points?

The analysis of these scales informed the intervention and use of cultural values by modifying any aspects that the participant scored as being low. For example, if the Tasks scale was rated lower on week 6, a conversation occurred between me and the adolescent client as to why they chose that score. This conversation provided insight related to the adolescent's perceived barriers and new strategies were tried that specifically targeted tasks within the intervention.

To accompany this more quantitative approach, a timeline of intervention sessions including implementation of culturally modified components, phase of therapy, and significant events as identified through supervision and personal reflection was developed in conjunction with these ratings to see if there was a correspondence between ratings on the WAI-S and/or attendance at therapy. Patterns in implementation of techniques (e.g., phase in intervention, use of a culturally modified techniques) and indicators of client response (e.g., missing therapy, appearing more engaged in therapy) were monitored and described.

Similar to the WAI-S, the responses to the MEIM-S were scored and analyzed to inform the use of cultural values in therapy. The following research question was answered by the noted strategies:

Q3　　How does the ethnic identity of the Latina adolescent participants, as measured by the Multigroup Ethnic Identity Measure-Short, and CM-TFT strategies interact throughout the therapy process?

As noted, the responses to the MEIM-S and the responses to the follow-up questions from the semi-structured interview were analyzed and informed the intervention and use of cultural values.

Qualitative Data

I analyzed the qualitative data by using the NVIVO software, Version 10. Audio recordings of the interviews were transcribed verbatim into a Microsoft Word file for analysis. Using a within-case analysis approach (Creswell, 2013), I first generated a detailed description of each case (e.g., brief background history of the adolescent and caregiver, results of the self-report measures, difficulties encountered throughout therapy, and other details that may help understand the interviewee's responses). Next, I analyzed the emerging themes and patterns generated from the semi-structured post-interviews to answer certain research questions. For example, the following research questions were analyzed using emerging themes and patterns:

Q1   How do the Latina adolescent participants who receive the CM-TFT intervention make meaning of their experience?

a.   What do the adolescent participants who receive CM-TFT perceive as beneficial or detrimental to their treatment?

b.   What role do Latino constructs play in the process of engagement in the CM-TFT intervention?

c.   What role do Latino constructs play in attendance in the CM-TFT intervention?

Q2   How do the caregivers of the adolescent participants who receive components of CM-TFT describe their experience with the intervention?

All post-interview transcripts were read multiple times, generating a detailed description of the participants' experience with CM-TFT. This method involved looking at single instances and generating meaning from them without looking for multiple

instances. In other words, I looked for single key issues expressed by the interviewee that described the experience of the participant (adolescent and/or caregiver) as it related to participating in the intervention. In this way, codes and themes were not imposed on the data but rather emerged from it. Commonalities and differences between the cases were gathered through a cross-case analysis and naturalistic generalizations (Creswell, 2013). As Merriam (2009) stated "a single case or small, nonrandom, purposeful sample is selected precisely because the researcher wishes to understand the particular depth, not to find out what is generally true of the many" (p. 224).

Finally, I tracked the Latina adolescents' academic progress by facilitating brief conversations with them about their grades, attendance, and overall school functioning. Their overall academic progress was tracked and noted on the S.C.O.A.P. notes. The following research question was answered using this strategy:

Q6   Do adolescents receiving the CM-TFT treatment in a school setting demonstrate increases in school behaviors suggesting improved functioning (e.g., increased school attendance, improved academics, and fewer behavioral referrals)?

Validation

In order to enhance the trustworthiness of the data and with the ultimate goal of translating the findings of this study to practice-based knowledge, a series of validation strategies were employed. An audit trail was kept through the use of S.C.O.A.P. notes for each intervention session as well as supervision notes where fidelity of intervention and integration of culturally modified components were described. This audit trail included rich, thick descriptions that would allow future readers to determine whether this information would be transferable to other similar cases. Additionally, data analysis incorporated three phases of analysis: description and analysis and interpretation in an

ongoing, integrated fashion consistent with the model developed by Wolcott (2002). The analysis addressed the research questions by using the themes that emerged throughout the interviews related to the participants' experience with the given intervention model. Triangulation of data from the pre and post PTSD-RI and formal and informal school data gathered were also used to enhance validity and reliability.

In order to check for possible misinformation in the transcripts and to provide an external check of the research process (Creswell, 2013), I recruited a doctoral level analyst who was trained in qualitative methodology to read the transcripts in order to further confirm the reliability of the emerging themes and patterns. This individual identified herself as a bilingual, first generation Mexican immigrant. She reported having had a wealth of experiences with immigrant and non-immigrant Hispanic youth and adults through her work as a counseling psychologist. During her review process, the analyst was blind to the themes that emerged from my readings of the transcripts. Both sets of themes were compared for similarities and differences. Overall, our observed themes and patterns were similar and did not require in-depth discussions to arrive at consensus.

CHAPTER IV

RESULTS

The focus of this chapter is to analyze and combine the quantitative and qualitative data gathered for each case study participant. Using these two methods in combination provides a better understanding of the participants as it relates to their experiences with CM-TFT. All of the results from the quantitative and qualitative data strands will be presented within each case study so that each element and the progression of therapy can be woven together into an integrated story. A thorough comparison of these cases is not the primary focus of this chapter as a more in-depth and comprehensive view of each dyad is needed to understand the dynamics that took place throughout each participant's CM-TFT intervention.

Participants

This study included six participants who are presented as two dyads composed of a parent and an adolescent participant, followed by two adolescents who chose to participate alone. One of the adolescents, Ruby, attended a total of ten therapy sessions and chose to discontinue with therapy. Her case study will be presented with all of the data gathered up until the day she dropped out of the study, as her case represents an exceptional observation within qualitative case study research and can offer valuable insight into variables that played a different role in her CM-TFT experience. The age of the adolescent participants ranged from 16 to 18 years old and parent participants, 45 to

55 years old. Each participant completed the WAI-S approximately every 3 weeks (refer to Figure 1 to review the WAI-S measurement points for all participants).

All participants were interviewed in person, with most interviews occurring at Andres Bello High School and two interviews occurring at participants' homes. The reasons for referral to trauma-specific therapy included domestic, sexual, and/or physical abuse histories. All instances of child abuse and/or neglect were reported to the local authorities regardless of whether the adolescent stated that it had already been reported. This was a necessary step for three participants (e.g., Ana, Gabby, and Ruby).
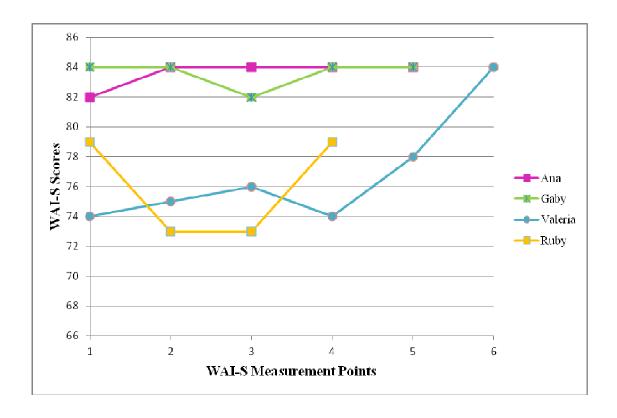

Figure 1. Working Alliance Inventory-Short Measurement Points for All Participants

Supervision meetings with Dr. Gomez are briefly summarized within each case, with the exception of Ana and Laura's case, as their active engagement throughout CM-

TFT made supervision from Dr. Gomez less needed. Finally, as stated in chapter three, all proper nouns included within this chapter are pseudonyms used to protect the identities of the participants. All interviews (adolescents and parents) were conducted in English, with the exception of Ruby, who preferred both languages.

First Dyad: Ana and Laura

Ana and Laura. Ana is a 17-year-old 12th grade student at Andres Bello High School. Although I had not worked with Ana in over six months, her face immediately lit up when I came to get her from her Chicano Studies class to talk to her about this study and obtain her consent to participate. During the administration of the Demographics Questionnaire, Ana expressed that she was born in the United States (second generation immigrant) and that she spoke English and Spanish fluently, though she preferred to speak English. Given that Ana had lived in the country since birth, the Immigration Events scale was not administered to her. Finally, Ana stated that her mother, Laura, was born in Mexico and spoke English and Spanish fluently.

Prior to the start of this study, Ana and I initially met the previous spring at Andres Bello High School. She and I had completed approximately five counseling sessions due to issues related to truancy, poor grades, and family problems related to her distant and conflictual relationship with her mother, Laura. Ana responded with hesitancy when I described the structure of TF-CBT and the parental involvement component of it, as she responded "Me and my mom don't get along. I don't know that I want her to come to therapy with me." I talked to her about the benefits of including her mother and describing her involvement as a way to help Laura understand and respond to her better.

With a suspicious look on her face, Ana reluctantly agreed to allow her mother to participate.

  Multigroup Ethnic Identity Measure-Short results. Ana self-identified as "Hispanic." She explained that for her, there is a difference between identifying as "Hispanic" versus "Mexican." For example, she stated even though both of her parents are "full blooded Mexican," that she identifies as Hispanic because she was not born in Mexico, she speaks English, and "I listen to Mexican and American music." She further explained that "Hispanic means being Latino, Mexican-American, knowing English or English and Spanish" and that identifying as Mexican means "No English, being a bean." Her face scrunched up as in an expression of slight disgust. When I asked her to explain further, she stated that her father is Mexican, emphasized the word *Mexican*, added "straight from Mexico," and briefly stated that she does not have or want a relationship with him due to a history of his emotional abuse toward her and her siblings. When asked to identify her mother's ethnicity, she described her mother as Hispanic, even though she was born in Mexico. It was clear that Ana saw a definite difference between the two ethnicities and her responses to the MEIM-S helped me understand and become aware of this important distinction.

  Ana's mean of the total items was 4.08 (score range between 1 and 5), indicating that she experiences a strong sense of her Hispanic ethnic identity (endorsement and ethnic exploration). The items within the exploration subscale indicated that she behaves and holds attitudes that depict moderately strong Hispanic ethnic identity exploration. For example, she responded *Strongly agree* to "I think a lot about how my life will be affected by my ethnic group membership" (item 4) and *Agree* to items 1 and 8 ("I have

spent time trying to find out more about my ethnic group, such as its history, traditions, and customs" and "In order to learn more about my ethnic background, I have often talked to other people about my ethnic group," respectively). When asked to elaborate on her responses, she reported that she was enrolled in a Chicano Studies class and that she enjoyed learning about Hispanic leaders, Hispanic students having different opportunities in school and college, and racism targeted toward Hispanic students and families. The items within the affirmation/belonging subscale indicated that she felt a strong sense of belonging, attachment, and personal investment with the Hispanic culture. For example, she responded *Strongly agree* to items 6, "I have a strong sense of belonging to my own ethnic group," and *Agree* to items 9 and 12 ("I have a lot of pride in my ethnic group" and "I feel good about my cultural or ethnic background," respectively). When elaborating on her responses, she talked about the racial composition of her friendships, feeling proud of being Hispanic and Catholic, and wanting to be a role model for other Hispanic students in her school. Clearly, Ana felt connected to her self-identified Hispanic ethnic identity.

Pre-treatment Posttraumatic Stress Disorder Reaction Index results. Ana's PTSD-RI Self-Report Trauma History included physical abuse from her father, seeing a dead body, sexual assault from her boyfriend's uncle, and lastly going through a difficult miscarriage which resulted in a brief hospitalization when she was 16 years old. When asked to choose the traumatic event that bothered her the most now, she chose her sexual assault. She appeared saddened and anxious when talking about this event, said "I'm sorry," and began to cry. She described that "it ruined my life. It made me feel so unsafe around any guy, I can't spend the night at anyone's house anymore, or stay after school

for tutoring when there are more guys than girls." I conducted the first part of the semi-structured interview simultaneously, as she responded to the PTSD-RI items, by asking follow-up questions, as needed, to obtain a deeper understanding of her experience with Posttraumatic Stress (PTS) symptoms. In order to gauge her level of anxiety/distress, I asked Ana how she was feeling and asked her to rate, on a scale of 1 to 10 (1 = "I'm doing well," 10 = "I'm really struggling right now"). Her ratings never went past a 6 and she was able to complete the scale in a calm manner.

I presented Ana with the results of her PTSD-RI during the second part of the semi-structured interview, the feedback session. As a part of this feedback, I educated Ana about the etiology of PTSD and provided information about how adolescents her age typically feel after being sexually assaulted. She appeared relieved to see that she did not qualify for a diagnosis of PTSD (see Table 2) and intrigued when she saw that her experiences with PTS symptoms were legitimate. For example, she stated "I thought I was going crazy" and "I wonder what my mom will think when you show her this [PTSD-RI results]." Ana found it easy to understand how the PTSD-RI results are laid out and said "It's easy to understand each [PTSD] category because they look like street lights." Overall, she agreed with the PTSD-RI results and expressed feeling optimistic about starting trauma-focused therapy.

Table 2

Ana's Posttraumatic Stress Reaction Index Pre- and Post-test Scores

Subscale	Pre-test Scores	Post-test Scores
Intrusion	13	3
Avoidance	8	2
Negative Cog.	19	3
Arousal/React.	5	2
Total	45	10
Meet Criteria for PTSD	No	No
Dissociative Type	No	No

In order to follow the TF-CBT model of providing parallel child and parent therapy sessions, I called Laura to share the results of Ana's PTSD-RI. Laura presented as very open to hearing about her daughter's results and voiced feeling "relieved, very relieved" to hear that Ana did not qualify for a diagnosis of PTSD. When I explained that Ana struggles particularly with negative cognitions and negative mood (e.g., negative beliefs, distorted negative cognitions, negative emotional states, and feelings of detachment), Laura noted that Ana refuses to talk to anyone about her sexual assault and that Laura did not understand her response and noted, "I've been raped before, so why can't she talk about it with me? I know what she went through, but she doesn't talk to me." I took this opportunity to educate Laura on avoidance and negative cognition symptoms; we also talked about how being involved in therapy will teach her how to actively listen to Ana and how to speak to her so that she will feel safe enough to talk

about her traumas. Laura expressed feeling appreciative of me sharing the PTSD-RI

results with her, stating that "I feel like I am getting to know her better already."

**Ana and Laura's Therapy Progression
and Working Alliance Inventory-
Short Outcomes**

Following the screening process and semi-structured interview, Ana began to

participate in weekly CM-TFT sessions. Her mother, Laura, agreed to hold parallel,

weekly sessions, with most happening at the school, and some over the phone, depending

on her availability. Ana completed 15 TF-CBT sessions and had zero cancellations (her

mother completed 10 sessions and two cancellations), all of which took place in her

school setting (refer to Table 3 for Ana and Laura's timeline of therapy sessions).

Although every effort was made to conduct one session per week, there were a few weeks

in which Ana was taking exams or school was cancelled. In those cases, the sessions

were rescheduled for the following week. Once all therapy sessions were completed, the

final adolescent and parent semi-structured interview took place in the educational

setting.

Table 3

Ana and Laura's Timeline of Therapy Sessions

Participant	Timeline	Therapy Phase	Culture	Working Alliance Inventory-Short Score
Ana	Week 1: 08/21/14	Initial Introduction		
Ana	Week 2: 08/28/14	Screening for Inclusion		
Ana	Week 3: 09/03/14	Feedback Session		82
Laura	Week 3: 03/04/14	Feedback Session		
Ana	Week 4:09/10/14	Psychoeducation	Yes	
Laura	Week 5: 09/17/14	Psychoeducation	Yes	
Ana	Week 5: 09/18/14	Relaxation	Yes	
Ana	Week 6: 09/24/14	Relaxation	Yes	84
Joint	Week 6: 09/24/14	Relaxation	Yes	
Ana	Week 7: 10/01/14	Relaxation & Affect	Yes	
Laura	Week 7: 10/01/14	Cancelled		
Laura	Week 7: 10/02/14	Affect		
Ana	Week 8: 10/08/14	Affect & Cognitive Coping	Yes	
Laura	Week 9: 10/09/14	Affect & Cognitive Coping	Yes	
Ana	Week 10: 10/15/14	Cognitive Coping & Trauma Narrative		84
Laura	Week 10: 10/15/14	Parenting Skills	Yes	
Laura	Week 11: 10/22/14	Parenting Skills	Yes	
Ana	Week 11: 10/23/14	Trauma Narrative	Yes	
Laura	Week 12: 10/31/14	Cancelled		
Ana	Week 13: 11/03/14	Trauma Narrative	Yes	84
Ana	Week 14: 11/13/14	Trauma Narrative	Yes	
Ana	Week 15: 11/20/14	Trauma Narrative		
Laura	Week 15: 11/20/14	Trauma Narrative		
Conjoint	Week 16: 12/17/14	Trauma Narrative & Safety		84

The first three weeks (sessions 1-3) of meetings were spent introducing Ana and her mother to the study, administering the MEIM-S and the PTSD-RI measures, and providing them with feedback about Ana's PTSD-RI results. On the third session (week 3), I administered the WAI-S to Ana toward the end of our feedback session. Using *personalismo* to highlight warmth and openness, I introduced the WAI-S by explaining that in order for us to have a strong and safe therapeutic relationship with each other, I wanted to periodically ask her questions about her perception of our relationship. As I explained the reason behind using this scale, I expressed that I was very interested in making sure she and I had open and honest conversations about whether our work together was truly working for her. "Ok, sounds good," she said, in an assertive and confident voice, and filled out the WAI-S without hesitation.

The overall score for week 3 was an 82 (highest score = 84), signifying a very strong working alliance. She scored all of the items with a 7 (*Always*) except for item 2 ("What I am doing in therapy gives me new ways of looking at my problem" rated as *Very Often*), and item 10 ("_____and I have different ideas on what my problems are" rated as *Rarely*). I asked follow up questions to each of the above items, and she expressed that she was not yet sure about the "talking about it over and over piece [trauma narrative], but I need to keep coming to therapy." She elaborated on her rating of item 10, stating that she was not sure about including her mother in therapy, though she again talked about "pushing myself to include her even though I don't want to." I was struck by Ana's willingness to commit to therapy despite her struggles and doubts. Out of all the participants, Ana seemed to be the one with the greatest intrinsic motivation from the beginning of therapy.

Ana's fourth session (week 4) began with exciting news. "My boyfriend and I were chosen as students of the month!" she said, an accomplishment that neither of them had reached in the past. This is a great opportunity to talk about strengths, I thought, and a good way to build up momentum for utilizing her strengths within therapy sessions. We spent about five minutes listing all of the things she thought she had done to receive such an award (e.g., arrive to school on time every day, turn in all assignments on time, stay after school for tutoring if needed, get only As and Bs) and made an informal checklist that we used about every two weeks throughout our time together.

The rest of the session was spent on providing psychoeducation about miscarriages and sexual abuse, with an emphasis on the rates of miscarriages and sexual abuse in Latina adolescents and the factors that put Hispanics at risk for experiencing either one. I chose to present this information to her in the form of a question and answer game to correct her inaccurate self-blaming thoughts about what she could have done to prevent her miscarriage and her sexual assault. After our question and answer game, Ana's statements about her miscarriage appeared more positive. For example, she stated "I think I believe that God took my baby because I wasn't ready for it yet" and "God does this for a reason, it just wasn't meant to be for me now." Recognizing her statements as an opportunity to use her religion, I highlighted that spirituality is an important factor in her life and that she uses her faith in God to cope with difficult life events. She agreed and stated that she has tried to use prayer as a way to cope. After this discussion, a pivotal moment in our therapeutic relationship occurred. "Someone in my family told me that therapists can see into our eyes and, feel what we feel, like you guys have special powers or something. Can you do that?" she asked. "Have you heard of the word empathy, Ana?"

and she nodded her head. We held a conversation about being able to understand and share the feelings of another person. "How do you do that? That sounds hard, Miss!" I gave her a smile and told her that I have practiced how to push all of my competing thoughts and really focus on her, her experience, how she feels, put myself in her shoes, and learn how to empathize with her. She responded with a smile and stated that she would like to learn how to do that at some point.

I met with Laura the following week and presented the same culturally modified psychoeducational materials about sexual abuse and miscarriages that I had presented to Ana. While Ana was able to handle hearing the facts of each, Laura had a more difficult time digesting the information and began to sob as she heard me talk about the symptoms of PTS in Hispanic adolescent girls who have been sexually assaulted. Statements of self-blame and anger surfaced, which were met by reflective and validating statements by me ("Your anger toward her did not make the miscarriage happen" and "You are so angry and disappointed at yourself for having let her go out that night, you wish you had supervised her more"). Particular attention was given to using *personalismo* during this conversation, while also helping to identify Laura's unhelpful thoughts about Ana's trauma. Using Laura's strong cultural value for respect within her family, I also took this opportunity to reframe one of Ana's current problematic behaviors (e.g., isolating herself from her mother), which was interpreted by Laura as disrespectful. "Most likely, she is telling you 'I am scared to talk to you about my sexual abuse, please give me space'" I reflected to Laura. "As a Hispanic mother, you are probably going crazy trying to be closer to your daughter yet feeling disrespected by her distance" "Yes! I want to feel closer to her but I need to stop smothering her and forcing her to talk to me about her

abuse." Toward the end of our session, Laura remembered a song Ana had dedicated to her some years back called *Mamá* by *Grupo Siggno*, a Mexican music band. "I know she loves me. I'll sing this song in my head next time, to remind myself that she does love me."

During the following three weeks (weeks 5-7), the primary focus of the sessions centered around teaching relaxation strategies to target her PTS symptoms. Using Ana's PTSD-RI to inform which PTS symptoms to target with relaxation strategies, we agreed to pay closer attention to her intrusion symptoms, particularly her physiological reactivity symptoms (e.g., feeling hot flashes, feeling flushed, and heart beating fast). Ana decided to draw a "safe place" for her to use in her imagination next time she felt anxious, hypervigilant, or experiences physiological reactions.

Using *personalismo* and cultural relevance, I brought culture into our session by drawing a safe place of my own and including the word "Venezuelan" across my drawing. I briefly talked about being proud of who I am and how it soothes me to think about my culture as a coping tool. "Interesting," she said, and shortly after she drew a Mexican symbol on her drawing to represent her culture. She chose to listen to a popular Latin American band called *Mana* as she delved into her safe place while drawing. Lastly, culture was also incorporated by reminding Ana of her already existing value of spirituality and how it can serve as a coping tool to counteract intrusion symptoms. I administered the WAI-S toward the end of this session, and she rated our working alliance with a score of 84, signifying that she perceived our relationship to continue to be strong. On session 9 (week 6), I held a conjoint session with Ana and Laura and used their *familismo* cultural value as a way to encourage them to feel closer to each other by

using the relaxation strategies they had learned in session. I encouraged Ana to use her learned breathing exercises with Laura while Laura sang the *Mamá* song to herself. Ana's eyes widened as she said "that song!?" while Laura explained that she listens to that song as a way to feel closer to Ana. Seeing that her mother had remembered the *Mamá* song from many years back may have encouraged Ana to consider building a deeper connection and relationship with her mother.

The tenth and eleventh session (week 7), were spent finishing the relaxation module and slowly beginning the affect modulation phase of TF-CBT. Laura spoke positively about the breathing exercises she had learned with me and stated that "For once, I was able to sit, by myself, without any noise from the TV or the radio for almost 30 minutes!" She continued, "Light my body felt light." She also spoke about her relationship with Ana, emphasizing that it continues to improve. Interestingly, her conversations about Ana changed from blaming and questioning statements (e.g., "I don't know why she's doing this!") to reflecting on the aspects of their relationship that were within her control. For example, Laura spoke about spending more quality time with Ana, stopping and breathing before she argues with Ana, and supporting Ana in using relaxation techniques at home. I had not heard Laura use terms of endearment with Ana and today, for the first time, Laura called Ana *mi chiquita* [my little one] "I'm proud of her". Laura's face glowed with a smile as she and I ended our session tonight.

Ana walked into my office appearing very tired for our twelfth session. "I stayed up all night studying for finals," she said, as I saw her face overshadowed by the dark circles under her eyes. Despite her tiredness, she agreed to continue with the session. In order to continue to incorporate Ana's native language into our therapy sessions, I

encouraged Ana to read a list of Spanish emotions as we worked our way through understanding the cognitive behavioral therapy triangle to understand the link between thoughts, feelings, and behaviors. "I like the Spanish feelings better," she said, as she worked through situations using the cognitive triangle. At the end of our session, I administered the WAI-S and she scored our working alliance with a score of 84, indicating that she continued to perceive a strong relationship between the two of us. Lastly, Laura and I connected by phone this week (session thirteen) and I summarized the cognitive triangle and Spanish emotions lesson. This week, Laura reiterated the improvement she has witnessed with Ana and thanked me for continuing to see them.

Ana began writing her trauma narrative on her fourteenth therapy session (week 10). Her level of motivation, drive to "get it [trauma] over with," and her creativity shined through each trauma narrative session, as she became actively engaged in writing her trauma as individual poems. As a result, this process took Ana about five sessions total. When she first began to think about how to structure her narrative, she asked that I type her trauma narrative as she constructed the poems in her head. This collaboration included me prompting her to use the Spanish feelings and include as much detail (e.g., thoughts, feelings, actions) in her narrative as she could. As she found herself struggling to describe a certain experience she had, she began to incorporate Spanish words and sentences into her trauma narrative. At first, Ana refused to read her narrative and asked if I could read it aloud for her. She expressed feeling hot when I read the narrative to her for the first time. Therefore, we incorporated relaxation strategies by playing the same *Mana* songs we played earlier in treatment and prompting her to take deep diaphragmatic

breaths once she hit a certain number on a "feeling thermometer" we created during the affective modulation phase of TF-CBT.

Ana's narrative continued to take shape and she slowly began to read it and re-read it aloud during our session. Ana seemed comfortable reading her narrative and her feeling thermometer rating tended to stay between a two and a four. "I don't feel a knot in my throat anymore," she expressed, her face showing slight disbelief. Ana spoke about how writing her trauma narrative had helped her, stating that she has gotten a chance to practice her assertive communication skills. "If I hadn't gone through therapy, I'd probably be out there destroying the world."

While Ana continued writing her trauma narrative with me, the focus of Laura's sessions centered on learning how to actively listen and begin to read parts of Ana's trauma narrative to Laura. This process started week 10 and culminated on week 15 (sessions 15, 16, and 21). The primary topics of discussion included how to actively listen to Ana's trauma narrative, how to validate Ana's feelings and thoughts, and how to maintain a supportive stance. "I want you to take notes and practice at least three of these skills with Ana over the next few weeks," I directed Laura, building on her motivation to learn and practice learned skills outside of session.

The conjoint parent-child session occurred on session 22 (week 16). They walked into my office smiling and seeking proximity toward each other. Today, Ana appeared anxious to read her trauma narrative to her mother. She stated "this feels weird!" I asked them both to take slow deep breaths and "let the jitters out!" They laughed, and Ana positioned herself in her chair demonstrating confident body language. I assumed the role of an observer and attempted to take rich mental notes in my ahead about what was

unfolding in front of my eyes. However, I became overcome with pride, as this was the

first time I had ever had a mother and a daughter complete TF-CBT with me. "This is so

beautiful," I thought, as I watched Laura practice her active listening stance and maintain

a supportive tone of voice and demeanor as they discussed the narrative with each other.

Laura's resounding "I'm so proud of you. I am so, so proud of you" made Ana tear up

and laugh at the same time. The three of us created a safety plan outlining underage

drinking rules and limits, strict curfews, safe sex and unwanted pregnancies, and

continuing to use learned skills. The session ended with Ana rating our working alliance

for the last time, giving us a score of 84, signifying that our strong alliance maintained

through the end of our therapy.

Post-Intervention Parent and Adolescent
Semi-Structured Interviews

      Motivation to heal. Prior to starting TF-CBT, Laura expressed feeling skeptical

of needing to be involved in her daughter's trauma-focused therapy. More specifically,

she voiced feeling as if Ana's therapy had no relation to her. Laura noted,

> I was walking into a dark room and I wasn't even sure what it was going to be
> like. I was like "Why was I going there? She's the one with the issues, why me?"
> But then you explained that it was for me to understand Ana and that's when I
> said "Ok, this is going to be good." Not just for Ana, but for me too.

The hope of understanding her daughter's struggles, her behaviors, why she would

emotionally shut down, and understanding her inner self better, seemed to motivate Laura

to participate with her daughter. She continued,

> I wanted to understand her feelings, why she wasn't talking, why she felt hatred,
> why she felt upset with the whole world. All that time, I did not know her. It's
> sad, it's sad because I raised her, I've been with her all of her life and it's like, it's
> really sad that I didn't even know her at the time. And I felt lonely, I felt like I
> had lost her.

Laura also spoke about feeling "helpless" prior to starting TF-CBT and needing to learn how to rebuild her relationship with Ana. Particularly, Laura spoke about feeling like a strict mother with Ana by yelling commands and expecting Ana to listen and obey. Although this may have worked for some Latina adolescents, it certainly was failing with Ana's bicultural ethnic identity. As she saw her methods fail, Laura found herself to grow more frustrated and helpless around her daughter. Additionally, Laura spoke about wanting to learn how to speak to and listen to Ana and how to control her own emotions when parenting her daughter. In contrast, Ana's primary motivation to begin trauma-focused therapy was being aware of how destructive, disrespectful, and uncaring she was towards others and herself. More specifically, Ana described that she struggled with truancy-related problems at school, did not feel motivated to do well in her classes or seek academic help through tutoring, and found herself being rude, disrespectful, and untrusting toward her parents and her friends.

Changes attributed to therapy. Laura saw significant changes in her ability to actively listen to and speak with Ana, as well as how to control her emotional reactions toward Ana. As she began to understand how to listen to and speak with Ana, Laura began to see changes in her daughter's ability to be mindful of her responses, increased ability to engage in appropriate conflict resolution strategies, and openness to hold meaningful conversations with Laura. "She's willing to let me help her. She accepts my [help] more now than before. She's closer to me now, so I talk to her and tell 'I want to talk to you, I want you to hear this from me first' or 'can you sit with me now' or 'what do you think?' That feeling, it was awesome." Laura also began to notice that her gains in

therapy had generalized beyond her relationship with Ana and into her romantic relationship and work environment with her boss and employees.

When asked to choose one word that would describe her before and after having completed therapy, Laura chose "hopeless and knowledge," respectively. Laura described herself and her daughter as being in a "dark room" and feeling desperate as a result of their inability to help themselves and each other. Repeatedly, Laura mentioned how much she learned in therapy and how she had acquired a wealth of knowledge about how to listen to and speak with others.

When Anna was asked the same question, she chose "worthless and a strong person," respectively. Ana noted,

> After my trauma I didn't feel like myself and I felt like I was no good for this world, that I just brought problems to my family, and I brought problems to my boyfriend's family and I felt like I wasn't worth being here. After a while in therapy, I realized that I am actually worth a lot.

She continued, "I just felt like I was always going to be by myself and that no one was going to respect me the way I wanted them to respect me." Fortunately, Ana's sense of worthlessness evolved into perceiving herself as a strong person who made the choice to actively engage in TF-CBT to leave her old perception of herself behind. "I did everything I could to get out of that place [PTSD symptoms]," she said, speaking about her intrinsic motivation to heal. "After all I've been through, I know there are other teens and young adults out there that have gone through the same experiences I have and I reacted differently, as a strong person. I feel like a strong person because I made it out."

Helpful aspects of her treatment. The primary aspect of CM-TFT that Laura found helpful to her daughter's healing was allowing her to write a detailed trauma narrative and exposing Ana to it by reading it over multiple times over multiple sessions.

"By reading it more than once, it wasn't hurting her as much," she said, as she spoke about the progress she saw in her daughter once the trauma narrative portion of CM-TFT began. During the parallel parent sessions, I observed Laura to be highly sensitive to hearing her daughter's trauma narrative, as she could only handle hearing small portions of the narrative at a time. "The breathing helped, a lot!" she noted, stating that she and Ana practiced diaphragmatic breathing and progressive muscle relaxation (PMR) at home by reading a PMR script to each other. Laura also spoke positively of the cognitive triangle to change her thoughts and consequently, her feelings toward hearing Ana's narrative. Laura also mentioned being able to prompt Ana to use the technique of having Ana imagine herself in a safe place during times when Ana struggled at home or school.

Ana echoed her mother's comments, agreeing that the most helpful part of CM-TFT was writing her trauma narrative in the form of poems and drawing her safe place. She noted that the breathing exercises were also helpful. All of these, in combination, "took a weight out of my body." Ana also reported that "the [cognitive] triangle also helped, because it helped me think things through and think about the consequences of my thoughts and actions."

Appreciation of mother's involvement in therapy. Initially, Ana reported feeling scared and nervous about including her mother in CM-TFT and reading her trauma narrative to her. She explained that "there was no trust, no connection, and no communication toward each other. After a while, though, I was like 'that's my mom,' she knows what I've been through," and began to speak positively and confidently about her mother's involvement in her trauma-focused therapy, particularly in the sense of feeling extra support outside of therapy. Additionally, Ana spoke highly of her mother's growth

during therapy, particularly her mother's ability to communicate more respectfully, her willingness to help and be more aware of Ana's needs, her attentiveness toward Ana when Ana was having personal problems, as well as her mother's ability to give her space when she needed it. "She would talk to me. She would tell me she was sorry and wishes she could have been there to protect me and stuff like that. She was there a lot."

Parent and adolescent's perception of cultural sensitivity. Laura denied being aware of my cultural modifications and sensitivity throughout therapy and stated that it had no impact in her decision to stay actively engaged in therapy. Instead, she attributed her engagement to her motivation to help her daughter. Additionally, Laura reported noticing that Ana seemed connected to me because of my flexibility with scheduling and arranging therapy days and times, my openness to helping Laura understand her better, and my commitment to helping her heal from her trauma. "Ana really felt like you cared for her and that you went out of your way to help us."

While Laura denied my cultural sensitivity had any impact on her or her daughter's engagement in therapy, she did share feeling comfortable in therapy and spoke highly of her strong perception of our working alliance. "You've changed me a lot. Definitely, you've changed me a lot. You have given me more strength than what I had," she said, as we shared an emotional moment speaking openly and honestly about our relationship.

Unlike Laura, Ana reported being aware of my use of cultural constructs and topics throughout therapy, particularly in the beginning of therapy. "After you started asking me questions about my culture and what I do, it was giving you a better perspective of me and it was giving me more confidence towards you. It helped me to

communicate without fear and just have a better connection with you as well."

Interestingly, Ana noted that these culture-rich conversations helped her become more

aware of her identity and who she was and wanted to be as an individual. "I was

remembering who I was and how I saw myself. It helped me to not let myself down, in

therapy or outside of therapy." In essence, welcoming a conversation about her cultural

identity encouraged Ana to hold higher expectations of herself as a Hispanic adolescent

and increase her trust toward me and my abilities to help her heal.

     Use of the Working Alliance Inventory-Short. In terms of using the WAI-S

throughout therapy, Ana stated that she perceived this tool to be useful for therapists to

become aware of and measure their own growth and progress as it relates to their

relationship with their clients. More specifically, Ana perceived it as a tool that I used to

notify myself as to how she felt in therapy and hold honest conversations about how we

were feeling in our therapeutic relationship. Ana's WAI-S ratings stayed high throughout

the course of therapy and she maintained an open stance when providing feedback at

every WAI-S checkpoint.

     Academics. In terms of CM-TFT's impact on Ana's academics, Laura spoke

about a sense of pride and respect toward her daughter for achieving 'Student of the

Month' early in therapy and maintaining her academic progress. More specifically, Laura

did not expect that Ana would stay on track to graduate high school early. "My baby's

growing up," she said, as she reminisced about seeing Ana's graduation pictures on the

wall at Andres Bello High School. Similarly, Ana reported that she began to care more

about her academic performance and began to demonstrate responsibility and

commitment to graduating by attending school every day and turning in all of her

assignments on time as she noticed that I was checking her grades and attendance. Prior to CM-TFT, Ana was put on an attendance contract due to the number of absences and tardies she collected over the course of her previous academic year. In terms of her relationship with her peers prior to CM-TFT, Ana spoke about engaging in arguments with peers and having an overall negative relationship with others. "[Now] I go to school every day no matter how I feel. I have good grades, I have a 3.8 GPA, and I communicate more with my teachers." Ana denied having any behavioral referrals over the past academic year.

Advice to others about therapy. Laura's resounding advice for other parents with adolescents who have experienced trauma was to engage in TF-CBT despite their preconceived negative ideas about it. Laura spoke about the importance of including parents in therapy, as she found herself to be an essential piece to her daughter's healing. Laura noted,

> To me, every single mother wants to help their kids, their troubled kids. So, the way I see it is that if you want to help your kids or your son or daughter, you have to go through therapy! That's the only way you're going to be able to help that troubled kid to get out of the dark room or dark hole. It's going to change their lives too, for the better.

Ana's message to other adolescents who have experienced trauma extended beyond just healing symptoms of PTSD. Her message conveyed an underlying sense of hope, empowerment, and courage. "I would tell them that therapy is a way to make you strong, to help you with your traumas and to never be afraid to speak with the therapist about your problems. After you take everything out of your chest, you feel different; you feel that you did right by communicating with your therapist about it." She went on to talk about adolescents dealing with avoidance,

> I would tell them not to avoid talking about their problems because that is what is going to hurt them the most, because they will always have that pain and that cut for the rest of their lives. It may hurt when they talk about it and they may hurt so bad when they talk about it, but after a while you realize that it was worth it because you will no longer take it with you.

"The cut" that Ana referred to was in relation to my use of metaphors and analogies to help her understand the pain associated with trauma-focused work. "I told myself that I'm just going to go through therapy and get this over with so I can feel different. I told myself that if I keep avoiding this [therapy], I'm going to keep on feeling the way I feel and I won't feel any different," she noted. "I'm able to move forward knowing that I've been through so much and that it was worth it. It was really worth it."

Second Dyad: Gaby and Karina

Gaby and Karina. Gaby is a 16-year-old 12th grade student at Andres Bello High School. During the administration of the Demographics Questionnaire, Gaby noted that she was born in the United States (second generation immigrant) and spoke English fluently, though she understood Spanish but could only speak it in an informal, conversational manner. Given that Gaby had lived in the country since birth, the Immigration Events scale was not administered to her. Lastly, Gaby stated that her mother, Karina, was born in the United States and spoke English and Spanish fluently.

Gaby was referred to me for treatment by the school-based therapist, Alyssa, at Andres Bello High School. During the referral process, Alyssa stated that "Gaby is a hard one to work with. She has refused to talk about her trauma history or acknowledge any feelings toward it, really." Alyssa shared with me that Gaby was sexually assaulted by her half-brother (i.e., Gaby's father's son from his first marriage) once when she was 12 years old. She then became pregnant with her son, Leo, by her ex-boyfriend, when she

was 14 years old. During our conversation, Alyssa emphasized that because of Gaby's tendency to minimize and avoid talking about her trauma, Alyssa had not been able to do any "trauma work" with Gaby.

I pulled Gaby out of class and we walked to the school's soccer field, which looked more like a large backyard with one soccer net on one side. Gaby's unkempt appearance struck me; her thick, black hair was pulled back in a messy pony tail, with flyaway hairs sticking out everywhere; dark circles under her eyes evidenced long sleepless nights and tiresome days; she did not wear any makeup which was unusual for girls her age in this school, and she wore a large, baggy, dark sweater and dark sweatpants. She looked so exhausted and unlike a typical high school student, I thought to myself as I waited to hear her story.

Receiving consent from Gaby was not as difficult as I thought it was going to be, given Alyssa's warning about Gaby's avoidance. When I explained the purpose of the study and therapy, I made attempts to normalize avoidance in adolescents with histories of sexual abuse and talked about the advantages and disadvantages of continuing to avoid processing her traumas. At this point, Gaby stated that she had already gone through therapy for her half-brother's sexual abuse and described her therapy as similar to TF-CBT (e.g., writing out a trauma narrative and sharing it with her mother). She noted a different trauma, running away from home and living on the streets for 1 week, as currently having a much stronger impact on her than her past sexual abuse.

Multigroup Ethnic Identity Measure-Short results. Gaby self-identified as "American Hispanic." Unlike Ana, who was elaborate in her ethnic self-identification, Gaby took a less active stance on it. For example, she circled "3" (*Neutral*) for most of

the items on the MEIM-S and when asked follow-up questions, she tended to respond "I don't know." Gaby's mean of the total items was 3.16 (score range between 1 and 5), indicating that she felt neither a strong or weak degree of her American Hispanic ethnic identity (endorsement and ethnic exploration). Her ratings of the items within the exploration subscale indicated that, overall, she behaves and holds neutral attitudes toward her ethnic identity. For example, she responded *Neutral* and *Strongly Disagree* to items related to spending time trying to learn more about her ethnic identity. Similarly, her ratings to the affirmation/belonging scale also indicated that she felt a mostly neutral sense of belonging, attachment, and personal investment with her ethnic identity. It was clear that Gaby felt mostly impartial to her ethnic identity, which suggested that therapy would not likely be as culturally modified for her. Her neutral attitude toward most of the items on this scale cued me to think about and explore her self-esteem during therapy, as her low exploration scale ratings, along with her appearance, seemed likely to represent a lower sense of self-identity exploration and sense of self.

Pre-treatment Posttraumatic Stress Disorder Reaction Index results. Gaby's PTSD-RI Self-Report Trauma History included being in a serious car accident, sexual assault by her half-brother on her father's side and sexual assault by her son's father, hearing about her friend's violent death, and living on the streets for one week when she ran away with her son's father and was forced to have sex with him. She also briefly talked about incidents of physical abuse prior to and during this one-week period. When asked to choose the traumatic event that bothered her the most now, she chose living on the streets for one week. I conducted the first part of the semi-structured interview simultaneously, as she responded to the PTSD-RI items, by asking follow-up questions,

as needed, to obtain a deeper understanding of her experience with Posttraumatic Stress (PTS) symptoms. In order to gauge her level of anxiety/distress, I asked Gaby how she was feeling and asked her to rate, on a scale of one to ten; her ratings never went past a 7 and she was able to complete the scale in a calm manner.

Gaby's PTSD-RI results were presented to her during the second part of the semi-structured interview, the feedback session. As a part of this feedback, I educated Gaby about the etiology of PTSD and provided information about the rates of adolescents who run away and are sexually and/or physically assaulted during their running away periods. When told that she qualified for a diagnosis of PTSD (see Table 4), she did not appear shocked or worried and I reflected that back to her, to which she responded "Yeah, I'm pretty numb. My mom tells me I'm emotionally constipated." She acknowledged feeling afraid often but having to stay strong for her son, stating "I'm still afraid he's going to find me and take my baby away." She also spoke of being afraid that the sister of her son's father would harm her because she has threatened her in the past. In order to ensure safety – and as part of the TF-CBT model--Gaby and I developed a thorough safety plan that included people she could contact if she ever saw either one of them at school, home, or the community. Overall, she agreed with the PTSD-RI results and expressed feeling optimistic about starting trauma-focused therapy.

Table 4

Gaby's Posttraumatic Stress Disorder Reaction Index Pre- and Post-test Scores

Subscale	Pre-test Scores	Post-test Scores
Intrusion	20	2
Avoidance	7	4
Negative Cog.	24	11
Arousal/React.	12	8
Total	63	25
Meet Criteria for PTSD	Yes	No
Dissociative Type	Yes	No

In order to follow the TF-CBT model of providing parallel child and parent therapy sessions, I met with Karina to share the results of Gaby's PTSD-RI (session 6, week 3). As safety was a significant worry for Gaby, Karina and I talked about Gaby's safety plan and she agreed to talk with Gaby about it when she returned home that evening. When I presented Gaby's PTSD-RI and told her about the trauma Gaby chose to focus on, Karina appeared concerned. She stated that Gaby may be attempting to avoid talking about the sexual assault by her half-brother and focus on her running away episode instead. We spoke about the importance of providing some element of control for Gaby and allowing her to make the choice of which trauma to begin her trauma narrative on.

Gaby and Karina's Therapy Progression
and Working Alliance Inventory-Short
Outcomes

Following the screening process and semi-structured interview, Gaby began to participate in weekly TF-CBT sessions. Her mother, Karina, agreed to hold parallel, weekly sessions in person or over the phone, depending on her availability. Gaby completed 16 TF-CBT sessions and had six cancellations (her mother attended 12 sessions with one cancellation), with most of them taking place in her school setting (refer to Table 5 for Gaby and Karina's timeline of therapy sessions). While every effort was made to conduct one session per week, there were a few weeks in which Gaby was taking exams, school was cancelled, or she had medical and/or therapy appointments for her son. In those cases, the sessions were rescheduled for the following week. Once all TF-CBT sessions were completed, the final adolescent and parent semi-structured interview took place in the educational setting.

Similar to Ana, the first three weeks (sessions 1-6) of meetings were spent introducing Gaby and her mother to the study, administering the MEIM-S and the PTSD-RI measures, and providing them with feedback about Gaby's PTSD-RI results. On the third session (week 2), I met with Gaby in the custodial staff's office. Gaby's appearance had not changed much from last week, her hair appeared messy, she did not wear an ounce of makeup, and she wore a baggy navy blue sweater with gray sweatpants. I had prepared to present her with psychoeducational materials about sexual abuse, teen mothers, and adolescents running away. However, our session became derailed when Gaby began expressing fear of her son's father, Alex, and his family. "His mother and her boyfriend are in jail for murder and one of my friends told me that his sister is about to

get out of jail for something related to the same murder, I think." She talked about her conflicted and unsafe relationship with Alex and his family and the fear that her son, Leo, may be taken away from her by one of Alex's family members. As a result, I took out the safety plan we had developed earlier and encouraged her to recite the plan and make any changes to it if she believed it was not thorough enough. Additionally, we made a list of her support system, including a genogram that included family members and close friends who could help her, should she need it.

I spoke with Karina over the phone for session 4 (week 2), as she was getting out of work around 6:30PM that day. Given that Gaby was experiencing fear related to feeling safe in her home, school, and community, I began by debriefing Karina on Gaby's fear. Karina noted that Gaby's fear of Alex's family had improved over the past two or three months. With a strong, though rather aggressive tone of voice, Karina spoke about making sure Gaby feels safe at all times and going out of her way to make sure her school is keeping her safe. Karina went on to describe an incident at school in which Gaby did not feel like her teacher understood her; in response, Karina went to the school and had a confrontational meeting with the principal and teacher about the way in which they were treating Gaby.

Table 5

Gaby and Karina's Timeline of Therapy Sessions

Participant	Timeline	Therapy Phase	Culture	Working Alliance Inventory-Short Score
Joint	Week 1: 09/15/14	Initial Introduction	Yes	
Gaby	Week 1: 09/16/14	Screening for Inclusion		
Gaby	Week 2: 9/23/14	Safety	Yes	
Karina	Week 2: 09/23/14	Safety	Yes	
Gaby	Week 3: 09/30/14	Safety Feedback Session		84
Karina	Week 3: 09/30/14	Feedback & Safety		
Gaby	Week 4: 10/07/14	Cancelled		
Karina	Week 4: 01/07/14	Safety & Education		
Gaby	Week 5: 10/16/14	Psychoeducation		
Karina	Week 5: 10/17/14	Parenting Skills	Yes	
Gaby	Week 6: 10/23/14	Crisis/Safety/Relaxation		84
Gaby	Week 7: 10/30/14	Relaxation		
Gaby	Week 8: 11/06/14	Relaxation		
Gaby	Week 9: 11/13/14	Affect		82
Gaby	Week 10: 11/20/14	Cognitive Restructuring		
Karina	Week 10: 11/20/14	Cognitive Restructuring		
Gaby	Week 11: 11/27/14	Cancelled		
Gaby	Week 12: 12/04/14	Cancelled		
Gaby	Week 13: 12/11/14	Cancelled		
Gaby	Week 14: 12/18/14	Cancelled		
	12/25/14 – 01/15	Cancelled -- Personal commitments		
Joint	Week 16: 01/19/15	Re-engagement		
Gaby	Week 17: 01/22/15	Cancelled		

Table 5 (continued)

Participant	Timeline	Therapy Phase	Culture	Working Alliance Inventory-Short Score
Karina	Week 18: 02/09/15	Parenting Skills		
Gaby	Week 19: 02/12/15	Trauma Narrative		84
Karina	Week 21: 02/23/15	Trauma Narrative		
Gaby	Week 22: 02/26/15	Trauma Narrative		
Karina	Week 22: 02/26/15	Trauma Narrative		
Joint	Week 23: 03/05/15	Trauma Narrative & Safety		84

While discussing Gaby's educational progress, Karina mentioned that she did not want Gaby to ever think she "doesn't have it in her to graduate." I asked if she could clarify, and Karina told me a story about a Mexican father she knows who discourages his daughter, who is also a teen mother, from finishing school so she can stay at home and take care of her daughter. "He's a traditional Mexican father and I hate that he treats her [his daughter] that way! Gaby will go to school and will finish and I will help her get there, that's for sure!" I praised Karina on her advocacy skills and on her willingness to parent her daughter and grandson. Karina struck me as a mother who takes pride in being a strong advocate for her daughter.

Safety education continued to be integrated into my therapy sessions with Gaby, including session 5 (week 3). As I walked over to Gaby's classroom to pull her out of class, she appeared unusually worried this time. Today, Gaby disclosed that Alex, Leo's father, enrolled in classes at Andres Bello High School. "I had a panic attack last week when I saw him, I couldn't even breathe," she said, as she told me about seeing him for the first time after her runway episode. Gaby talked about feeling stressed and worried

that Alex would enter the school daycare and try to interact with Leo, attempt to break into her home, or try to take Leo away from her in some other way. Therefore, we added more details to her safety plan and included people in her school who she could contact should she have any fears about Alex attempting to contact Leo. We walked over to the assistant principal's office and spoke with her about what measures she could take to limit Alex's access to the daycare. Finally, we spoke about child custody and how important it is that Gaby and Karina continue to seek full custody of Leo.

After finishing the safety plan, I administered the WAI-S to Gaby for the first time. I followed the same procedures of introducing the WAI-S as I did with Ana and emphasized wanting to have and maintain a strong and safe therapeutic relationship with her. Similar to Ana, Gaby said "Okay" with a smile on her face and began to fill out the WAI-S without hesitation. Gaby scored our working alliance with a score of 84, indicating that she continued to perceive a strong relationship between the two of us. "This tells me that you and I are on the same page when it comes to what we are going to do in therapy and how our relationship is," I said, to open a conversation about working alliance. "Yup!" she expressed, confidently agreeing with her scores.

The majority of supervision time with Dr. Gomez was spent discussing the significant amount of time Gaby, Karina, and I had spent on safety planning. Dr. Gomez's thoughts highlighted the lack of supervision and safety Gaby has experienced over many years and the resulting ongoing sense of fear that Gaby continues to feel. Dr. Gomez recommended revisiting Gaby's safety plan every few weeks, to make sure she is still on board with the specifics of it. Dr. Gomez also recommended that I spend some

time getting to know and understand Gaby's strengths and hopes for her and her son's future, to begin to build resiliency within her.

Gaby cancelled our seventh session because she needed to complete a final exam in her class, so we rescheduled our session for the following week. Despite this cancellation, Karina and I connected over the phone and I spoke to her about psychoeducational information about statistics of sexual abuse as well as youth running away from home (session 7, week 7). We paid particular attention to the reasons why many adolescents run away from their homes and highlighted factors that were present at the time Gaby chose to run away. Karina spoke about Gaby not feeling heard and understood by others, feeling alienated from her friends and family, and having a difficult time expressing herself to others. We briefly spoke about Karina's harsh tone of voice and the seemingly aggressive attitude she adopts toward Gaby when Gaby does not listen to her. "I need to make sure I don't talk to her that way or she'll never feel safe to talk to me," Karina stated, taking a minute to reflect on how she approaches Gaby.

On our eighth session (week 5), Gaby presented as more guarded at the beginning of our session. I asked her how her week was, including probes about potential panic attacks or interactions with Alex. The answers "I'm fine" and "nothing much" dominated the first five to seven minutes of our session, and Karina's description of Gaby as "emotionally constipated" came back to my head. Without emphasizing her resistance too much, I continued by presenting the psychoeducational materials I had presented to Karina the previous week about sexual assaults and adolescents who run away. I talked to her about the percentages of adolescents who run away after having been sexually assaulted, potential reasons behind running away, and how adolescents who run away

from home usually feel. Slowly, Gaby began to talk about feeling rejected by her family, feeling blamed for her sexual assault, and feeling confused about her purpose in life. I was impressed by Gaby's ability to talk about her feelings and emotions and focused on validating and normalizing her feelings. Her "I'm fine" statements turned into "yeah" and "it's whatever" and she quickly began to close up again.

During supervision, Dr. Gomez and I talked about Gaby's ability to separate herself from her traumas in order to function in her home and school environments. Although this might be viewed as a personal strength that enabled her daily functioning, it had also allowed her to feel empty inside and discouraged her from being mindful of her emotions. Dr. Gomez suggested I use the following metaphor with Gaby: "Everywhere you go you carry such a heavy box filled with your traumas. You get through your day, every day, but wouldn't it be easier to carry a lighter box by allowing yourself to feel again?"

Karina and I met over the phone for the ninth session (week 5). The focus of this session was to increase Karina's ability to speak to Gaby in a way that might increase Gaby's ability to listen without becoming defensive and argumentative. I taught Karina the concept of "message received versus message implied," highlighting how her harsh voice and often aggressive way of speaking to Gaby may be pushing Gaby away and increasing her defensiveness. I affirmed Karina's need for closeness as typical for Hispanic mothers like herself, and reframed her harsh voice as an attempt to alert Gaby and protect her from any more harm (e.g., "You are being harsh because you are trying to protect your daughter from any more pain and hurt). "I think you nailed it on the head…

I'm very scared that we are going to be back at square one, so I raise my voice at her," Karina admitted, taking accountability for her demeanor toward Gaby.

The tenth session (week 6) with Gaby was marked by crisis management, affective expression and relaxation training, as Gaby had been experiencing significant stress as a result of a recent mediation court meeting between herself and Alex regarding their son, Leo. Given that her mediation meeting was emotionally charged, we spent time sifting through the variety of emotions she felt during and after the meeting. Using an emotion list, Gaby was able to identify feeling overwhelmed, scared, worried, and somewhat relieved. Further, I engaged her in a discussion about the ways in which she releases stress. "Music. I like to listen to music in the classroom when I'm doing work or at home when I'm doing homework," she said, continuing to note that she tends to try to relax while she works, something that seemed counterproductive. However, given her resistance toward finding time to only relax, I decided to encourage listening to music more often over the next week. She also agreed to confide in Mrs. Garcia, the daycare director, more often, as Mrs. Garcia was a significant support system for Gaby. Finally, Gaby completed the WAI-S at the end of our session, and she rated our working alliance with a score of 84, suggesting that she perceived our relationship to be strong and our therapeutic work to be relevant to her.

Session 11 (week 7) took place at Gaby's home because school was out of session for most of the week due to professional development days for school personnel. Gaby lives in a trailer park neighborhood that is locally known for being a popular spot for gang members to recruit young children into their gangs. The poverty level struck me, as I saw trash scattered around on the street and drying clothes hung outside on wire fences.

Gaby welcomed me into her home and excused herself as she was sweeping the floor. I took a closer look at the dust and trash pile and saw baby bottles, pacifiers, string cheese sticks, and markers all swept into one pile in the middle of the living room floor. Leo barely noticed that I was in his home and continued running around the house without clothes or a diaper on. "He doesn't like wearing diapers," Gaby said, as she laughed nervously. Leo's little footsteps kept getting faster and faster and his incomprehensible speech louder and louder, as he roamed around the house demanding things of his mother. Gaby's attempts at ignoring his misbehavior were unsuccessful at best, as she would first ignore his attempted verbalizations and then laugh at him. As Gaby continued to ignore him, Leo threw his lollipop at Gaby and then spat at both of us. "That's it! You're going to time out!" Leo began to cry and scream and refused to serve his time out.

I could see Gaby's face as she struggled to discipline her son. I wondered what her days and evenings must be like with such an active young son and so few resources. "I have to sleep on the couch or else I won't wake up for school. My mom sleeps on the other couch and she tends to put Leo back to sleep when he wakes up in the middle of the night," she said, smiling and letting out another nervous laugh. "You don't let yourself feel much do you?" I asked, noticing her unwillingness to admit that she is struggling. "You gotta do what you gotta do, you know?" she responded, continuing to push away an opportunity to feel vulnerable. We finished the session by drawing a detailed safe place that she could imagine in times of stress. She added many details to her safe place, including friends, how it would smell, what she could taste, the temperature of it, and phrases she could say to herself the next time she experienced stress. I encouraged her to play her favorite music, given that it is an already existing coping skill of hers.

Supervision with Dr. Gomez and the TF-CBT consultation calls with Dr. Shipman focused on finding ways to encourage Gaby to release stress by engaging in relaxation exercises. One of the clinicians on the consultation call suggested that I engage Gaby in progressive muscle relaxation in the beginning of every session. In this way, my therapy session would become Gaby's time to relax and she would not likely feel guilty for relaxing because she was not taking time out of her busy schedule. Therefore, sessions 12 and 13 (week 8 and 9) primarily focused on teaching Gaby how to use progressive muscle relaxation (PMR) as a way to decrease tense muscles and improve her sleeping routine. "I'm sleepy," Gaby reported, after having done the PMR exercise. "Excellent, that's exactly what it's supposed to do, Gaby, make you feel relaxed and calm."

Affective modulation was addressed by allowing Gaby to pick situations she struggled with over the past few weeks. As expected, Gaby became resistant to utilizing emotions beyond happy, mad, sad, and annoyed. We used the metaphor of an iceberg to illustrate that most of the emotions she lets others see are the very tip of the iceberg and that there is much more she is not letting herself feel. The use of a feeling thermometer and a feelings list, coupled with encouragement and modeling, made it easier for Gaby to express herself more congruently with accurate feelings. Feelings such as betrayal, guilty, discouraged, and troubled dominated her situations and she appeared more open and honest, and less defensive, as she included these feelings into the content of her conversations.

Gaby agreed to fill out the WAI-S toward the end of our session and she rated our working alliance with a score of 82. She scored all of the items with a 7 (*Always*) except for item 8 ("We agree on what is important for me to work on" rated as *Very Often*) and

item 11 ("We have established a good understanding of the kind of changes that would be good for me" rated as *Very Often*). I asked follow up questions to each of the above items, and she expressed that "the talking about it, all the things, it's hard. I can write it, but I can't talk about it." I validated her feelings and thanked her for her honesty. We discussed the progress she and her mother had made and the importance of making her trauma filled box just a little lighter each day. We also agreed to spending only 15 minutes writing her trauma narrative and having me read it out loud for her for the first few trauma narrative sessions.

Shortly after pulling her out of class for session 14 (week 10), Gaby reported that she had gone to court earlier that week. She reported feeling more relieved and relaxed after hearing that she had full custody of her son. Consistent with the advice that Dr. Gomez and the TF-CBT consultation group gave me about providing a space for Gaby to relax in the session, I engaged her in the same PMR exercise we used in previous sessions. She expressed liking PMR and wanting to use it before she goes to sleep. Next, we discussed thinking mistakes as we delved into the cognitive restructuring phase of TF-CBT. After quickly skimming the page of thinking mistakes, she admitted to struggling with the mental filter and the all or nothing thinking mistakes. The idea of the cognitive triangle (e.g., connection between thoughts, feelings, and behaviors) was easy for her to grasp.

Karina and I met at her home for session 15 (week 10) and discussed the thinking errors with which she tended to struggle. Interestingly, Karina identified the same thinking errors as Gaby. Karina enjoyed talking about her own thinking errors and discussing those that Gaby tended to have, as well as how to change her thinking to be

more helpful and healing. Part of our session also focused on practicing active listening, as Gaby and I were ready to begin her trauma narrative. Even with her noted areas of growth, Karina tended to struggle with sustaining her focus on Gaby's stories rather than proving her own side of the story. We practiced active listening and reflecting emotions by engaging in brief role plays with each other.

Gaby cancelled one of our sessions toward the end of November due to the Thanksgiving holidays. Four other sessions were cancelled in the month of December due to final exams, upcoming deadlines for school assignments, and Leo's unexpected trip to the emergency room due to illness. Additionally, I had other commitments in January and had to cancel two sessions.

In order to re-engage Gaby and Karina after several cancelled sessions, I decided to hold a family therapy session at their home (session 16, week 16). Leo, Gaby's sister, Marcia, and Marcia's three year old daughter were at the home when I arrived. The children were running around the house with diapers on their heads and knocking over things on the coffee table. "It's just the way they play, I guess," sighed Karina, as she attempted to sit down calmly for the session. As the family began talking about their week, the conversation centered on Gaby's unwillingness to ask others for help. For example, she had failed to ask her guidance counselor for help in registering for a different class and as a result, failed that class. As I sat there observing the general family dynamics, I noticed that Gaby's passive pleas for help (e.g., "I need you guys to take care of the kids more when I get home so I can do my homework") were met with Karina's questioning, challenges, and dismissive statements, which seemed to result in Gaby's unwillingness to ask for help again.

This in-home session was extremely helpful in understanding Gaby's emotional distance and tendency to minimize her problems. I shared my observations with the family and prompted them to utilize the skills they had learned in sessions (e.g., active listening, expressing emotions, becoming aware of thinking errors, cognitive restructuring). Unfortunately, I became pulled into the family dynamics during this family therapy session and I did not administer the WAI-S to Gaby this week.

In supervision this week, I shared with Dr. Gomez my struggle in maintaining fidelity to TF-CBT when I noticed so much family discordance during my in-home session. More specifically, I spoke with her about feeling pulled toward staying loyal to the TF-CBT model and offering Gaby and Karina help with managing Leo's disruptive behaviors in the home and helping Gaby and Karina learn how to co-parent. There were several systemic factors to address at the same time as Gaby's trauma and I struggled with staying focused on the model. Dr. Gomez agreed, stating that it is difficult to either focus solely on the trauma or address several areas of need all at once. She also emphasized that perhaps one of the reasons why Gaby's trauma work continued to be less prioritized was because of the amount of family discord and disruptive dynamics that came from being a teen mother living in a poor neighborhood and struggling with PTSD. For the purposes of this study, Dr. Gomez encouraged me to continue to focus on Gaby's trauma and Karina's ability to actively listen without judgment and utilize more positive parenting skills.

Karina and I met outside of her home, in the front yard, for session 17 (week 17), due to Gaby's sister having a few friends over at the house. The main focus of the session was directed toward processing the previous family therapy session and helping her to

continue to learn how to actively listen and validate Gaby's experiences while decreasing her tendency to interject her own thoughts and opinions. Karina continued to accept my feedback and acknowledging that her forceful way of speaking with her family members tends to decrease their willingness to speak with her. "I tend to be the voice of the family though! If I lower my voice and don't talk, no one will talk. Everyone's emotionally constipated in this family!" Cognitive reconstruction allowed Karina to slowly change her perception of her family's hesitancy about conversing with her. Karina agreed to continue to work on being aware of the power of her voice with her family.

Gaby and I were able to meet after school after two weeks without seeing each other, as she had to cancel another session because Leo had an appointment for an assessment to determine whether he had a developmental disability. Our eighteenth session (week 18) marked the initial development of her trauma narrative. Gaby had agreed to write her trauma narrative in the form of chapters in a book and I was surprised to see that she independently chose to include her sexual abuse trauma as a chapter in her book. Unexpectedly, our agreed 15 minutes of trauma narrative writing turned into 45 and Gaby expressed not feeling as scared to write about it as she originally had thought. I read her trauma narrative out loud and mostly prompted her to include her feelings within her narrative. On her next trauma narrative session (session 20), feelings such as scared, hungry, alone, regret, and estranged began to surface through Gaby's narrative. She began to read her chapters on her own and denied feeling anxious. I engaged her in PMR exercises at the end of every session, in order to send her back to class relaxed and calm.

While Gaby worked on her trauma narrative, Karina and I spent two sessions reading Gaby's trauma narrative. Initially, Karina struggled with stopping herself from

interjecting her own thoughts and emotions after hearing me read her daughter's narrative. However, after a couple of practice rounds of role plays, I observed Karina to be much more able to actively listen and refrain from questioning Gaby's experience.

The conjoint parent-child session occurred on session 22 (week 23). Karina and Gaby met me at Gaby's high school while Leo waited in the daycare with Mrs. Garcia. Gaby appeared slightly uncomfortable reading her trauma narrative to her mother, stating that it felt "a little weird." Despite her discomfort, Gaby was able to read her narrative out loud while Karina actively listened and validated Gaby throughout. Karina praised Gaby for her efforts and apologized for the harsh tone of voice she uses with her at times. "I want to protect you," she stated, as she explained why she tends to raise her voice at her. The session ended with the three of us revisiting the safety plan we had originally drafted and including factors related to safe sex, strict curfew times, and consistent parental supervision. The session ended with Gaby rating our working alliance for the last time, giving us a score of 84, signifying that our strong alliance maintained through the end of our therapy.

Post-intervention Parent and Adolescent
Semi-Structured Interview Findings

The value of therapeutic directiveness. Karina had expected TF-CBT to be harder on Gaby than it proved to be. In her post-interview, she compared Gaby's reactions to her (Gaby's) first experience with therapy to her current participation in TF-CBT, and described Gaby to "have more flare ups before. Anybody pushing her [to engage in therapy] wouldn't succeed in engaging her. Instead, Gaby would cop out of it for a week and she would be mad at me and ask me 'why in the hell would you make me do this!'" Like Alyssa who had referred Gaby, Karina described Gaby's efforts to avoid

trauma-focused therapy and the therapists' inability to engage her without reinforcing Gaby's avoidance. "They would never push her, ask questions, or anything. She [Gaby] wasn't really thinking about it, she was avoiding it and it became unbearable because she didn't know how to deal with it appropriately," Karina also reported growing impatient and losing hope with Gaby's previous therapists, as they reportedly were not as directive as I was and as a result, allowed Gaby's avoidance to grow and take charge. "I don't know if they were afraid of anything she may do, but they just wouldn't push and they wouldn't hold her to what, you know, you wanted her to write. You held her to it."

For Gaby, the work required of TF-CBT seemed "pretty scary, because it was supposed to be specifically to talk about my trauma, so I thought it was going to be too intense and it gave me anxiety at first." Gaby stated that she recognized that neither her mother nor I would allow her to continue to avoid processing her trauma, which made her come to terms with TF-CBT and feel more intrinsically motivated to actively engage in therapy. Given that I was Gaby's fourth therapist, she also expected that I was not going to encourage her and push her to process her trauma. She stated that "They [previous therapists] didn't push me to talk about anything. They mainly talked about how everything went that week and stuff like that. I didn't write the trauma narrative and with you, I wanted to write it and finish it so I can be done with therapy."

Motivation for healing: intergenerational trauma. A central motivating factor that helped Karina to start TF-CBT with her daughter was Karina's fear that Gaby's PTSD may continue to worsen and result in Gaby committing suicide in the future. She spoke about her own unresolved trauma and feeling ashamed of her family members for not recognizing her own trauma as valid and in need of treatment. "I didn't deal with my

own trauma for the longest time, my rape, and years later I had to work through it and deal with it. I did it all on my own," she stated, implying that she wanted to support her daughter through her trauma-focused work. "I didn't want her to commit suicide when she grows up to be an adult or even now as a child. I want her to survive and know that it can happen. She had to empower herself." Lastly, Karina feared that Gaby's trauma may make her at-risk for becoming abusive toward her son, Leo. "If she didn't get help with it [her trauma], she had a chance of being an offender herself and take it out on Leo," she said, as she spoke about news reports she had read that linked unresolved trauma to future abuse on children. "I've been trying to get Gaby to this point for almost five years."

Changes attributed to therapy. Karina described herself as "tense" and "relaxed" before and after therapy, respectively. The frequency and magnitude of Gaby's irritability toward her family members resulted in frequent parent-child conflicts that resulted in Karina feeling tense most days of the week. As TF-CBT progressed, Karina began to notice gradual changes in Gaby's ability to control her emotions and her emotional reactivity as well as Gaby's ability to sleep more through the night and work through her problems more appropriately. "I've also learned that when I see her go through these waves, where she fights and fights with me, it's most likely because she's working through it and it's taking her longer to process," she said, in reference to her ability to understand Gaby's struggles. "I see her as being more relaxed and less stressed now and I think she feels freer." Gaby described herself as "angry" prior to TF-CBT and "happier" after it. She also noted changes in her ability to communicate with her mother and seek help from others.

Lastly, Karina noticed changes in Leo as well. In particular, Karina became aware of Leo's ability to soothe himself when Gaby was doing so, and struggle emotionally when Gaby was struggling as well. She noted,

> He feeds off of her. When she's tense, that's part of the reason why he acts out, because he is so high strung that he doesn't know what to do with it. I think it's starting to level out for her and we just have to continue to teach Leo how to follow with that.

Helpful aspects of the intervention. Karina reported that the most helpful factor she found within TF-CBT was its directiveness in holding Gaby accountable for processing her trauma without feeding into her avoidance. "If they [previous therapists] would have done their work along the lines of what you did, Gaby would have probably been off her [psychiatric] medications within a year of her traumas," Karina voiced, stating that Gaby had tried a variety of medications to address her symptoms and suffered when having to deal with multiple medication changes as a result of unwanted side effects and adverse reactions. She expressed gratitude for having been directive with her daughter to help her heal faster and become less dependent on psychiatric medications.

Gaby perceived the trauma narrative, affective modulation, and cognitive restructuring portions of TF-CBT to be the most helpful to her healing process. She stated that feeling surprised at how much she enjoyed writing her narrative. She noted that "I wanted to get it off my chest and get it done and over with. It was the right time because I am almost done with school and I'm getting ready to go to college and writing that narrative was one more thing off my plate." Lastly, she recognized her difficulty with vulnerability and allowing herself to feel pleasant and unpleasant emotions. She reported that "putting my feelings out there and owning how I felt helped me to deal with it and think of myself first instead of putting others ahead of me."

Sensitivity, flexibility, and family orientation. In terms of my cultural modifications and sensitivity, Karina stated that she was not particularly aware of them during therapy. Instead, she was highly aware of my ability to understand her role as a mother to Gaby, a mother to a teenage mother, and a mother and grandmother to a three year old. She commented positively on my ability to maintain a humble demeanor and embrace stepping into their lives to understand their struggles. She noted,

> You weren't on the outside looking in going 'I'm better than you.' You actually got to know actual people, actual facts, and understand the whole picture. Some therapists will just do the immediate picture and fail to look at the wider picture, and they get lost in what they're doing. They get lost and forget that, you know, certain people have to be treated differently. You put yourself in our shoes and tried to understand the dynamics of what she [Gaby] was thinking and nobody ever did that.

Additionally, Karina reported being thankful that she was made to feel as if she was an important part of therapy. "They [previous therapists] wouldn't use me for therapy," she noted, as she spoke about the importance of actively engaging family members in the child's therapy to get a comprehensive understanding of their strengths as well as their struggles. Lastly, Karina stated that she was able to keep Gaby accountable for practicing her learned skills at home and finishing the homework assignments because I made a conscious effort to make Karina an integral part of therapy.

Like Karina, Gaby was not as aware of cultural modifications to her therapy. However, this made sense given that cultural modifications were not needed within her therapy as much as the other adolescent participants. However, Gaby expressed gratitude for my flexibility and willingness to work around her busy schedule. "There's a lot of work I have to do with my baby, like all of his appointments, his daycare, his bills. Finding a person that can be flexible can be hard."

Advice to others about therapy. Karina expressed that she would advise other parents to engage in therapy, regardless of the opinions or beliefs of other unsupportive family members. Surprisingly, she spoke about cultural barriers that exist for women to be able feel valuable, important, and worthy of owning their emotions and experiences. More specifically, she noted,

> I feel like for other cultures, including the Hispanic culture, the women are pushed aside and made to believe that they don't matter. They don't realize that women sometimes become desperate because they sometimes feel like they don't have the right to feel their emotions. Life isn't something to run from, it is something to enjoy and live and do. Looking back at it now, I know that Gaby always has it in her to encourage other teenage moms who have been sexually assaulted to go through therapy.

Gaby described the decision to engage in trauma-focused therapy as being necessary and "not a bargain anymore." She explained that attempting to avoid processing her trauma would likely backfire in the future and encouraged other adolescents to explore their identities and find their true, authentic selves through therapy. She noted,

> You find your inner self and who you are through therapy. You realize that you are more than whoever made you suffer. You have to think of yourself and your children too. If your children see you avoid processing your trauma, they'll think that it's okay to do that. Once they go through the therapy, they'll realize that it's made them who they are and they have to find a way to shape their trauma to fit their lives without it hurting them anymore.

Academic impact. Gaby did not notice much change in her academics as a result of engaging in TF-CBT. However, she reported that she perceived therapy as a break from school and her day to day routines. "Stress got easier for me with therapy," she said, and admitted to using some of her learned strategies in her classroom, such as PMR. In terms of ease of access to therapy, Gaby stated that had therapy not been provided at her school, she likely would not have been able to attend. "It's easier at school, because I'm always there. It would have been harder to find a ride to some place [outpatient

behavioral health agency] because of my son's appointments and his daycare being here at school."

Single Participant: Valeria

Valeria. Valeria is an 18-year old student who was in the 12th grade at Andres Bello High School at the time of the study. She was born in the United States to Mexican-born parents. Valeria's living arrangements were unusual in that she lived half time with her mother and siblings and half time with her boyfriend and his mother. She explained that she tries to split her time between her family and her boyfriend, but did not elaborate further. Valeria was referred for treatment by her Chicano Studies teacher, Mr. Martinez. Mr. Martinez's referral was vague in nature and he did not specify a trauma that Valeria had experienced. Instead, he reported that Valeria "has had a tough background and it would be a good idea to screen her for trauma."

Multigroup Ethnic Identity Measure-Short results. Valeria self-identified as an "American-Mexican" adolescent born in the United States with Mexican parents. I thought to myself that American Mexican sounded unusual but she explained that she puts the "American" before the Mexican because she was born in the United States while her parents were born in Mexico and migrated to the United States together when they were younger. I carefully observed Valeria's body language and tone of voice and her face turned with a slight discomfort as she said the word "Mexican." There was a slight, though notable discomfort in her face that made me think of the way Ana described herself as "Hispanic" instead of "Mexican."

Similar to Ana, Valeria also adopted a slightly disgusted facial expression when describing the ethnicity "Mexican." I mirrored Valeria's facial expression and asked her

to describe it, to which she answered "It makes me think of my dad, who is Mexican, and he and I don't talk." She looked down and up again at me, as to imply that there is a rich story behind that statement. Interestingly, she did not react with the same facial expression when talking about her mother, who is also Mexican. Quickly, Valeria began reading and answering the MEIM-S items. It was interesting to see that Valeria and Ana both made similar expressions when they heard or said the word "Mexican" and "Hispanic" by themselves without pairing it with another ethnicity. It was clear that Valeria saw a definite difference between the "Mexican" and "American-Mexican" and administering the MEIM-S measure helped me understand and become aware this important distinction.

Valeria's mean of the total items was 4.33 (score range between 1 and 5), indicating that she felt a strong degree of her "American-Hispanic" ethnic identity (endorsement and ethnic exploration). The items within the exploration subscale indicated that she behaves and holds attitudes that mimic a strong ethnic identity exploration. For example, she responded *Agree* to items 2, 4, and 8, and *Strongly Agree* to item 10 (*Neutral* to item 1). When asked to elaborate on her responses, Valeria reported that she does not "purposefully find out about my American-Mexican culture, but sometimes I'll ask my mom and my mom's boyfriend about us as American-Mexican people in [city she was living in]." She also reported not knowing how to speak Spanish and having to ask her mother how to pronounce certain words. She spoke about taking a Chicano studies class at her school last semester and enjoying learning about Mexican and minority leaders. Most of her friends are Mexican and Hispanic and they enjoy listening to *Banda* music together and eating Mexican food prepared by their parents.

Lastly, she spoke about her awareness of discrimination toward Mexican people and how she can be affected by her ethnicity and color of her skin. I silently wondered whether her slightly disgusted facial expression when she said "Mexican" had anything to do with her awareness of discriminative acts toward Mexican people in the area where she has grown up. This knowledge coupled with her experiences with her Mexican father, may have prompted her to distance herself from being perceived as Mexican.

Valeria's responses to the items within the affirmation/belonging subscale indicated that she felt a strong sense of belonging, attachment, and personal investment with her ethnic identify. For example, she responded *Agree* to items 3, 7, and 11 and *Strongly agree* to items 5, 6, 9, and 12. She described her feeling of belonging to her ethnic identity like this: "I am glad to be who I am and I don't feel like I should be anything else. I believe that my culture is pretty but I also don't want to ever be looked at as someone who says bad things about other cultures or other people." She wanted me to know that she values and takes pride in her culture though not enough to make her racist or prejudiced against other cultures. Clearly, Valeria felt connected to her self-identified ethnic identity.

Pre-treatment Posttraumatic Stress Disorder Reaction Index results. Valeria's PTSD-RI Self-Report Trauma History included witnessing her uncle hitting her aunt multiple times across a period of time, seeing someone being beaten up, being touched inappropriately by her cousin, hearing about her brother's father dying in a serious car accident, hearing that her mother was sexually assaulted, and coming home and finding out that her father was deported back to Mexico. Interestingly, when I asked Valeria how he was deported, she refused to state the reason behind his deportation and

wanted to change the topic. When asked to choose the traumatic event that bothered her the most now, she chose seeing her uncle hitting her aunt multiple times. Valeria expressed feeling intense fear during the physical altercation as she tried to push her uncle off her aunt and he in turn, shoved her on top of the stairs. She described seeing her younger cousin's riddled with fear and had to take them upstairs until the physical fight ended.

I conducted the first part of the semi-structured interview simultaneously, as Valeria responded to the PTSD-RI items, by asking follow-up questions, as needed, to obtain a deeper understanding of her experience with Posttraumatic Stress (PTS) symptoms. In order to gauge her level of anxiety/distress, I asked Valeria how she was feeling and asked her to rate, on a scale of one to ten (1 = "I'm doing well," 10 = "I'm really struggling right now"). Her ratings never went past a 5.

Valeria's PTSD-RI results were presented to her during the second part of the semi-structured interview, the feedback session. I conducted this part of the session similarly to the other adolescents, educating Valeria about the etiology of PTSD and provided information about the rates of adolescents witness domestic violence. When told that she did not qualify for a diagnosis of PTSD (see Table 6), she appeared relieved. I communicated to her how impressed I was that her PTSD-RI showed very low levels of distressing PTS symptoms and that she appeared to be functioning well in her home and school environments despite her trauma history. She told me "I guess I thought I was struggling more than I really am."

Table 6

Valeria's Pre- and Post-treatment Posttraumatic Stress Disorder Reaction Index Scores

Subscale	Pre-test Scores	Post-test Scores
Intrusion	5	1
Avoidance	3	0
Negative Cog.	8	3
Arousal/React.	8	4
Total	24	8
Meet Criteria for PTSD	No	No
Dissociative Type	No	No

During our supervision session this week, Dr. Gomez and I discussed the lack of elevations in Valeria's PTSD-RI scores. Internally, I thought this meant she did not truly need to go through TF-CBT. However, Dr. Gomez disagreed, stating that Valeria was still a decent candidate for TF-CBT due to the extensiveness of her traumatic experiences (e.g., being molested by her cousin, witnessing domestic violence, her father being deported). Dr. Gomez emphasized that while Valeria was not experiencing significant distressing PTS symptoms and denied that the symptoms she endorsed were affecting her functioning in her home or school environments, Valeria is currently stable (e.g., no suicidal ideation or unstable home environment), which put her in a solid place to start TF-CBT and be receptive to learning the skills necessary to be successful at TF-CBT. Dr. Gomez encouraged me to emphasize Valeria's resiliency throughout the TF-CBT process as much as possible, to instill a sense of hope for the future.

Valeria's Therapy Progression and
Working Alliance Inventory-Short
Outcomes

Valeria began to participate in TF-CBT sessions shortly after the screening

process and semi-structured interview. Valeria completed a total of 14 TF-CBT sessions

and had five cancellations, with most sessions taking place in her school setting (refer to

Table 7 for Valeria's timeline of therapy sessions). Reasons for cancellations were all

related to academics including attending school fieldtrips, making up late class work, or

studying for or taking final exams. In those cases, the sessions were rescheduled for the

following week. Once all TF-CBT sessions were completed, the semi-structured

interview took place in Valeria's home, at her request.

The first three weeks (sessions 1-3) of sessions were spent introducing Valeria to

the study, administering the MEIM-S and the PTSD-RI measures, and providing her with

feedback about her PTSD-RI results. I administered the first WAI-S to Valeria on her

third session, after she completed the MEIM-S. She scored our working alliance with a

score of 74, and rated most items on the scale with a *Very Often* except for "I believe ___

likes me" and "___ and I are working towards mutually agreed upon goals," which were

both were rated as *Always*: and "___ and I trust one another," which was rated as *Often*.

The negatively worded items (items 3 and 10; e.g., "___ does not understand what I am

trying to accomplish in therapy" and "___ and I have different ideas on what my

problems are") were rated as *Never* and *Rarely*, respectively. A closer examination of

each of the subscales on the WAI-S revealed that the Bond subscale was lower than the

rest of the scales (e.g., goal and task) by one point. For example, Valeria rated item 9

(e.g., "___ and I trust one another") as *Often*, which was the lowest rated item in the entire scale.

Table 7

Valeria's Timeline of Therapy Sessions

Participant	Timeline	Therapy Phase	Culture	Working Alliance Inventory-Short Score
Valeria	Week 1: 08/28/14	Screening for Inclusion		
Valeria	Week 2: 09/04/14	Feedback Session Psychoeducation		
Valeria	Week 3: 09/10/14	MEIM	Yes	74
Valeria	Week 4: 09/18/14	Cancelled		
Valeria	Week 5: 09/25/14	Cancelled		
Valeria	Week 6: 09/26/14	Psychoeducation	Yes	75
Valeria	Week 7: 10/02/14	Psychoeducation		
Valeria	Week 8: 10/09/14	Cancelled		
Valeria	Week 9: 10/16/14	Relaxation	Yes	76
Valeria	Week 10: 10/23/14	Relaxation & Affect		
Valeria	Week 11: 10/31/14	Affect		
Valeria	Week 12: 11/06/14	Affect	Yes	74
Valeria	Week 13: 11/13/14	Cancelled		
Valeria	Week 14: 11/20/14	Affect & Cognitive Restructuring		
Valeria	Week 15: 12/04/14	Trauma Narrative		78
Valeria	Week 17:12/18/14	Cancelled		
Valeria	Week 18: 01/13/15	Trauma Narrative & Relaxation	Yes	
Valeria	Week 19: 01/21/15	Psychoeducation, Trauma Narrative, & Safety		84

A deeper conversation with Valeria about her ratings on the Bond scale revealed that she has difficulties with trusting others and that she has never received individual therapy, which intimidated her. She further stated that she agreed that therapy would help her though was not sure she trusted me quite yet. I thanked her for her honesty and willingness to be open about our working alliance and normalized feelings of distrust toward a new therapist. A side conversation about barriers to making it to therapy on a weekly basis also emerged, when Valeria stated that she uses the public bus for transportation and it takes her approximately 45 minutes to arrive to school. I praised Valeria for speaking openly about treatment barriers and assured her that close communication between the two of us would likely lead to fewer missed appointments or conflicts with scheduling.

Valeria's fourth session (week 6) took place after the school day was over, two weeks after our last session due to cancellations related to two school fieldtrips. Valeria agreed to meet in the school gymnasium because the office we typically used was locked. Valeria appeared somewhat distraught; she looked pale and had dark circles under her eyes. As I shared my observations with her, emphasizing that I had observed her this way multiple times in the past, she dismissed it with a "there's a flu bug going around I guess" comment. However, as our conversation continued, Valeria spoke about feeling stressed because of being close to failing one of her classes, not having enough time to work on her class assignments because of her job, and her mother's upcoming back surgery. Valeria expressed that she loves her mother and worries constantly about her wellbeing. "Did you know that it is common for Hispanic girls to feel physically ill when they experience stress?" I commented, in an attempt to connect her constant physical

symptoms to psychological symptoms in a culturally sensitive manner. With a contemplative look on her face, she stated "I never thought of it like that. Maybe that's something my mom and I have in common," implying that her mother's stress also presents as physical symptoms (e.g., stomach aches, headaches, sore muscles).

Apart from psychoeducation about somaticizing psychological symptoms, I engaged Valeria in a conversation about domestic violence. After going through the psychoeducational material, Valeria's mood changed and she appeared more depressed. She asked "Is that why I sometimes push and hit my boyfriend?" and began to quietly cry. Normalization of PTS symptoms as well as education about the effects of witnessing domestic violence was utilized as a way to help Valeria understand her behaviors and symptoms. The session ended with the second administration of the WAI-S; she rated our alliance with a score of 75, slightly higher than her first WAI-S score. Her rating of item 4 (e.g., "___ does not understand what I am trying to accomplish in therapy") changed from a *Rarely* to a *Never*.

Valeria's history of witnessing domestic violence combined with her existing anger problems and physical aggression toward her boyfriend were the primary clinical issues discussed during supervision with Dr. Gomez. Dr. Gomez and I discussed Valeria's risk for domestic abuse within her family and interpartner violence with her boyfriend. She suggested that I present Valeria with psychoeducation about domestic abuse and healthy relationships and continue to periodically ask and monitor Valeria's aggressive behaviors and safety with her boyfriend.

The fifth session (week 7) took place at the school, in the school psychologist's office. Given Dr. Gomez's suggestion about providing more specific information about

domestic abuse, I presented Valeria with more information regarding six different types of abuse (e.g., physical, mental, economic, verbal, sexual, and emotional abuse). Valeria's strong grip on the sheet while she was reading about each type of abuse was visibly noticeable. As I reflected this to her, Valeria began to cry and reported that she had experienced and also witnessed almost each type of abuse, with the exception of physical abuse. Further, she expressed not having known that each of those experiences were abusive in nature, as she had grown up seeing the different types of abuse and believed them to be normal behavior within families. Valeria also admitted that her current boyfriend has been mentally and emotionally abusive to her, though she quickly dismissed it and stated that he has not acted this way in a while. We took time to address what healthy relationships look like and the cycle of domestic violence. The session ended with the creation of a safety plan and me providing Valeria with community resources where she could reach out for help if needed in the future.

Valeria cancelled and re-scheduled the next session due to her taking final exams in her classes. The following week, we held our sixth session (week 9) in the school psychologist's office. The goal of today's session was to briefly review her thoughts on the psychoeducational materials related with domestic violence and abuse and begin the relaxation training phase of TF-CBT. As we began talking about domestic violence, I asked Valeria about her perception of gender roles within her family to learn more about how women were perceived in her own family and her boyfriend's family. She spoke about women being expected to be submissive and leaving decision-making to men. We spoke about the meaning of respect and power for her and the way in it looked within her current romantic relationship. "Women don't really go to college in either one of our

families and he [boyfriend] doesn't want me to go to college," she said, with a defeated expression on her face. Our conversation was filled with various cultural pieces about intergenerational trauma and gender-role expectations within her family, the meaning of respect in her family and that of her Hispanic community, the value she places on being close with her family members and how her values are incongruent with her current behaviors, and her own aspirations for the future as an American-Hispanic young woman.

As I prompted her to think about a safe place to draw (real or fake), Valeria began to softly cry as she said "I don't have one." She became embarrassed because she did not know how to draw well and asked if I could draw it for her if she told me what to include in it. Some of the themes of her safe place included: wanting to be far away from her boyfriend's house, needing peace and quiet from her family members, and having her father back in the United States with her with her mother by her side. Toward the end of our session, Valeria filled out the WAI-S for the third time and she rated our working alliance with a score of 76. Her ratings of each item did not differ from the previous WAI-S administration except for item 2 ("What I am doing in therapy gives me new ways of looking at my problem" rated as *Always*).

Session 7 (week 10) was marked by managing Valeria's emotional reaction to her decision to break up with her boyfriend and move back in with her mother. We processed the event leading up to her breakup, including Valeria hitting her boyfriend after she felt humiliated by him. Psychoeducation was utilized by highlighting the cycle of aggressive behaviors and we drew an anger curve to highlight the progression of her anger. Given the emotionally-charged topic, I encouraged Valeria to utilize a feelings list to express herself in session. Further, I encouraged her to utilize the safe place she had drawn the

previous session to control her emotions in the session. I prompted her to utilize both skills over the next week.

I met Valeria at her home for session 8 (week 12) because her school was closed due to professional development days for school staff. We expanded upon the affective modulation work we did during our last session and used a feelings list, drawing of a feeling thermometer, and using the idea of a mountain or an iceberg as a metaphor for primary and secondary emotions. As we began to process another emotionally-charged incident she had experienced over the past week, her family began to fill the living room and kitchen, which did not allow us the privacy she expected to have. Because of lack of privacy at her home, we re-scheduled our session for the follow week at her school (session 9, week 11). She responded positively to being given the opportunity to express deeper emotions (e.g., isolated, empty, confused, humiliated) and admitted to believing that she had anger problems rather than feeling humiliated and rejected by her boyfriend and other family members. The session ended with Valeria filling out the WAI-S and rating our working alliance with a score of 74, two points lower than the previous administration of the WAI-S. When asked to elaborate on her ratings, she stated that she would like for me to give her more coping tools and strategies to help her manage her anger more appropriately (e.g., without becoming physically aggressive toward her boyfriend).

Our next session was cancelled by Valeria because she was falling behind in her classes and had gotten the opportunity to make up some of her work during the class period during which we typically met. Therefore, session 10 occurred the following week (week 14), during her 3rd hour class. I started the session by handing Valeria a list of

coping strategies she could choose to use at different stages of her anger cycle (developed in a previous session). Valeria and I spent a significant amount of time problem-solving a variety of scenarios that have happened in the past and the ways in which she could use certain coping skills to dissipate her anger. Additionally, we utilized cognitive restructuring by identifying helpful and unhelpful thoughts and defining the connection between her thoughts, feelings, and her behaviors. Valeria appeared to respond well to our work during this session. As we finished our session, she reported that she keeps her safe place drawing in her binder as a reminder when feeling difficult emotions throughout her day.

Valeria begun to write her trauma narrative on session 11 (week 15) and continued writing her chapters through session 13 (week 18). Independently, Valeria chose to add her father's deportation to her trauma narrative, stating that she had accepted the event and needed to process it. Initially, Valeria was observed to be resistant toward beginning her trauma narrative, stating that she felt anxious to tell me how her father was deported over five years ago. "He did bad things and I'm ashamed of him for it," she stated. Instead of forcing her to tell me, I asked Valeria if we could play a guessing game in which I guessed any possible action or crime he committed. With a slight smile on her face, she agreed. "Did he touch you when you did not want him to?" "No, not that," she quickly said. "How about anyone else in your family or people outside your family?" I asked; "No." After several guesses, I asked "Did he buy, sell, or do any illegal drugs?" and Valeria stayed quiet. Her father was involved in a Mexican drug cartel in charge of smuggling and selling cocaine in the United States.

At the end of session 11, Valeria rated our working alliance with a score of 78. She rated the following items *Always* instead of *Very Often*: "What I am doing in therapy gives me new ways of looking at my problem," "I believe ___ likes me," "We agree on what is important for me to work on," and "We have established a good understanding of the kinds of changes that would be good for me." It was clear that our therapeutic relationship had continued to improve and strengthen after almost every session.

Over the next two sessions, Valeria became more comfortable with writing her trauma narrative. On session 12, she expressed enjoying the opportunity to write her trauma narrative because it had given the opportunity to allow herself to think of the positive and negative side of her father and allow herself to miss her father despite his criminal background and poor choices. I challenged Valeria to write "my father sold cocaine" instead of "he did something bad," to discourage avoidance and practice exposure to trigger words. We spoke openly about deportations and their effects on children and families, paying particular attention to the ways in which it had affected her and her family's lives. Overall, Valeria spoke about feeling proud of herself for having accomplished her goal of writing her trauma narrative and finishing therapy successfully. "I'm also starting one of my college classes next month," she said, as she spoke of her accomplishments. Valeria completed her last WAI-S scale on this session, and she rated our alliance with a score of 84 – her highest score yet.

Post-intervention Semi-structured Interview Findings

Initial low expectations of therapy. Valeria admitted to having little confidence that I would help her feel better with TF-CBT. "I didn't think you were going to help me, so I said 'I'm going to pray and give her a chance to see if it works,'" she said, stating her

low expectations of therapy. As therapy progressed, however, Valeria began to notice that I listened to what she needed and delivered her therapy accordingly. For example, she talked about the different ways she learned to manage her explosiveness and aggressiveness toward her boyfriend.

Finding herself. Valeria described herself as "lost" prior to starting TF-CBT. She felt isolated as a result of her trauma and believed others would be judgmental to her if she shared her experiences. "Relief" was the word she used to describe herself after completing CM-TFT and identified having multiple coping tools to use at her disposal, particularly with dealing with her anger and physical aggression toward her boyfriend. Additionally, Valeria found herself having fewer arguments with others around her as she began to slow down her thinking and make healthier decisions.

Cultural sensitivity and working alliance. Valeria spoke highly of her sense of connection with me and the impact our strong relationship had on her openness to continue attending therapy and actively engage in treatment.

> I took your advice instead of just hearing it. It helped me release my demons. That sounds weird! But it's like releasing demons you have inside of you. You told me all these things I didn't know about myself and taught me how to get them [the demons] out of me.

In terms of my cultural sensitivity in therapy, Valeria reported that it proved to her that I genuinely wanted to know who she was. Given that Valeria was already skeptical of therapy, culture-rich conversations helped her to feel respected and trusted by me. Specifically, she noted "I felt respected by you. I value that word and I think everybody should be respected. I felt like you wanted to get to know me." A particular example she gave was when we talked about the tendency that Hispanic people have to somaticize psychological symptoms. "Hearing that made me become more aware of what I do to

myself to make me feel so stressed out. Since then, I haven't really been as sick." She acknowledged learning how to be more aware of her stress to decrease the likelihood of becoming physically ill.

Valeria was the only adolescent participant who found the use of the WAI-S helpful to monitor her own progress in therapy. She added that using the WAI-S also helped her monitor her relationship with me.

> The more I saw the numbers on the sheet, the more I saw that I was making progress. Going from 5 to 6 or from 6 to 7, I saw my progress. I actually felt like what we are doing [in therapy] was actually working. The more I actually saw it, the more I felt, like, you were helping me.

Academic impact. Valeria attributed her academic improvement to herself solely. "My grades were all dependent on myself, so if I made the choice to do better, I would." However, she attributed her increased hope and perseverance to our therapeutic relationship and her progress in therapy. "You made me want to do better so I don't have to stay here, in high school, forever. You kept my eyes on the future and my goals. There are people that helped me get there, but having that thought that I will get there, it helped more."

Advice to others about therapy. Valeria advised other Latina adolescents who have struggled with trauma to engage in therapy regardless of their preconceived ideas about whether therapy will work or not. She also encouraged other adolescents to let their guards down and "let therapy work. If you don't, there's no progress." She spent some time reflecting on her own initial hesitancy and low confidence in my ability to help her:

In the beginning, I didn't think much of therapy. I just thought you were going to give me all this crap and not really anything helpful. I didn't think any of it. Therapists aren't your friend, so don't think that they'll just sit there and listen to you. It's more than that. Therapists give you more than just listening.

Single Participant: Ruby

Ruby. Ruby is an 18 year old student who was in the 12thgrade at Andres Bello High School at the time of the study. Ruby, like Valeria, was referred to this study by Mr. Martinez. Mr. Martinez knew that Ruby had been sexually assaulted approximately three years ago and thought this study would be a perfect opportunity for Ruby to begin trauma-focused treatment. When I pulled Ruby out of her class, she appeared shy, reserved in her self-disclosure style, and very respectful (e.g., "Good morning, Ms. Kathy, how are you?" and "Have a good day Miss"). She spoke about having been born in Mexico (first generation immigrant) and coming to the United States when she was five years old. She expressed that her parents chose to move to the United States "for a better future here, for us to get a better education and for them to get better work."

Immigration events results. When the Immigration Events scale was administered to Ruby (she chose to complete it in English), she appeared hesitant to answer it because she did not remember much about her immigration experience. "I'd like you to hear the questions and you can choose 'Yes' or 'No,' as you see fit." "Okay," she shyly responded. She answered 'No' to most of the items on the scale, except for item 3 and item 7. Ruby elaborated that her oldest sister had been sexually assaulted by a "Coyote" – a person that helps migrants cross the United States border – when she was attempting to cross the border as a teenager. I asked her if her sister had ever attended therapy for her sexual assault, to which Ruby answered "No, she doesn't have papers

[legal documentation for residing in the country].” Ruby also self-disclosed to not having legal documentation to reside in the U.S. either.

We seemed to find common ground when speaking about the experiences that undocumented people face when attempting to find mental health supports without having legal documentation. During this conversation, I observed that Ruby appeared to open up and talk more freely, as if her level of trust toward me increased slightly. She then went on to describe that she fears being deported because she also does not have any legal documentation for residing in the United States. She disclosed that her father had been deported about five years ago as well as her brother in law. “You have had so many people taken from you,” I reflected, and we sat in silence as she began to cry. It was clear that the history of deportations in Ruby’s life as well as her own precarious status had affected her on a deeper level.

Multigroup Ethnic Identity-Short results. Ruby self-identified as a “Mexican” adolescent born in Mexico to Mexican-born parents. Ruby’s mean of the total items was 4.33 (score range between 1 and 5), indicating that she felt a strong degree of her “Mexican” ethnic identity (endorsement and ethnic exploration). The items within the exploration subscale indicated that she behaves and holds attitudes that mimic a moderately strong ethnic identity exploration. For example, she responded *Agree* to items 4 and 8, and *Strongly Agree* to item 10 (*Disagree* to item 4). When asked to elaborate on her responses, Ruby reported that most of her friends were born in the United States but see themselves as “Mexican.” Ruby asserted that she is proud to be Mexican and felt she was more connected to her Mexican ethnic identity because she was born and raised there until the age of five. She narrated short stories about the neighborhood in which she used

to live and her friends with whom she played; I caught a small smile as she reminisced about her life in Mexico. Ruby's tone of voice grew more assertive as she talked about her response to item 4, "Being Mexican doesn't change anything and I know it's not going to affect me when I'm older."

Ruby's responses to the items within the affirmation/belonging subscale indicated that she felt a strong sense of belonging, attachment, and personal investment with her ethnic identify. For example, she responded *Strongly Agree* to items 3, 5, 6, 7, and 11, *Agree* to items 12, and *Neutral* to item 1. When elaborating on her responses, Ruby talked about attending *bailes* (dances) on the weekends, celebrating her *quinceañera* (15th birthday/introduction to society), attending church on Sundays with her family, and going to *fiestas* with her large family. It was clear that Ruby experienced a strong connection to her self-identified ethnic identity.

Pre-treatment Posttraumatic Stress Disorder Reaction Index results. Ruby's PTSD-RI Self-Report Trauma History included witnessing multiple episodes of domestic violence between her mother and father, hearing that her uncle had died of a heart attack, and being sexually assaulted at a public park when she was 14 years old by a boy with whom she had gone on a date. When asked to choose the traumatic event that bothered her the most now, she chose her sexual assault. I conducted the first part of the semi-structured interview simultaneously, as Ruby responded to the PTSD-RI items, by asking follow-up questions, as needed, to obtain a deeper understanding of her experience with PTS symptoms. In order to gauge her level of anxiety/distress, I asked Ruby how she was feeling and asked her to rate, on a scale of one to ten (1 = "I'm doing well," 10 = "I'm

really struggling right now"). Her ratings never went past a seven and she was able to complete the scale without issues.

Ruby's PTSD-RI results were presented to her during the second part of the semi-structured interview, the feedback session. Overall, Ruby responded positively to the PTSD-RI results (e.g., did not become teary eyed, accepted the results). She stated that something that was a surprise about her results is that she did not know she was suffering as much as would be expected based on her PTSD-RI results (see Table 8). We talked about symptoms of avoidance and negative cognitions and mood, which were the most elevated scores for her, which gave space for her to admit that she has never talked about her sexual assault with anyone. She also shared feeling resentful toward her two sisters as well as her mother for having blamed her for the assault and having shown little to not support toward her.

Table 8

Ruby's Pre- and Post-treatment Posttraumatic Stress Disorder Reaction Index Scores

Subscale	Pre-test Scores	Post-test Scores
Intrusion	13	13
Avoidance	7	6
Negative Cog.	25	21
Arousal/React.	11	13
Total	56	53
Meet Criteria for PTSD	Yes	Yes
Dissociative Type	Yes	Yes

Ruby's Therapy Progression and Working
Alliance Inventory-Short Outcomes

Ruby began to participate in TF-CBT sessions shortly after the screening process and semi-structured interview. Ruby completed a total of 10 TF-CBT sessions and had 7 cancellations (highest number of cancellations out of all of the adolescent participants; refer to Table 9 for Ruby's timeline of therapy sessions). Reasons for cancellations included having to attend a fieldtrip to a local community college, doctor's appointments, needing to care for her younger siblings and nieces, and stress due to final exams approaching or turning in late class assignments, among others. In those cases, the sessions were rescheduled for the following week. Unfortunately, Ruby chose to terminate therapy early and a semi-structured interview could not be held. Instead, our informal conversation about her decision to terminate therapy is described.

Similar to the rest of the participants, the first three weeks (sessions 1-3) of sessions were spent introducing Ruby to the study, administering the MEIM-S and the PTSD-RI measures, and providing her with feedback about her PTSD-RI results. I administered the first WAI-S to Ruby at the end of the feedback session. She appeared to approach the scale with some reservation, as evidenced by her shy demeanor. Hence, I assured her that her honest ratings were valued and appreciated and emphasized that her ratings would not hurt my perceptions of her. She smiled and said "Okay" as she began to complete the scale. Ruby rated our working alliance with a score of 79. A closer examination of her ratings revealed that she scored the Bond subscale the lowest (Bond = 25), followed by the Goals subscale (26), and the Tasks subscale (28).

Table 9

Ruby's Timeline of Therapy Sessions

Participant	Timeline	Therapy Phase	Culture	Working Alliance Inventory-Short Score
Ruby	Week 1: 08/21/14	Initial Introduction		
Ruby	Week 2: 08/28/14	Screening for Inclusion	Yes	
Ruby	Week 3: 09/04/14	Feedback Session		79
Ruby	Week 4: 09/11/14	Cancelled		
Ruby	Week 5: 09/18/14	Psychoeducation	Yes	
Ruby	Week 6: 09/26/15	Relaxation	Yes	73
Ruby	Week 7: 10/03/15	Cancelled		
Ruby	Week 8: 10/06/14	Relaxation		
Ruby	Week 9: 10/16/14	Cancelled		
Ruby	Week 10: 10/23/14	Affect	Yes	73
Ruby	Week 11: 10/31/14	Cancelled		
Ruby	Week 12: 11/06/14	Affect	Yes	
Ruby	Week 13: 11/13/14	Affect Cognitive Restructuring	Yes	79
Ruby	Week 14: 11/20/14	Re-engagement		
Ruby	Week 15: 12/11/14	Cancelled		
Ruby	Week 16: 12/18/14	Cancelled		
Ruby	Week 18: 01/29/15	Termination		

When asked to elaborate on her responses, Ruby primarily focused on feeling

unsure and intimidated by having to talk about and process her sexual assault trauma. She

reiterated not having discussed her trauma with anyone and feeling afraid that it may

make her feel worse. I praised her for her honesty and normalized her thoughts and

feelings by educating her about how common it was for children, adolescents, and even

adults to avoid talking about their trauma and feeling as if processing through it may worsen their symptoms. In an attempt to build upon her strengths, Ruby and I talked about her immense resiliency and her ability to function well at school, as I had heard many teachers as well as the assistant principal speak highly of Ruby, and how these strengths had helped her to continue to function fairly well in many aspects of her life. Toward the end of the session, Ruby appeared more confident in her ability to do trauma-focused work and agreed to continue to meet on a weekly basis.

Ruby cancelled our next therapy session because she had a fieldtrip to a local college – the same fieldtrip Valeria had attended. Therefore, session 4 (week 5) occurred two weeks later. Providing psychoeducational materials about sexual assault and acquaintance rape was the primary focus of this session. Ruby appeared to tolerate hearing facts and information about acquaintance rape, though she tended to listen quietly to the information rather than ask questions about it or provide her own comments. I noted her lack of expression in therapy and her emotional distance when hearing the information. However, as the session came toward an end and we began to talk about her weekend activities and her reserve slowly disappeared. Ruby spoke about wanting to attend more *bailes* (Mexican dance parties) more often. In an attempt to build a closer connection with her, I asked her to play her favorite Mexican *Banda* music on my phone. Suddenly, her demeanor changed from quiet and reserved to talkative and open.

During supervision with Dr. Gomez, I spoke with her about my own reactions to Ruby's avoidance and emotional distance, including feeling disconnected from her, at times frustrated by her passive resistance, and struggling to understand how to engage her in session. Dr. Gomez recommended that I take it slower with her and focus on

continuing to build rapport with her and find relaxation strategies that fit within her cultural frame. Further, she recommended that I continue to find ways to understand her immigration history more, as she had responded positively toward this when completing the MEIM-S questionnaire. Lastly, she encouraged me to provide Ruby with immigration-related resources that she can use to understand her and her family's rights as an undocumented young adult in the United States.

Ruby's fifth session (week 6) took place outside of her apartment home, on a bench by a small community park. Today, Ruby described a recent fieldtrip to a local theater where students watched a film about illegal immigration. She described scenes in the film that portrayed a father with substance abuse problems being physically and emotionally abusive to his family. These scenes triggered negative memories and flashbacks of her family's history of domestic violence. Further, a sexually-explicit scene in the film had triggered worse flashbacks of her own sexual assault. "It reminded me of that thing that happened to me," she said, trying to avoid saying the words "sexual assault" or "rape." "It triggered your brain to push unwanted memories of when you were sexually abused," I replied, as a way to safely expose her to her trauma-triggering words. We continued our conversations about deportations, their effects on adolescents her age, as well as the effects of multiple traumas.

In order to find culturally-informed relaxation strategies, I encouraged Ruby to draw a picture of her safe place and to include phrases, things, people, places, or other details that would help her ground herself when experiencing trauma reminders. As I observed her draw her safe place, I noticed a small drawing of a doll mounted on a wall. "When my dad was taken, he spent a month at a jail waiting to be deported back to

Mexico. He's a very good artist, so he drew this princess on fabric he somehow found at the jail and sent it to me," she said, as she stared at the picture and fought back her tears. I encouraged her to use her father's picture as mental reminder of his love for her and to practice using its image as a way to center her thoughts and during guided imagery exercises we practiced in session.

Ruby completed the WAI-S toward the end of our session and she rated our working alliance with a score of 73, with the Goals subscale having the lowest score (Goals = 19, Bond = 26, and Tasks = 28). Given that her Goals scores had dropped from her previous ratings, I asked her to elaborate on her scores. She stated that she is still unsure about processing her trauma and whether it is necessary for her healing. She had questions about the necessity of the trauma narrative and fears about being unable to handle it. Out of all of the participants in this study, Ruby presented with the most avoidance and the highest degree of PTSD, suggesting that trauma-focused work was even more indicated for her. I encouraged Ruby to find natural support systems that could help her through this work so she does not face her trauma alone and welcomed her to bring a close friend to therapy, with parental consent. Internally, I began to question whether TF-CBT was the right treatment modality for Ruby, given her high avoidance and resistance toward talking about her trauma. Questions about treatment modality and timing of therapy continued to challenge my confidence that TF-CBT was the right approach for almost every sexual abuse case. I wrote down my thoughts and questions for my next supervision with Dr. Gomez.

The next session was cancelled by Ruby because she had to attend a doctor's appointment. Fortunately, we were able to re-schedule our sixth session (week 8) for the

same week. We met at her home and sat on the same bench as before. Continuing with the relaxation module of TF-CBT, I began the session by asking Ruby about whether she wanted to include a supportive friend or relative in our sessions, though she politely declined and stated that she does not trust anyone with knowing her trauma. She stated that the last time she told her friend about her sexual assault, her friend betrayed her trust and told other students at her school. The rest of the session focused on practicing guided imagery and diaphragmatic breathing, to reduce the impact of her intrusion symptoms. Throughout the session, however, Ruby's emotional distance and disconnect from the session increased, and I continued to find it difficult to engage her.

I shared my concerns about Ruby with Dr. Gomez, who also began to wonder whether Ruby was truly ready for TF-CBT. I shared that Ruby was not presenting as open to learning relaxation strategies or using them in session and wondered whether moving to the affective modulation of therapy would be appropriate. Dr. Gomez agreed, stating that it is counterintuitive to force an adolescent to relax.

I received a call from Ruby about three hours before our session, stating that her mother has been caught drinking and driving and was put in jail. Ruby apologized for cancelling our session and stated that she was still interested in continuing to meet with me the following week. Our seventh session (week 10), we began the affect phase of TF-CBT. Using a Spanish feelings list, Ruby and I engaged in a discussion about the purpose of feelings and used more structured activities as a way to decrease her resistance. While she engaged in expressing herself in Spanish, her resistance still lingered in the session. Despite this, she stated it would be beneficial for her to express her emotions more often. She stated "my friends and my boyfriend always tell me that they don't know how I feel

because I don't tell them much. My mom gets mad at me too." She agreed to practice the use of "I" statements this week with a person she trusted.

Ruby rated our working alliance with a score of 73, which perplexed me given her resistance in session and continued emotional disconnect. The scores for each of the subscales were exactly the same as the previous WAI-S, except item 10 (e.g., "Kathy and I have different ideas on what my problems really are"), which she rated as *Sometimes*. "Thank you for your honesty, Ruby. I am interested in hearing what you believe your problems to be, since you marked *Sometimes* on this item," I said, in an attempt to elicit a clearer idea of her perceived problems. At first, she expressed being unsure of her own problems. After some silence, she noted needing to learn how to communicate with others and how to begin to trust others around her.

Ruby cancelled the following session due to another conflict and rescheduled our session for the following week. Sessions 8 and 9 (week 12 and 13) focused on continuing to focus on emotional identification and expression and beginning cognitive restructuring work. Most of the cognitive restructuring work was spent on identifying unhelpful thoughts about writing her trauma narrative and changing her perspective in order to change her feelings toward it. Toward the end of session nine, Ruby mentioned enjoying Mexican *Telenovelas*, which prompted me to encourage her to identify a variety of positive and negative emotions the next time she watches her favorite *Telenovela*. She laughed and agreed to try it this week.

Ruby completed the WAI-S at the end of session 9 and gave a score of 79 (Tasks = 27, Bond = 26, and Goals = 26). She elaborated on her responses independently today and stated that the reason why she is rating many of the items as *Very Often* instead of

Always is because she is not sure she can provide any details of her sexual assault during the trauma narrative. I thanked her for her honesty and validated her hesitancy toward starting her trauma narrative. I also assured her that she is safe and that we ease into the trauma narrative very slowly, in small pieces, and utilize all of her already learned skills to ensure her safety and ability to process her trauma appropriately.

In supervision, I shared with Dr. Gomez my continued struggle with engaging Ruby and successfully preparing her to writer her trauma narrative. Dr. Gomez suggested using therapeutic immediacy as a way to share my experience of Ruby's emotional disconnect in session. Dr. Gomez and I both wondered about Ruby's motivation for actively engaging in session and agreed on using motivational interviewing and therapeutic immediacy in our future sessions.

Ruby and I held her 10th session (week 14) during her first class period at her school. Our session began by using therapeutic immediacy and sharing my thoughts about Ruby's hesitation to actively engage in therapy. Using motivational interviewing strategies, I asked Ruby about her motivation for doing well in therapy. She stated that she truly believes that she needs to engage in trauma-focused work, but does not believe talking or processing her trauma is necessary. "I only think about my trauma when I talk about it with you or when I'm by the park where it [sexual assault] happened," she stated. She denied having used any of the skills learned in session throughout her week. My personal belief that TF-CBT was not the right type of treatment for her was solidified in during this session.

As expected, a series of cancellations occurred over the following 2 months. Three cancellations occurred due to the Thanksgiving holiday and the school's two-week

winter break. Similar to the other participants in the study, the rest of the December

cancellations occurred because of final exams and needing to turn in late assignments. In

the month of January, I attempted to call Ruby and her mother a total of five times with

no call backs. Fortunately, Ruby called back at the end of January and scheduled one

more therapy session with me.

Ruby's last session (week 18) took place at a public library directly across the

school. She began by apologizing for not having returned my phone calls and stated she

was disrespectful for doing so. Finally, Ruby was able to clearly state that she could not

find it within herself to process her trauma at this time. She explained having a

conversation with her brother, in which he encouraged her to be honest with me and

communicate more clearly. "I know I have to do this, I know I still struggle with it daily,"

she said "but I'm not ready, I'm just not ready right now. I can't do it." I felt her pain as

she finally felt strong enough to terminate therapy while admitting that she was aware of

her difficulty with PTSD. Ruby agreed to complete a PTSD-RI and agreed to allow me to

include her story and data in this study despite her early termination.

CHAPTER V

DISCUSSION

While TF-CBT continues to be widely accepted as the single most researched and effective intervention for addressing trauma-related symptoms in children and adolescents, little is still known about how traumatized Latina adolescents and their families perceive TF-CBT, as well how a culturally modified version of this treatment influences their attendance and engagement in therapy. Failing to integrate important cultural constructs and values into the therapeutic process can result in early termination of treatment and reduce the full therapeutic effect of any intervention (Paniagua, 2005). Therefore, this research study explored the experiences of four Latina adolescents and two mothers who participated in Culturally-Modified Trauma-Focused Treatment (CM-TFT). The overarching expectation for this mixed methods study was that all Latina adolescents and their parents would have a positive experience with CM-TFT and observe personal growth that extended beyond clinical symptomatology and into their familial, school, and community functioning.

The overall guiding question that served as a foundation for this study was whether using CM-TFT with Latina adolescents would improve retention, engagement, and working alliance in therapy. Further, I wanted to understand how these Latina adolescents and their parents experienced CM-TFT, with special attention given to how they made meaning of their CM-TFT journey. Focused interest was directed toward the influence that cultural modifications had on attendance and engagement both within and

outside of therapy sessions, whether there was a decrease in PTSD symptoms, and any observed improvements in their school functioning.

Findings

The three adolescent participants who completed CM-TFT appeared to experience important changes over the course of therapy. Each one agreed that the CM-TFT experience had been positive, although each adolescent identified different parts of the therapy as helpful (i.e., Ana identified the trauma narrative as most helpful, while Valeria found coping tools to manage her anger as most useful for her). Over the course of the intervention, all participants who completed CM-TFT experienced their working alliance as strong or increasing as therapy progressed, observed a decrease in their PTSD symptoms, and saw some improvement in their academics or overall school experience. These findings were not unexpected because of the strong research support for TF-CBT as an evidence-based treatment for trauma. However, these results also lend support to its effectiveness with Latina adolescents and their mothers.

In terms of the way the ethnic identity of the Latina adolescent interacted with certain CM-TFT strategies, it was found that those with a stronger endorsement of their Latino ethnic identity tended to appreciate the use of Latino constructs within therapy more so than Gaby, who did not endorse a strong sense of a Latino ethnic identity. Lastly, both parents appreciated CM-TFT's directiveness and skill-based nature and found CM-TFT as helpful in addressing their daughter's PTSD symptoms and improving certain parts of their parent-child relationship. Review of data through a cross case analysis suggested that each individual portrayed improvements but to varying degrees.

Adolescents' Experience of Culturally
Modified Trauma-Focused
Treatment

One of the guiding questions of this study was to understand what the adolescents would perceive as beneficial or detrimental to their treatment. Results from this study concluded that none of the adolescent participants who completed treatment reported perceiving any parts of CM-TFT as detrimental or unhelpful to their treatment. On the contrary, all of them found the trauma narrative, cognitive restructuring, relaxation, and emotion expression and modulation as important components of CM-TFT. This finding is consistent with those of Dittmann and Jensen (2013) who found that adolescents tended to experience TF-CBT positively and considered working through their trauma narratives as one of the most helpful interventions. In this study, both Ana and Gaby spoke highly of their experience of the trauma narrative in decreasing PTSD symptoms and improving their sense of closeness with their mothers. Both of these adolescents described the trauma narrative as having helped them take "weight out of my body" and "get it off my chest." Perhaps the reason why the other adolescent (Valeria) did not find the trauma narrative as helpful was because she was not experiencing significantly distressing intrusion or avoidance symptoms and rather requested more help with relaxation training and emotional expression and regulation to avoid physical altercations and cope better with irritability and anger. For Ruby, the trauma narrative served as a deterrent to successful treatment of her PTSD (see "Dealing with avoidance" section.)

Intervention's impact on therapeutic attendance and engagement. One of the major guiding assumptions of this study was that the use of Latino cultural constructs would increase attendance and retention in the Latina adolescents and mothers of this

study. Based on the work of Paniagua (2005), it was believed that integration of cultural values into the therapeutic process would decrease early termination and increase client engagement. In this study, Ana and Valeria reported that CM-TFT helped to increase and improve their attendance and engagement in therapy and there was a clear relationship between the use of Latino constructs and their observed engagement in sessions. For example, in each of the sessions in which culture was infused, both of these adolescents tended to respond positively to my use of culture-rich conversations and topics, as evidenced by their increased level of self-disclosure about family and relationship problems, increased level of vulnerability and emotional expression, decreased avoidance of difficult conversations (e.g., family deportations), increased openness to continue talking about culturally-loaded topics (e.g., discrimination experiences, religiosity within the Latino culture), and openness to explore already existing culture-specific protective factors (e.g., openness to including parents in therapy and increased interactions with family).

One adolescent (Ruby) discontinued treatment due to perceiving the trauma narrative as detrimental to her overall healing. However, while Ruby terminated therapy early, she tended to respond positively to my use of culture-rich conversations and topics. For example, she appeared to become more talkative, relaxed, and open as culture-rich conversations occurred (i.e., talking about her father's deportation, expressing disappointment toward her family's distance and rejection after her rape), and tended to become withdrawn in sessions where culture was not used as often. Ruby attended a total of 10 CM-TFT sessions, which is higher than the average number of sessions ethnic minorities tend to attend after their initial appointment (Horrell, 2008). In particular,

Horrell (2008) highlights a pattern of lower utilization and premature attrition among ethnic minorities, with about 50% of ethnic minority clients failing to return after their initial therapy appointment. Thus, while Ruby chose to terminate treatment early, it is possible that CM-TFT had a positive impact on her willingness to continue to attend therapy sessions beyond our initial appointment.

Consistent with the interpretation that certain cultures may place particular focus on the physical rather than the psychological origins of symptoms (de Arellano et al., 2012; Hinton & Lewis-Fernandez, 2011), Valeria also endorsed this view and appreciated the culturally-relevant psychoeducational materials presented to her. More importantly, Valeria reported that the use of this culturally-relevant psychoeducation helped her to feel less skeptical of me as her therapist and CM-TFT as a whole. Thus, Valeria's reports of CM-TFT's helping her feel more engaged in therapy is consistent the widely held belief that ignoring or misusing culture-driven variables may be perceived as insensitive by clients (Paniagua, 2005; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002; Sue et al., 2009; Zane et al., 1994) and result in higher dropout rates (Gelso & Fretz, 2001; Horrell, 208). Similar to Valeria, Ana reported that my purposeful inclusion of her culture within therapy helped her feel more confident in my ability to help her in therapy, encouraged her to "communicate without fear," and have a stronger therapeutic connection with me, which in turn encouraged her to continue attending therapy. Thus, the use of culture-relevant materials, conversations, and overall culturally-sensitive therapeutic atmosphere created a sense of cultural match (Ibaraki & Nagayama Hall, 2014) that helped to foster trust, confidence, and a stronger engagement in CM-TFT.

Through culture-rich conversations, Valeria and I explored concepts related to how she would like to be treated in her romantic relationships, her aspirations for higher education as a young Latina, as well as the impact that her negative experiences with her father's criminal history and deportation have had on her perceptions of the Mexican culture. The purposeful exploration of Valeria's bicultural ethnic identity, my encouragement for her to pursue her goal of graduating high school and going to college, and my overall use of *personalismo* throughout treatment translated into her feeling respected and cared for by me. Further, my use of her inner protective factor of *familismo* helped her to see it as a personal strength and use it as a way to buffer against depression by seeking out more opportunities to interact with her family members and isolate less.

In Gaby's case, she did not verbalize the use of Latino constructs as having had an impact on her engagement or attendance. However, she reported that my flexibility with scheduling and willingness to work with her busy and hectic life as a teenage mother were helpful in increasing her attendance and engagement in therapy. Hence, targeting of contextual variables (consideration of economic and social contexts, Bernal et al., 1995) within Gaby's ecology was appreciated the most by her.

Dealing with avoidance. Traumatized youth tend to present with more reluctance and hesitancy to engage in a therapeutic relationship (Ormhaug et al., 2014), often because of their heightened levels of distrust and reduced confidence in an adult's ability to protect them from danger (Eltz et al., 1995; Ormhaug et al., 2014). This reluctance was observed in both Valeria and Gaby in the early stages of therapy, and for Ruby throughout her sessions. However, while Valeria and Gaby were able to overcome their hesitancy to engage in CM-TFT, Ruby was unable to do so. One paradoxical finding of

this study was the minimal impact that the use of Latino cultural constructs appeared to have on Ruby's active engagement in the core components of CM-TFT, even though she was the least acculturated participant in the study.

First, Ruby's MEIM-S scores indicated that she held a strong Mexican ethnic identity, which would indicate the use of more cultural modifications in her treatment. However, despite the use of various cultural constructs in multiple sessions, she continued to present with emotional distance and disconnection in almost every phase of CM-TFT and she had the highest number of cancelled sessions, which was further evidence of her lack of engagement. Even after employing Lambert and Shimokawa's (2011) recommendations of employing real-time client feedback, such as maintaining an ongoing discussion about our therapeutic relationship through the frequent use of the WAI-S, discussing her motivation for treatment, exploring her social support systems, and discussing negative life events she had experienced. Unfortunately, these strategies did not appear to have a strong influence on Ruby's engagement in therapy or in her ultimate decision to continue participation in the study. It is important to consider Ruby's undocumented legal status as a possible explanation for her high resistance to engaging in TF-CBT. Perhaps her perception that TF-CBT may cause her symptoms to worsen heightened her fear about losing her achieved psychological stability and having a negative impact on her legal status (e.g., possible deportation if she loses control).

It is important to note that perhaps the cultural modifications that I employed throughout her treatment helped her to sense a stronger bond with me as her therapist and still reject CM-TFT as the appropriate treatment for her. Her openness to apologize for failing to return my phone calls and her ultimate willingness to acknowledge to me her

awareness of her internal struggle with rejecting a treatment while being fully aware that she experienced PTSD are clear examples of our therapeutic bond. Thus, her case should not be seen as an overall treatment failure and instead should be depicted as a treatment mismatch. As a whole, it seems that interpersonal conflicts, a lack of readiness for change, combined with high avoidance and treatment mismatch all contributed to her early termination. Thus, despite the research literature supporting the use of cultural sensitivity in increasing therapeutic engagement in minority populations, Ruby's case does not support cultural sensitivity as the be-all and end-all to increasing engagement in ethnic minority adolescent clients. Instead, her case highlights the need to match evidence-based interventions (EBI) with the adolescent, the timing of therapy, and other factors more so than merely the presenting symptomatology.

Parents' Experience of Culturally Modified Trauma-Focused Treatment

To address how parents of the Latina adolescents who participated in CM-TFT described their experience with the treatment, their responses to the post-treatment interview were examined in conjunction with their overall engagement throughout CM-TFT. Although very diverse in nature, the results from this study indicated that the two parents experienced CM-TFT positively, they observed decreases in each daughter's PTSD symptomatology, and reported an improvement in their relationships with their daughters. Interestingly, it appeared that both parents tended to echo their daughter's positive remarks about their experience with CM-TFT. For example, both of the parents and the adolescents spoke highly of the trauma narrative phase of CM-TFT as well as the usefulness of the cognitive restructuring and relaxation components.

The parents' readiness to help their daughters heal from PTS symptoms was found to be a highly important factor for Laura and Karina. Particularly, this readiness to help seemed to have sparked their interest in CM-TFT and helped to maintain their active engagement throughout the treatment. However, their initial reactions to the parent involvement required of CM-TFT differed. Initially, Laura admitted her reluctance to begin CM-TFT, stating that she did not understand the role she would play in her daughter's ability to make progress in therapy. Laura and Ana's conflicted relationship may have helped to explain Laura's initial reluctance to participate in her daughter's therapy. However, as recommended by Santiago-Rivera et al. (2002), once the cultural value of *familismo* was used to frame CM-TFT as an opportunity to increase cooperation, cohesion, and interconnectedness between Laura and Ana, Laura's motivation increased enough such that she agreed to participate in CM-TFT.

While Laura demonstrated reluctance to CM-TFT initially, Karina presented with a higher level of readiness for change. Particularly, the fear of Gaby's PTSD worsening with time and ending in suicide was one of the primary motivating factors she identified for engaging in CM-TFT. Additionally, Karina was motivated to positively model openness to processing sexual assault traumas and willingness to attend therapy, a construct that had not been adequately modeled to Karina per her report.

Both parents spoke positively about the directiveness in teaching skills to address PTSD symptoms. For example, Laura spoke highly about having learned positive parenting skills, relaxation strategies, and effective ways to listen and talk to Ana. Laura also spoke highly of the changes she saw within herself as she progressed through CM-TFT, particularly her ability to actively listen to and speak to Ana. These gains were

voiced by Laura throughout treatment and her active engagement was apparent throughout CM-TFT. An unexpected outcome of this study was Laura's ability to generalize her learned skills to other areas of her life.

Results from this study also supported CM-TFT as a helpful treatment for avoidance and numbing behaviors in adolescents with PTSD. Both mothers reported that the trauma narrative and my strategic way of encouraging the adolescents to actively participate in this phase of therapy was helpful in discouraging avoidance behaviors and holding the participants accountable for going through this exposure-based phase of therapy. One of the mothers spoke extensively about her negative experience with less directive therapies, which had failed at successfully engaging her daughter in completing trauma-focused work. This finding is consistent with research supporting TF-CBT as more effective in comparison to other non-directive, child-centered, supportive therapies, particularly with sexual abuse (Cohen et al., 2004; Cohen & Mannarino, 1996, 1998; Deblinger et al., 1996). Further, both mothers spoke positively about the exposure-based component of CM-TFT as having helped their daughters to desensitize themselves from trauma reminders in a safe and healthy way. Their positive reports of this exposure-based component is consistent with much of the research literature supporting cognitive-behavioral therapy and gradual exposure as a way to treat avoidance and numbing in individuals exposed to trauma (Cohen et al., 2006; Deblinger et al., 1990).

In essence, addressing the role of the family and the expectations for participation was an important factor to address with both families, as they both held the value of familism as important to their treatment (de Arellano et al., 2012). In this study, it played a significant role in successfully engaging both of the participating mothers. Additionally,

keeping Karina involved in her daughter's therapy, whether by phone or in person, helped Karina to feel useful and an integral part of her daughter's progress. As suggested by Santiago-Rivera et al. (2002), the use of the Latino construct of *familismo* in this study was a strong cultural protective factor for both of the mothers and most of the adolescents of this study. Utilizing this knowledge was key to building a stronger alliance with most of the study participants and it increased the likelihood of continued engagement in CM-TFT. The use of *personalismo*, combined with sensitivity and flexibility, were highlighted as positive by these mothers, and the use of it with their daughters was reported as helpful in keeping both the participants and their mothers engaged in treatment.

While all adolescents were encouraged to include their mothers, Valeria and Ruby chose to engage in therapy alone. In Valeria's case, she did not express any parent-related conflicts during her CM-TFT experience. Instead, she reported not wanting to burden her mother with therapy because of her mother's upcoming surgery, work schedule, and family responsibilities. Ruby frequently spoke of her distrust and distance from her mother and sisters, an interpersonal challenge that may have had an influence on her low engagement and working alliance. Perhaps prioritizing the conflictual family dynamics over trauma-focused therapy may have increased the likelihood that Ruby would have continued to attend therapy. For example, in Gaby's case, quite a few of our first sessions were directed toward helping her feel safe in relation to her ex-boyfriend and other external factors such as settling the custody issues around her son. Because her mother was involved, we were able to work on establishing helpful responses which furthered Gaby's sense of safety. It is possible that had those issues not been worked out during the

course of treatment, Gaby might not have been able to continue or engage as well as she did.

Adolescent Ethnic Identity and Culturally Modified Trauma-focused Treatment

Another guiding question for this study was to understand how ethnic identity and the incorporation of cultural constructs would interact throughout the therapy process. Overall, exploring the adolescents' ethnic identity led to the initial discovery of many character strengths, such as understanding their values, closeness with their identified ethnic self-label, culturally-based hobbies, and aspirations for their future. In turn, these were useful throughout therapy to increase engagement and motivation within the CM-TFT weekly lesson. Further, the adolescents' ethnic identity informed the use of Latino constructs within CM-TFT in many aspects. For example, Ana's bicultural identity indicated the use of several Latino constructs within CM-TFT. Her moderately strong ethnic exploration coupled with her strong affirmation/belonging suggested the use of a variety of cultural components throughout the different phases of CM-TFT. The inclusion of several Latino constructs and the facilitation of culture-rich conversations seemed to encourage Ana to go through a process of self-definition (Kiang et al., 2010), to explore her identity, and remind herself of the qualities that made her a Latina. This self-exploration seemed to help her to look for strengths within herself and motivated her to actively engage in therapy to overcome her PTSD symptoms. Moreover, her self-reported ethnic and self-identity exploration was consistent with the work of Erikson (1968) and Tajfel (1981) who described identity development as a central task during adolescence

and thus, would lead to solid identity development and positive psychosocial outcomes, as observed in Ana.

Through the use of a tool to explore ethnic identity in the beginning stages of therapy, I learned that Valeria endorsed a bicultural ethnic identity (i.e., American and Mexican ethnic identities), which likely influenced her more positive mental health outcomes. This study finding falls within the literature on the relationship between bicultural identity and positive mental health outcomes (Berry et al., 2006; Carvajal, et al., 2002; Roberts et al., 1999; Umaña-Taylor et al., 2002). Becoming aware of Valeria's covert rejection of the purely Mexican culture and her particular usage of her "American-Mexican" ethnic self-label, cued me to explore and understand that side of her in therapy. Had it not been for the use of this scale, I likely would have encouraged her to process her witnessing of domestic violence only and would have missed including her narrative of learning her father's criminal acts resulting in his deportation back to Mexico. Additionally, Valeria's bicultural ethnic identity may explain her rejection of traditional Mexican gender roles for women and also promote the idea of exploring a broader role for herself as a young Latina woman (Berry et al., 2006).

Gaby's self-identified American-Hispanic ethnic identity, coupled with her neutral degree of exploration and affirmation/belonging suggested that cultural modifications were not likely as needed throughout therapy as with the other three adolescents. While Gaby's developmental and environmental contexts constituted primarily Latino adolescent and adult populations, it seemed that her life experiences had not created an impetus for her to question the meanings and implications for her ethnic group membership, as suggested by Pahl and Way (2006). Perhaps her perception of

being safely in the majority within her school context may have produced less of a reason for her to explore her identity as much as the rest of the adolescent participants. Just as important to consider is the influence that Gaby's busy and hectic life as a teenage mother suffering with PTSD may have meant she had fewer opportunities for ethnic identity exploration and belonging. Lastly, despite her neutral degree of ethnic identity exploration and affirmation/belonging, Gaby demonstrated a shift in her self-identity, from one of a victim to that of a survivor. Her post-treatment interview quote "you realize that you are more than whoever made you suffer" beautifully exemplifies this shift in her self-identity.

Adolescent Working Alliance

This multiple case study also informed the question of how participants receiving CM-TFT would rate their level of therapeutic alliance using the Working Alliance Inventory-Short (WAI-S) across different measurement points. The implementation of culturally modified components, phase of therapy, and other significant events were examined to determine if there was a correspondence between ratings on the WAI-S and phase of therapy. Overall, working alliance between the adolescents and myself as their therapist tended to be rated as moderately high to high and fluctuations toward lower scores tended to correlate with fears or anxiety regarding the trauma narrative phase of CM-TFT. This was the case for both Ana and Gaby, who voiced concerns about their ability to engage in the trauma narrative at the same time they rated their alliance with lower scores. However, scores tended to trend back up once open and honest conversations about their fears where held and steps to mediate their concerns were taken.

Findings of this study are consistent with the notion that alliance is an important predictor of intervention outcome (Bordin, 1979; Russell et al., 2008; Shirk et al., 2011), as this was the case for three of the four adolescents of this study. For example, high alliance scores were observed in both Ana and Gaby, which predicted positive CM-TFT outcomes. Similarly, Ruby's lower and inconsistent alliance scores predicted her eventual early termination of CM-TFT. A closer look into Ruby's interpersonal background showed that she had experienced higher levels of interpersonal problems, had weaker support systems, and experienced lower interpersonal expectations than most of the other participating adolescents, which combined are predictors for difficulties in alliance formation over time (Eltz et al., 1995; Levin et al., 2012). Although I used the working alliance measure at multiple points during the intervention to increase opportunities for client-therapist feedback (Kataoka el al., 2002; Levin et al., 2012; Shirk et al., 2011; Tracey & Kokotovic, 1989), this did not seem to have an influence in preventing Ruby's choice to terminate treatment. However, these recommended strategies did have a positive effect on the majority of the participants in this study.

Valeria's WAI-S scores did not predict her positive treatment outcomes as strongly as the rest of the participants. However, an examination of the approach she took to scoring her monthly WAI-S revealed interesting results. Her scores started off lower than the rest of the adolescents and they were observed to consistently increase throughout her 19 weeks of CM-TFT, with the exception of week 12, where it decreased by two points from the previous administration, because she wanted to inform me of her need for more coping strategies to manage her anger. Her proactive approach to the WAI-S underscores Lambert and Shimokawa's (2011) suggestion to utilize client feedback

measures to mediate for therapists' limited ability to accurately recognize client worsening in therapy. This opportunity also served as a learning moment where Valeria was able to advocate for her needs in therapy in a constructive and assertive manner.

Posttraumatic Stress Disorder
Symptomatology

An additional guiding question of this study was whether adolescent participants would experience a decrease in PTSD symptoms compared to their pre-treatment number of symptoms, as measured by the PTSD-RI. Findings of this study indicate that all participants who completed treatment experienced a decrease in PTSD symptoms compared to their pre-treatment PTSD-RI scores. Further, none of these adolescents continued to qualify for a diagnosis of PTSD post-treatment. Unfortunately, Ruby, who was the only adolescent to drop out of treatment early, continued to qualify for a diagnosis of PTSD, which also provided support for CM-TFT's role in decreasing symptoms of PTSD. In all, the adolescents' decrease in their PTSD symptoms underlines the literature supporting the use of TF-CBT to decrease symptoms of PTSD (Cohen et al., 2004; Cohen & Mannarino, 1996, 1998; Deblinger et al., 1996; Fitzgerald & Cohen, 2012).

Academic Functioning

A final inquiry of this study was whether these Latina adolescents would demonstrate increases in secondary behaviors suggesting improved functioning, such as increased school attendance, improved academics, and fewer behavioral referrals. Although the degree and exact types of changes were not similar among all three adolescents, over the course of CM-TFT, all adolescents who completed therapy experienced a positive impact on their school functioning. Similar to Fitzgerald and

Cohen's (2012) theory that school-based TF-CBT could have a positive impact on grades, attendance, and overall school performance, Ana reported fewer missing assignments, an improvement in her relationship with peers and teachers, and an improved overall grade point average (GPA). Prior to CM-TFT, Ana had been put on an attendance contract due to a high number of absences and tardies that she had collected over the course of the previous academic year. After completing CM-TFT, she noted that checking her grades, attendance, and overall academic goals and aspirations was helpful in improving her grades and attendance and in keeping her on track and accountable for her actions.

Unlike Ana, Valeria did not view CM-TFT as having a direct influence on her grades and attendance. However, during the intervention she reported an increased sense of hope and perseverance to graduate from high school as a result of our frequent conversations related to her overall school functioning. It is unknown to what extent this reported increased hope and perseverance translated into increased motivation to do better academically to pass all of her classes, or the extent to which her increased sense of hope and perseverance had an influence on her decision to start college courses earlier than she had expected.

Gaby denied seeing any changes in her academics as a result of engaging in TF-CBT. However, she found therapy to be more accessible to her as a result of it taking place at her school. She reported perceiving therapy as giving her a break from her school and daily life and found relaxation strategies to be useful inside of the classroom.

Collective Themes Cross Case Analysis

An overarching theme among all participants was their sense of readiness for change. Both parents spoke largely about their readiness to help their daughters heal from their PTS symptoms and become more actively involved in their recovery process. Similarly, all three adolescents used phrases such as "I wanted to get it out," "I wanted to get it off my chest and over with," and "I couldn't handle it anymore" to describe their sense of readiness for change. Unfortunately, this innate readiness for change was not observed in Ruby throughout the course of therapy, which likely predicted her early termination of therapy.

Both parents agreed that TF-CBT proved itself to be more directive in nature when compared to other therapy approaches they had experienced previously. In Karina's case, she had developed so much frustration because her daughter had been able to continually avoid processing her traumas and struggled psychologically as a result. Karina spoke about growing impatient and losing hope with Gaby's previous therapists, as they reportedly were not as directive and allowed Gaby's avoidance. Similarly, Laura spoke about her previous therapy experience as being mostly an opportunity for her and Ana to vent their thoughts and feelings toward each other. Laura reported missing skill-building, role-plays, and overall structure and directiveness in previous therapies she's engaged in and voiced feeling empowered with newly learned skills as a result of the directive nature of TF-CBT. Other specific aspects of the model that were considered helpful were construction of the trauma narrative, cognitive restructuring, and affective modulation. Only Ana and Gaby reported relaxation as useful for their healing.

Surprisingly, neither one of the participating parents attributed their own or their daughter's engagement to the cultural sensitivity of the therapist. Instead, their sense of readiness for change and need to help their daughters feel from their trauma was regarded as the primary factor for their engagement. Instead of being aware of cultural modifications throughout treatment, the parents were more aware of my flexibility in scheduling and therapy setting, ability to take into account their socioeconomic status (SES) and barriers to access treatment as a result of it, and overall sensitivity to the unique needs of their families. Interestingly, the adolescent participants appeared more aware of my attention to cultural sensitivity. Both Ana and Valeria reported that their perceived trust and sense of connection to me improved as a result of using culture-rich language in sessions. Conversations about who they were in relation to their culture were regarded as a sign of genuine interest by me and as a sign of respect. Even though the effect on Ruby was unknown, it was notable that some of the few times that she was really engaged and open was when we were talking about her cultural-interests and activities (e.g., *bailes*, *telenovelas*).

In terms of academic growth, Ana reported that my therapy approach helped her reach her fullest potential that resulted in more academic gains than was the case for Gaby and Valeria. More specifically, Gaby reported that she found therapy helpful in relieving stress when she was at school and found school-based therapy particularly accommodating to her needs as a busy teenage mother. On the other hand, Valeria found my encouragement and support helpful in staying hopeful about graduating high school and attending college. In contrast, Ana spoke highly of the change she made in her attendance and commitment to improving her academics. It is important to consider that

all three adolescent participants differed in terms of grades and academic achievement, with Ana being more academically advanced than the other two. However, all three adolescents were able to graduate from high school on time or early.

Limitations

A clear limitation of this study--one that is inherent of studies utilizing participant observer methodology--is the extent to which the observer affects what is being observed. The participants' awareness of their participation in a research study may have influenced them to act in more socially acceptable ways, particularly with their ratings on the WAI-S. Therefore, it is possible that social desirability played a role given the lack of variability within their monthly WAI-S administrations. However, when the ratings lowered, the adolescents tended to share their concerns with me, indicating that social desirability did not sustain over time. As Merriam (2009) notes, the presence of an observer may elicit polite, formal, or guarded behavior initially but these behaviors are unlikely to be sustained over time. It is also unknown whether adolescent and parent participant's responses to the post-treatment semi-structured interview questions were influenced by my being the interviewer, therapist, and primary researcher in this study.

Another potential limitation of this study was the variability between the Latina adolescents and the parent participants. However, these differences allowed for the in-depth examination of TF-CBT and cultural sensitivity on varied states of PTSD severity. Regardless, having a larger sample would have provided higher transferability, examination of trends within the data, and generalization of outcomes within the context of a qualitative study. Additionally, natural maturation of each participant must be considered when interpreting the therapeutic and academic progress made.

Many cancellations happened during the month of January 2015 that occurred as a result of my being out of town for professional reasons. It is unknown the extent to which these cancellations influenced participant's level of engagement and working alliance with me. Additionally, multiple cancellations also occurred due to final exams, necessity to work on late assignments, and various school field strips, which could not have been re-scheduled due to scheduling conflicts. Given my immersion into the personal lives of each participant, and in an attempt to not overburden them or impose on their academic progress, I accepted many cancellations at the cost of losing data. Hence, my more intimate relationship with them may have weakened my ability to set firmer boundaries around turning in class assignments on time or re-scheduling appointments with more notice. Regardless, the reasons for these cancelations are a reality of providing school-based therapy.

One final limitation of this study is my own novice status as a TF-CBT therapist. Due to limited time and resources, I received one hour of bi-weekly supervision by Dr. Gomez and a total of five hours of bi-weekly telephonic group supervision by Dr. Shipman, which offered limited opportunities to discuss my participants' progress. Perhaps more opportunities for clinical supervision would have provided more guidance during difficult phases of therapy, particularly with Ruby and Gaby.

Implications

Trauma Focused Cognitive Behavioral Therapy in the Schools

The mission of public schools tends to be more heavily weighed on academic rather than mental health outcomes, often despite the high instances of the wide range of traumatic events that their students and their families have experienced and the negative

impact that those events have had on school outcomes. Moreover, school-based mental health clinics and culturally-sensitive TF-CBT trained therapists continue to be the exception in many public schools. However, the imperative need for trauma-focused interventions in schools continue to be documented in the literature. The overall findings from this study suggest that CM-TFT holds promise for school settings and can actually result in positive academic growth for students. The findings of this study also suggest the need to evaluate the need for training of teacher and other school personnel in recognizing the potential for the development of PTSD symptoms in children and adolescents.

In this study, the adolescent's positive experiences with CM-TFT provided evidence to suggest that CM-TFT can have an overall positive influence on adolescents' sense of hope, perseverance, intrinsic motivation, and academic improvement. Additionally, the delivery of CM-TFT in the schools made the intervention more accessible for students who likely would not have had access to high quality trauma-focused interventions, particularly for low income, teenage mothers suffering from PTSD. As a whole, the results of this study point to CM-TFT being considered a priority rather than a luxury in schools with high populations of Latino children suffering from symptoms of PTSD. In order to close the gap between the psychosocial and the academic needs of Latino children, it is imperative that culturally-informed, trauma-focused interventions such as CM-TFT be afforded the attention and value they deserve, as all Latina adolescents and the mothers who completed CM-TFT in this study regarded it as the most valuable intervention that effectively reduced their PTSD symptoms and helped them to reach their educational goals.

Incorporating Culture into Treatment

The concept of ethnic match in therapy has been studied for many years. However, the variables at play that account for ethnic minority members staying longer in treatment are still unknown. In this study, the content of culturally-rich therapy sessions was explored and analyzed to bring to light the process variables that play a key role in increasing attendance and engagement among a sample of Latina adolescents. This study demonstrated the interpersonal impact that incorporating culture into therapy can have in the engagement and follow-through with treatment. More specifically, Latino adolescents may be more likely to actively engage and create powerful meaning from their treatment beyond surpassing their PTSD symptoms by being engaged in CM-TFT. The findings of this study provide additional support for the use and acceptability of cognitive-behavioral and exposure-based interventions to effectively treat posttraumatic stress in Latino adolescents and their families. However, just as important is the deeper understanding of how culture shapes the ways in which individuals experience traumatic events and the treatment modalities used to treat the disorder. In particular, Marsella (2010) challenges the overreliance of verbally-loaded treatment modalities and describes the limited attention that is given to other therapies that put less emphasis on verbal/cognitive treatments (e.g., *curanderos*, traditional healers, etc.). Given that in many cultures, the verbal mode used to heal traumatic experiences is less preferred, it is imperative that different non-traditional modalities are equally explored.

Further, the findings of this study help to provide a foundation for when and how to integrate cultural constructs to optimize treatment outcomes, increase engagement, decrease premature terminations, and hold courageous and meaningful discussions about

the ways in which adolescents perceive themselves in relation to their ethnicities and cultural identities (e.g., Valeria's resistance toward the term "Mexican" as being a factor of her negative experiences with her Mexican father) and how their experiences give shape and meaning to their cultural realities. Highlighted in this culturally-sensitive approach is the therapist's willingness and ability to deepen her understanding of the Latina adolescent's clinical presentation and symptomatology and explore her cultural worldview, to recognize and appreciate her ethnic identity and culture as essential aspects to explore and utilize throughout treatment.

Practical, real-world strategies were delineated and described in the present study, with the goal of contributing to the literature the process of incorporating cultural modifications into the ongoing therapy process. As such, this study has the potential to increase the confidence, cultural-sensitivity, and willingness of TF-CBT trained and untrained therapists to begin to actively use culture with Latino students and decrease chances for low engagement and eventual early termination. Further, this study has implications to enhance the use of ethnic identity measures as a vehicle for youth's cultural exploration with the goal of unpacking natural strengths and resources that can drive active engagement and successful completion of therapy.

**Purposeful Inclusion of Parents
into Treatment**

Working with adolescents who have been victims of trauma can be a challenging journey for even the most experienced of therapists. Often times, successfully engaging a parents in their traumatized adolescent's treatment is difficult, as the adolescent's sense of trust and confidence is skewed by wariness and reduced confidence in their parents and other adults' ability to help them. These difficulties were faced in the present study,

and despite the adolescent's initial reluctance, the added parental participation had a positive effects on the adolescents' sense of engagement, accountability, and perceived support. This observation has important ramifications in the positive aspects of including parents, such as improvement in their relationship with their children, increased sense of importance and value in the lives of their children, and overall increased sense of accomplishment for having had a positive impact on their children's mental health. Additionally, maintaining the parents involvement can help to maintain the adolescent's accountability for their homework assignments and daily practice of learned coping skills. Lastly, parental involvement allows for the creation of wider systemic effects that have the potential to impact the adolescents and parents' lives beyond the PTSD symptoms.

The Use of Working Alliance Measures

I found the use of the WAI-S to be a helpful tool for a number of reasons. First, this tool allowed for open and honest conversations about the adolescents' progression in therapy to occur. The purposeful act of asking them to provide me with feedback about the goals and tasks of treatment as well as our therapeutic bond gave the adolescents an active voice in CM-TFT, which likely allowed them to feel empowered in their own treatment. Additionally, the systematic use of this tool helped me to model how to ask for and respond to feedback in an appropriate and respectful manner. Lastly, the use of this tool to receive client feedback about the therapeutic process served as a useful formative evaluation method for my therapeutic practice.

Researcher Reflections

The dual role of participant observer proved to be both advantageous and disadvantageous as I attempted to play the role of therapist and researcher at the same time. For example, as I began using TF-CBT with each participant, the complexities of maintaining a clear and solid stance as a TF-CBT therapist implementing the model with strong fidelity proved to be harder than I originally thought. In particular, as a family systems-oriented therapist, observing and letting go of my typical role with manipulating and intervening with multiple dysfunctional family dynamic patterns playing out inside and outside of my sessions was rather difficult. Although the parallel parent-child sessions made it easier for me to have a connection with the parent and teach effective parenting and communication skills, they were not sufficient to address my tendency to include multiple family members in the therapy and extend my therapy beyond solely trauma and into intergenerational patterns of abuse, defective family boundaries and communication systems, and dysfunctional parental and family hierarchies, among other family systems strategies. With evidence-based, trauma-focused interventions, the core of the therapy work lies primarily within relieving symptoms of PTSD and maintaining this particular stance was indeed difficult.

Apart from maintaining fidelity to TF-CBT, switching gears between being the therapist and the researcher was also a challenging, though valuable, aspect of my experience. One example of my family system's orientation having had a minor negative effect on the research happened during Gaby and Karina's re-engagement, in-home family therapy session, where I forgot to administer the WAI-S at the end of the session. Witnessing the chaotic environment of the home, the ineffective communication patterns,

and the systemic effect of poverty took automatic priority above my researcher stance at the cost of missing data. Additionally, stepping into the therapist role requires a more profound level of involvement and attention than that of a primarily researcher role, which likely clouded some of my observations of the therapy sessions.

One of my deepest inner struggles was observing Ruby's continued resistance to actively engage in CM-TFT despite her difficulties managing her PTSD symptoms. Ruby's overall disengagement signaled to me that this treatment approach was not appropriate for her, despite its research evidence suggesting otherwise. Figuring out culturally-informed and creative ways to engage her in therapy was stimulating, as it challenged me to think beyond her trauma and spend more time understanding her struggles. However, strictly speaking, TF-CBT is meant to be directive, though flexible, in nature, which meant focusing primarily on the trauma. Had I had more time and flexibility with this approach, it would have perhaps helped her to find more comfort in telling her story. Regardless, her case helped me to continue to think beyond EBIs and cultural sensitivity more into individually-tailored approaches.

Despite the noted difficulties, I found a new appreciation for having held high fidelity standards to TF-CBT, as I was able to witness its powerful effects with most of the adolescent and parent participants. Additionally, my dual therapist and researcher role allowed me to gather rich strands of qualitative and quantitative data that would not otherwise have been possible. Moreover, the purposeful and systematic use of the WAI-S created space for open conversations about working alliance to occur, for progress monitoring to happen, and for fears related to hearing client feedback to dissipate. In sum, the dual researcher and therapist role I assumed in this study proved to be a useful

approach in balancing fidelity to the model, utilizing assessment tools throughout therapy, and maintaining a strong, client-centered approach with all of the participants.

Future Research

While the use of the ethnic identity and working alliance measures were useful in improving the engagement of the Latina adolescents who participated in this study, it may also be important to explore the use of these tools with participating caregivers and other family members. Future research might include the use of these types of measures with other participating family members, including the therapist, in order to further explore their influence on the therapeutic process, the adolescent's overall sense of family support, and to increase family engagement. Further, the use of ethnic identity measures with the adolescent and the parent may be useful in understanding and exploring parent-child acculturation gaps that may be playing a role in relationship and discipline conflicts reported by the family members.

Parent participants were not as explicitly aware of culture-rich conversations and cultural modifications incorporated into their therapy as were the participating youth. This study had placed importance on using cultural modification with adolescents, and similar direct conversations related to culture had not been as incorporated into parent sessions. More research is needed to explore the ways in which adults experience cultural modifications in TF-CBT and how these modifications may influence motivation for treatment.

Interestingly, the power that my Latino cultural adaptations had on the engagement and motivation did not suffice in maintaining all adolescents in treatment. Avoidance symptoms are inherently a part of PTSD and can be one of the hardest

symptoms to address in adolescents who do not have external or internal motivation to participate in treatment. While Ruby's early termination was unfortunate, it also provided much information about the usefulness of using cultural modifications with a highly avoidant adolescent whose therapeutic style did not match the EBI. A necessary question might be how to match EBIs with the personality, readiness to change, and intrinsic motivation of an adolescent client and how to determine this match early on in treatment. Just as important to consider is the undocumented legal status of adolescents and their families and the ways in which it may explain avoidance and treatment resistance (e.g., fear about actively engaging in trauma-focused treatment due to perceived risk in losing stability in their mental health).

As I had the opportunity to use TF-CBT with an adolescent experiencing low levels of PTSD symptomatology (i.e., Valeria), I wondered whether this intervention might be used with other youth with lower levels of PTSD symptoms. Future research could be targeted toward understanding the prevention-related effects that TF-CBT could have with adolescent populations who have experienced several traumatic events but are not experiencing clinical levels of symptoms. Lastly, while this study was limited to three participants, as one terminated early, future research is needed to explore additional benefits of CM-TFT participation as well as intervention fit for adolescents whose personality, interpersonal and intrapersonal factors, as well as motivation for change differ from that of the adolescents in this study. Lastly, future studies should systematically gather objective school performance data (e.g., grades, GPA, behavior referrals) throughout TF-CBT in order to denote correlations between phase of therapy and school data.

Conclusion

The vast majority of the existing literature on culturally-sensitive practice with ethnic minority adolescent clients centers around the ethical need for practitioners in the mental health field to account for and actively use their clients' cultural background and values into therapy. Despite this need, few studies have explored how cultural modifications of evidence-based trauma treatments impact retention and therapeutic working alliance between therapists and Latina adolescents. Given the alarming need to deliver culturally-informed trauma treatments to the Latino population, it was imperative to understand not only the practical implications of using CM-TFT with this population but also to describe how to do so in the weekly therapy progression.

Overall, the Latina adolescents and the two mothers who participated in this study voiced overwhelmingly positive conclusions regarding their participation in CM-TFT. The three adolescents who completed their treatment experienced their working alliance as strong or increasing as therapy progressed, observed a decrease in PTSD symptoms and did not continue to meet criteria for a diagnosis of PTSD, and witnessed improvements in their academics or overall school experience. Ethnic identity played a key role in the adolescent's perceptions of cultural modifications to their treatment and the use of the MEIM-S and active use of culture throughout therapy made room for the discovery of natural strengths and protective factors in the adolescents and the mothers who participated in this study. Both parents expressed deep appreciation for CM-TFT in helping them to learn skills to help their daughter with their symptoms and agreed that CM-TFT improved certain parts of their parent-child relationship.

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APPENDIX A

**STUDENT DEMOGRAPHIC INFORMATION
QUESTIONNAIRE**

Student Demographic Information Questionnaire

Name: _____

Phone number to reach you: _____

Parent or guardian's name: _____

Parent or guardian's phone number: _____

Your date of birth: _____

Sex/Gender: _____

What school do you attend? _____

What grade are you in school? _____

Please answer these questions to help me get to know you better.

1.   Where are you from?

      _____

2.   If you were born outside of the United States, when did you move here?

      _____

3.   If you were born outside of the United States, why did you and/or your family decide to move to the United States?

      _____
      _____

4.   What languages do you speak?

      _____

5.   Do you drink alcohol and/or use illegal drugs? If so, how often do you drink and/or use drugs?

      _____
      _____

6.   Have you ever heard voices that were not there or seen things that others could not see? If so, tell me more about these things that you heard and/or saw.

      _____
      _____

Información Demográfica del Estudiante

Nombre: _____

Numero de teléfono: _____

Nombre de su padre/madre o guardian: _____

Numero de teléfono de su padre/madre o guardian: _____

Fecha de nacimiento: _____

Sexo/genero: _____

¿A cual escuela asistes? _____

¿En que grado estás? _____

Por favor, conteste las siguientes preguntas para conocerte mejor.

1.   ¿De dónde eres?

        _____

2.   Si naciste afuera de los Estados Unidos, ¿cuando se mudó para acá?

        _____

3.   Si naciste afuera de los Estados Unidos, ¿por qué usted y / o su familia decidió
        mudarse a los Estados Unidos?

        _____

4.   ¿Qué idiomas hablas?

        _____

4.   ¿Tomas drogas y / o utilizas drogas ilegales? Si es así, con que frecuencia bebes y
        / o tomas drogas?

        _____

        _____

5.   ¿Has escuchado voces que no existen (que otros no pueden escuchar) o has visto
        cosas que otros no pueden ver? Si es así, dime más acerca de estas cosas que se
        escuchas o vez.

        _____

        _____

APPENDIX B

IMMIGRATION EVENTS

Eventos de Inmigración

Algunos jóvenes quienes han inmigrado a los Estados Unidos nos cuentan que durante el proceso de inmigración han sido golpeados, asaltados, apuñalados, o incluso disparado o que vieron que esto le sucedió a alguien más. Los atacantes pueden ser personas a quienes usted no conoce, o tal vez que si conoce, como amigos, parientes, u otras personas quienes le ayudaban a venir/cruzar a los Estados Unidos. Mientras cruzan o cuando están en camino, a veces una persona le puede hacer cosas sexuales a otra persona más joven, cosas que la persona más joven no quiere. Estas cosas sexuales le pueden suceder a los niños y niñas, y también a hombres y mujeres jóvenes. La gente que intenta hacerles cosas sexuales indeseadas a los jóvenes no siempre son gente desconocida. Pueden ser personas que usted conozca como algún amigo, pariente, o alguna persona que le estaba ayudando a venir a los Estados Unidos. Muchas veces los jóvenes nunca le cuentan a nadie sobre estas experiencias. Me gustaría que usted pensara en cualquier experiencia que usted haya tenido mientras venia/cruzaba a los Estados Unidos, no importa quién lo haya hecho, ni cuando tiempo haya pasado desde entonces, ni siquiera si el incidente se halla reportado a la policía o alguna otra autoridad.

1.	Sin contar los incidentes de los cuales usted ya me hablo, alguna vez tuvo miedo de que alguien fuera a abusar o asaltarla/o sexualmente mientras inmigraba a los estados unidos? Por ejemplo, en un campo de refugio, buscando asilo, por un coyote, un extraño, o algún oficial de la ley.	Si	no
2.	Mientras inmigraba a los Estados Unidos, ¿alguna vez tuvo miedo de que alguien abusara o asaltara sexualmente a alguno de sus seres queridos? Por ejemplo, en un campo de refugio, buscando asilo, por un coyote, un extraño, o algún oficial de la ley?	Si	no
3.	Mientras inmigraba a los Estados Unidos, ¿alguna vez abusaron o asaltaron sexualmente de usted o de algún miembro de su familia? Por ejemplo, en un campo de refugio, buscando asilo, por un coyote, un extraño, o algún oficial de la ley.	Si	no
4.	Sin contar los incidentes de los cuales usted ya me habló, ¿alguna vez tuvo miedo de que alguien lo/la lastimara físicamente mientras inmigraba a los Estados Unidos?	Si	no
5.	Sin contar los incidentes de los cuales usted ya me habló, ¿alguna vez tuvo miedo de que lo/la fueran a matar mientras inmigraba a los Estados Unidos?	Si	no
6.	Mientras inmigraba a los Estados Unidos, ¿resultó herido/a usted o alguno de sus seres queridos?	Si	no

7.	Durante su tiempo viviendo en Estados Unidos, ¿alguna vez a sentido temor de ser deportado/a?	Si	no
8.	¿Teme ser deportado actualmente?	Si	no
9.	¿Alguna vez lo/la han deportado?	Si	no
10.	¿Alguna vez lo/la han arrestado por cuestiones de inmigración?	Si	no

APPENDIX C

**MULTIGROUP ETHNIC IDENTITY MEASURE-
SHORT (MEIM-S)**

Multigroup Ethnic Identity Measure

Name: _____   Date: _____

In this country, people come from many different countries and cultures, and there are many different words to describe the different backgrounds or *ethnic groups* that people come from. Some examples of ethnic groups are Latino, African American, Mexican, Asian American, Chinese, and many others. These questions are about your ethnicity or your ethnic group and how you feel about it or react to it.

Please fill in: In terms of ethnic group, I consider myself to be _____

Use the numbers below to indicate how much you agree or disagree with each statement.

(5) Strongly agree   (4) Agree   (3) Neutral   (2) Disagree   (1) Strongly disagree

1.	I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs	5	4	3	2	1
2.	I am active in organizations or social groups that include mostly members of my own ethnic group	5	4	3	2	1
3.	I have a clear sense of my ethnic background and what it means for me	5	4	3	2	1
4.	I think a lot about how my life will be affected by my ethnic group membership	5	4	3	2	1
5.	I am happy that I am a member of the group I belong to	5	4	3	2	1
6.	I have a strong sense of belonging to my own ethnic group	5	4	3	2	1
7.	I understand pretty well what my ethnic group membership means to me	5	4	3	2	1
8.	In order to learn more about my ethnic background, I have often talked to other people about my ethnic group	5	4	3	2	1
9.	I have a lot of pride in my ethnic group	5	4	3	2	1
10.	I participate in cultural practices of my own group, such as special food, music, or customs	5	4	3	2	1
11.	I feel a strong attachment towards my own ethnic group	5	4	3	2	1

12.	I feel good about my cultural or ethnic background	5	4	3	2	1

13.   My ethnicity is (check one)

      (1)   Asian or Asian American, including Chinese, Japanese, and others
      (2)   Black or African American
      (3)   Hispanic or Latino, including Mexican American, Central American, and others
      (4)   White, Caucasian, Anglo, European American; not Hispanic
      (5)   American Indian/Native American
      (6)   Mexican
      (7)   Mexican-American
      (8)   Mixed; Parents are from two different groups
      (9)   Other (write in): _____

14.   My father's ethnicity is (use numbers above): _____

15.   My mother's ethnicity is (use numbers above): _____

La Medida de Identidad de Multigrupos Étnicos

Nombre: _____   Fecha: _____

En este país, la gente viene de diferentes culturas y países. En este cuestionario usamos la palabra "grupo étnico" para referirnos a esas diferentes culturas de origen. Algunos nombres de estos grupos étnicos son, por ejemplo, Mexicanos-Americanos, Hispanos, Negros, Asiáticos-Americanos, Indios-Americanos, Anglo-Americanos, y Blancos. El pertenecer a uno o a varios grupos étnicos, y los sentimientos que tenemos al respecto, tienen una influencia en diferentes áreas de nuestra vida. Las siguientes frases tienen el propósito de definir cuáles son tus actitudes y pensamientos en referencia a tu grupo étnico.

Por favor llene el siguiente cuestionario. En términos de grupos étnicos, yo me considero: _____.

Usa los números que se encuentran abajo para calificar cada frase de acuerdo tu opinión al respecto:

(5) Muy de Acuerdo   (4) Un Tanto de Acuerdo   (3) Neutral
(2) Un tanto en desacuerdo   (1) Muy en desacuerdo

1.	He dedicado tiempo para averiguar más acerca de mi grupo étnico, como la historia, tradiciones y costumbres	5 4 3 2 1
2.	Estoy activo en organizaciones o grupos sociales en los cuales la mayoría de sus miembros son de mi propio grupo étnico	5 4 3 2 1
3.	Tengo una idea clara de lo que es mi grupo étnico y lo que significa para mí	5 4 3 2 1
4.	He pensado bastante en como mi grupo étnico influye en mi vida	5 4 3 2 1
5.	Me siento contento de pertenecer a mi grupo étnico	5 4 3 2 1
6.	Me siento muy identificado con el grupo étnico al que pertenezco	5 4 3 2 1
7.	Entiendo claramente lo que significa pertenecer a mi propio grupo étnico	5 4 3 2 1
8.	Para aprender más acerca de mis raíces étnicas, he hablado con otros acerca de mi grupo étnico	5 4 3 2 1

9. Estoy orgulloso/a de mi grupo étnico	5 4 3 2 1
10. Participo en actividades culturales de mi propio grupo étnico como, por ejemplo, comidas especiales, música y costumbres	5 4 3 2 1
11. Siento un gran afecto hacia mi grupo étnico	5 4 3 2 1
12. Me siento a gusto con mi herencia cultural y étnica	5 4 3 2 1

13. Mi etnicidad es:

    (1)   Asiático/a, Asiático/a-Americano/a, o Oriental
    (2)   Negro/a o Afro/a-Americano/a
    (3)   Hispano/a o Latino/a
    (4)   Europeo/a, Caucáseo/a, Blanco/a (No Hispano/a)
    (5)   Indio/a-Americano/a
    (6)   Mexicano/a-Americano/a
    (7)   Mixto/a; mis padres son de dos diferentes grupos étnicos
    (8)   Otros (escríbalo): _____

14. El grupo étnico de mi padre es (use los números de arriba para contestar esta pregunta): _____

15. El grupo étnico de mi madre es (use los números de arriba para contestar esta pregunta): _____

APPENDIX D

WORKING ALLIANCE INVENTORY-SHORT (WAI-S)

Working Alliance Inventory-Short
Client Form

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her therapist (counselor). As you read the sentences mentally insert the name of your therapist (counselor) in place of _____ in the text.

(1) Never (2) Rarely (3) Occasionally (4) Sometimes (5) Often
(6) Very Often (7) Always

_____and I agree about the things I will need to do in therapy to help improve my situation	1 2 3 4 5 6 7
What I am doing in therapy gives me new ways of looking at my problem	1 2 3 4 5 6 7
I believe _____likes me	1 2 3 4 5 6 7
_____ does not understand what I am trying to accomplish in therapy	1 2 3 4 5 6 7
I am confident in _____'s ability to help me.	1 2 3 4 5 6 7
_____and I are working towards mutually agreed upon goals	1 2 3 4 5 6 7
I feel that _____appreciates me	1 2 3 4 5 6 7
We agree on what is important for me to work on	1 2 3 4 5 6 7
_____and I trust one another	1 2 3 4 5 6 7
_____ and I have different ideas on what my problems are	1 2 3 4 5 6 7
We have established a good understanding of the kind of changes that would be good for me	1 2 3 4 5 6 7
I believe the way we are working with my problem is correct	1 2 3 4 5 6 7

Inventario de Alianza-Corto
Forma del Cliente
Alianza con el Terapeuta

La siguiente es una lista de frases acerca de su relación con su terapeuta. Considere cada frase con cuidado e indique a que nivel esta de acuerdo con cada una de ellas. Al leer las frases, mentalmente inserte el nombre de su terapeuta (consejera) en la línea _____. Por favor anote su respuesta según la escala.

(1) Nunca (2) Raramente (3) De vez en cuando (4) A veces (5) A menudo
(6) Muy a menudo (7) Siempre

_____y yo estamos de acuerdo en las cosas que yo voy a tener que hacer en terapia para mejorar mi situación	1 2 3 4 5 6 7
Lo que yo estoy haciendo en terapia me da nuevas maneras de ver mi problema	1 2 3 4 5 6 7
Yo creo que le caigo bien a _____	1 2 3 4 5 6 7
_____ no entiende lo que yo estoy tratando de realizar en terapia	1 2 3 4 5 6 7
Estoy seguro de la habilidad de _____ para ayudarme	1 2 3 4 5 6 7
_____ y yo estamos trabajando hacia metas que decidimos mutuamente	1 2 3 4 5 6 7
Yo siento que _____ me aprecia	1 2 3 4 5 6 7
Estamos de acuerdo en lo que es importante que yo trabaje	1 2 3 4 5 6 7
_____ y yo nos tenemos confianza el uno en el otro	1 2 3 4 5 6 7
_____ y yo tenemos diferentes ideas sobre cuales son mis problemas	1 2 3 4 5 6 7
Hemos establecido un buen entendimiento acerca de los tipos de cambios que serian buenos para mi	1 2 3 4 5 6 7
Yo creo que la manera en que estamos trabajando con mi problema es la correcta	1 2 3 4 5 6 7

APPENDIX E

SAMPLE SCRIPT FOR FEEDBACK SESSION

Sample Script for Feedback Session
(Obtained from a TF-CBT In-Person Training)

1) Explain what will be covered:

 "Today I am going to share the results of our assessment and talk to you about what they mean and how they relate to your concerns. For example, [adolescent's name] you mentioned that you have been avoiding going to the lunch room and meeting new people. By explaining the results of the assessments you and I did a few days ago I will help you understand what is happening to you and why. We will talk about your areas of concerns as well as your strengths. We will be using all of this information throughout the treatment. What questions do you have for me so far?"

2) Present results of PTSD-RI and psychoeducation:

 "This questionnaire measures posttraumatic stress. Have you heard of that? [pause] *It's what happens to people after they experience a really scary event, or where they were afraid for their safety, or the safety of someone they care about. It is normal to have intense reactions right after a trauma. Usually the reactions get less intense over time, but sometimes they can continue or even get worse. This questionnaire really helps us understand if adolescents are still struggling with what happened to them. When we see scores above 38 on this scale, we know that children are still really having a tough time because of what happened. Your responses total ___, so you can see that you are dealing with high levels of posttraumatic stress symptoms, enough to be really upsetting. No wonder things have been hard lately."*

"If we look a little closer at different types of reactions that contribute to post-traumatic stress, we see that kids can have intrusion symptoms, which include things like nightmares, or feeling as though the scary event is happening again, even when things are safe [use examples that parent/adolescent endorsed and pause for parent reaction]. *Adolescents who are struggling often also find ways to avoid thinking about what happened or people or places that remind them of the trauma* [pause to reflect on avoidance symptoms]. *Also, many adolescents who are struggling have what we call hypervigilance or arousal symptoms, where they seem constantly on alert for danger. For example, they may startle easily, or be easily irritated or "set-off," and they might even look like they are unable to concentrate or sit still. Lastly, some adolescents also struggle with negative thoughts and mood, such as having beliefs about never getting better or trusting others again. These are actually things that our body does naturally when we are in danger – to protect us. The problem is that your body is doing these things even when there isn't any danger* [pause for parent reaction and focus more or less on four areas, as they are relevant for the adolescent].

3) Instill hope. Remember, YOU are the expert. Present this with confidence ☺:

"While it can be hard to know that [adolescent's name] is really struggling, the good news is that we know how to treat these symptoms and make them get better with a treatment called TF-CBT. This measure was really important, because now we have a way to track these symptoms, and we will be able to see them decrease over time with this treatment. We'll see these numbers go down, because TF-CBT specifically helps adolescents understand when they are safe and how to calm their bodies. That way, their body does not have to be on alert all the time, like it is now. It also gives adolescents tools to face things that they might be avoiding because of what happened to them with less fear or anxiety. The treatment also helps parents and children talk to each other about what happened, and it will give you many skills for managing your behaviors."

4) Pause for reactions/questions--NORMALIZE parent reactions to this news:

Parent: *"Wow. . . . I had no idea she was really struggling so much. I've been so frustrated with her behavior lately that I didn't notice she was still so affected by what happened. I feel terrible."*

Clinician: *"You know, a lot of parents feel that way, and I can tell you, it can be SO HARD to notice how all of these behaviors are connected. Some of these trauma symptoms can seem like just common behavior problems, and it can be hard to sort out which is which. We'll give you strategies that will help.* [GIVE EXAMPLES relevant to child – e.g. avoidance can seem like oppositionality/refusal, hypervigilance/arousal can seem like hyperactivity or rudeness, etc].

6) Link behavior problems to trauma symptoms:

"Sometimes after an adolescent experiences a traumatic event like witnessing domestic violence, their behavior seems to be different. They might do things they've never done before, like arguing with their parents, or stop talking to their parents. Or, sometimes, even if these behaviors existed before, they can get worse after a trauma." [PAUSE – Get feedback about timing of behaviors. If parent is talkative about externalizing behaviors, begin to elicit SPECIFIC examples, so that you can begin to get a sense of the function of the behaviors].

"The good news is that TF-CBT is successful in helping with these behavior problems, too! Not only does it help adolescents feel better, they act better too. And, often this really helps caregivers feel better, too."

[FOR INTERNALIZING behaviors]: *"It also looks like [adolescent] is struggling quite a bit internally, which we can tell because he/she is* [pull out a few examples from items that were endorsed e.g. crying a lot, staying in her room a lot, worrying often]. *This is common for adolescents that are also struggling with post-traumatic stress, and some of these symptoms also overlap with those four areas we talked about before. We'll help him/her out with these difficult feelings right along with helping her with trauma symptoms"*

7) Check in about safety concerns – make a safety plan, if needed:

"You mentioned that sometimes [adolescent] can really attack you physically when they are mad. Can you tell me about that? Are you concerned for your safety or their at these times? Let's think about what we can do to avoid having anyone get hurt"

"It sounds like [adolescent] still sees [perpetrator] sometimes. Can you tell me about that? Are the visits supervised? What are your concerns?"
"So, it sounds like [adolescent] may try to run away when they are really mad. Have they ever gotten away? Let's think about making a plan for them to go someplace safe when they are feeling this way."

[Discuss with supervisor if you feel that there are safety concerns]

8) Check in with family:

"This is a lot of information, so far – How does this fit with what you are experiencing at home? How are you doing with this information so far? I know it can feel like a lot."

9) REVIEW link between behavior problems to trauma:

"So, looking at this all together, we know that [adolescent] is really struggling with PTS symptoms, and that many of the behavioral and emotional problems that you are noticing could very well be tied to the trauma reactions. For example, [adolescent] may be staying in their room a lot because they are avoiding something that reminds them of the trauma, and that is making them more and more lonely or sad. OR [adolescent] may be getting angry super easily because they are constantly on-edge or on-alert for danger, even when it isn't there. When we treat the PTS, we often see many of these behaviors go away, too. And we'll also give you skills that are generally helpful for any type of behavior problem." [USE EXAMPLES RELEVANT TO adolescent].

10) Summarize all together and instill hope again:

"I just want to check in about how all of this is feeling for you. I know you brought in a lot of concerns about [adolescent]'s behavior, and hopefully it is making sense how the behaviors might be connected to what you, as a family, have experienced. And, although, it can sometimes seem like the behaviors come out of nowhere, we are beginning to understand the underlying reasons, and how treatment can help. By reducing the PTS

that [adolescent] is experiencing, and giving you some helpful tools for how to manage these behaviors and help [adolescent] with difficult feelings related to the trauma, we'll surely see things start to improve"

11) Discuss parent functioning:

"Lastly, if you remember, we also asked some questions about how you are doing and feeling, as well as some of the things that might be stressful in your life. I know that we have been focused on [adolescent]'s reactions to what happened to them, but it also seems that you have been struggling with some of the same things. [PAUSE] I want you to know that while this treatment can often help parents feel better, sometimes it is also important for them to get their own outside support, as well. We can point you in the right direction if that is something that you think would be helpful for you. Also, it looks like you have some real stressors in your life that can make things overwhelming at times. We'd like to help you with as much of those as possible."

12) Answer questions--make plan for next session

APPENDIX F

**POST-INTERVENTION INTERVIEW
QUESTIONNAIRES**

Post-Treatment Interview Questions:
Adolescent Participants

1.   Tell me about what you thought therapy was going to be like before it started.

2.   If you could pick one word or phrase to describe yourself before and after having gone through therapy, what would they be? Why?

3.   (For adolescents who have tried other therapies in the past) What was different about this therapy and the previous therapies you have tried in the past?

4.   How did this expectation change (if at all) after you started therapy?

5.   What was it about this therapy that you found helpful to your healing process?

6.   What was it about this therapy that you found not so helpful to your healing process?

7.   During your treatment, the therapist used what she learned about you and your culture to make your treatment more individual for you (follow by showing them S.C.O.P.E. excerpts that illustrate when I used Latino constructs).

     a.   How do you think that using these helped you stay in treatment?

8.   Sometimes we talk about "being engaged in treatment" and what we mean is how connected and active you feel during your treatment process and your therapist (for example, more willing to try learned strategies and coping skills inside and outside of therapy)? The reason why you filled out those questionnaires every three weeks was to see how engaged you were in treatment.

     a.   How do you think that using what I learned about you and your culture during treatment help you become more engaged in the treatment?

9.   Tell me about how you were doing in school prior to and after therapy. Have you seen any improvements? (e.g., increased school attendance, improved academics, and fewer behavioral school referrals).

10.   If you had the opportunity to talk to other Latino adolescents who have struggled with trauma, what would you tell them about therapy?

Post-Treatment Interview Questions:
Caregiver

1.   Tell me about what you thought therapy was going to be like before it started

2.   If you could pick one word or phrase to describe yourself before and after having gone through this therapy, what would they be? Why?

3.   (For caregivers who have tried other therapies in the past). What was different about this therapy and the previous therapies you have tried in the past?

4.   What was it about this therapy that you found helpful to your adolescent's healing process?

5.   What was it about this therapy that you found not so helpful to your adolescent's healing process?

6.   During your treatment, the therapist used what she learned about you and your family's culture to make your treatment more individual for you and your adolescent (follow by showing them S.C.O.P.E. excerpts that illustrate when I used Latino constructs).

   a.   How do you think that using these helped you stay in treatment?

   b.   How do you think that using these helped your adolescent stay in treatment?

7.   If you had the opportunity to talk to other Latino and Latina caregivers with adolescents who have experienced traumatic events, what would you say to them about therapy?

APPENDIX G

INSTITUTIONAL REVIEW BOARD APPROVAL

UNIVERSITY *of*
NORTHERN COLORADO

Institutional Review Board

DATE: May 18, 2014

TO: Katherine Sanchez Castejon, B.S.
FROM: University of Northern Colorado (UNCO) IRB

PROJECT TITLE: [599725-3] A Culturally-Informed Trauma-Focused Intervention for Latino and Latina Adolescents
SUBMISSION TYPE: Amendment/Modification

ACTION: APPROVED
APPROVAL DATE: May 18, 2014
EXPIRATION DATE: May 18, 2015
REVIEW TYPE: Expedited Review

Thank you for your submission of Amendment/Modification materials for this project. The University of Northern Colorado (UNCO) IRB has APPROVED your submission. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on applicable federal regulations.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of May 18, 2015.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Sherry May at 970-351-1910 or Sherry.May@unco.edu. Please include your project title and reference number in all correspondence with this committee.

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APPENDIX H

REFERRAL SOURCE SCREENING QUESTIONS

Screening Questions for Trauma-Focused Study
Researcher: Kathy Valadez-Sanchez
Email: Sanc2839@bears.unco.edu
Phone Number: (480) 329-2280

Dear [name of referral source],

Thank you for referring [name of student] to this study! Please take a few minutes to complete this screener form in order to make sure that this student's mental health problems are the right fit for this intervention.

a) Name of student: _____

b) Is this student of Hispanic/Latino? _____

c) Please check off the traumatic event(s) you believe this student has ever experienced:

- □ Neglect
- □ Physical abuse
- □ Psychological (emotional) abuse
- □ Sexual abuse
- □ Witness or victim of domestic violence
- □ Witness or victim of community violence (gang-related, neighborhood crimes, etc.)
- □ Witness or victim of war/political violence
- □ Serious accident (motor vehicle, hospitalized, etc.)
- □ School violence (shooting; bullying, etc.)
- □ Disaster (earthquake, fire, flood, etc.)
- □ Kidnapping
- □ Interpersonal violence (robbery, homicide, suicide, assault)
- □ Bereavement
- □ Other: _____

d) What concerns do you have for this student? For example, list any symptoms you believe the student is experiencing; any concerning comments you have heard the student say; any change in behavior that you have noticed; etc.

_____
_____
_____

Thank you!

APPENDIX I

**TRAUMA-FOCUSED COGNITIVE BEHAVIORAL
THERAPY SUPERVISION CONTRACT**

Supervision Agreement
Evelin Gomez, Ph.D. & Katherine Valadez-Sanchez, B.S.

The following is a written representation of the supervisory relationship between Katherine Valadez-Sanchez, candidate in School Psychology at the University of Northern Colorado, and Evelin Gomez, Ph.D. Dr. Gomez has agreed to supervise Ms. Sanchez for the purposes of my dissertation study, *Culturally-modified trauma-focused treatment: A qualitative look at working alliance with Latino adolescents.*

Goals: Dr. Gomez' goals for supervision are:
1.   Facilitate the development of clinical competence in TF-CBT with Latino Families
2.   Ensure adherence to the intervention content and integration of core elements
3.   Utilize a reflective supervision approach to facilitate self-reflection

My goals as a supervisee are to:
1.   Learn about the application of TF-CBT with Latino adolescents and their caregivers
2.   Gain a deeper understanding and practice how to utilize the culture of Latino families as a way to increase attendance and engagement in therapy
3.   Incorporate cognitive-behavioral and family systems methods according to the needs of the adolescent and his or her caregiver
4.   Track the adolescents' progress through the use of assessments

Term of Relationship: Our working relationship will start when I recruit the first participant in the summer/fall of 2014 and will continue throughout the course of my study (latest expected date of completion is May 2015). The end of the study will be defined as the last session I have with the adolescent and/or his or her caregiver.

Schedule: We will meet at least once every two weeks, for an hour, either face to face or by phone, during the course of the study to discuss treatment progress, case issues, and other relevant topics needing consultation. Our meeting time will be flexible in order to accommodate each of our schedules.

Documentation: I will maintain one file documenting each session I have with the adolescent and his or her caregiver. Additionally, I will maintain a second file documenting our supervision time, topics discussed, plans for future client sessions, and other topics discussed during supervision time.

Fee Arrangement: Dr. Gomez has agreed to provide her supervision time at no cost.

_____*Katherine Valadez-Sanchez*_____   ___*Evelin Gomez*_____
Katherine Valadez-Sanchez, B.S   Evelin Gomez, Ph.D.
Date: _____5//27/14_____   Date: _____5/27/14._____