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Culturally Responsive Family Therapy with Post-Risk Assessment Juvenile Fire Setting and Bomb Making: A Forensic Psychology Paradigm

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Abstract

Internationally, research on juvenile fire setting and bomb making creates an empirically based rationale that supports at least two intervention practices. First, there is a forensic mental health justification for remaining attentive to the recurring public safety risks attached to these high profile cases. Second, there is a post-risk assessment preference for using culturally responsive family therapy within a JFSB context. Largely, JFSB does not occur in isolation from the family. The author argues that post-risk assessment family issues must be addressed as a means to mitigate recidivism. The major purpose of this article four-fold when it comes to exploring the current research literature and reviewing risk assessment methods. First, the articles discuss the prevalence of the JFSB problem and referral matters. Second, the article stresses the necessity for forensic mental health adaptations to be made during family therapy with respect to JFSB cases. Third, ethical and legal issues are examined along with culturally responsive post-risk assessment family therapy specific to JFSB. Finally, conclusions, implications for practice, research, training, and supervision are discussed.

Keywords: Family therapy; Bomb making; Forensic psychology

Introduction

Juvenile Fire Setting and Bomb Making (JFSB) is a major public safety issue that transcends international boundaries. Historically, the United States has been in the forefront for research and clinical forensic practices related to JFSB. Typically, different clinical forensic programs address by fire setters and bomb makers since they share similar referral routes. Many of the JFSBs have garnered considerable interest across several disciplines (e.g., fire service, criminal justice, education, and mental health). Most researchers worldwide agree that JFSB is a costly problem, both from a health care and economic standpoint [1-3]. Of specific interest to family therapy, the assessment and treatment of JFSB has proven to be challenging because of the uneven availability of qualified professionals who can encounter these juveniles anywhere from the time of the initial incident (i.e., fire setting or bomb making), through legal authority processing, risk assessment, public safety interventions, and to post-risk assessment treatment (Johnson, In press). In sum, there is a paucity of ethically competent service providers with the relevant expertise required for working with these complex clinical forensic JFSB cases.

Juvenile fire setting (JFS) FEMA model

There are standards for what some might identify as best practices contained in the most frequently used edition of the FEMA Juvenile Fire setter Intervention Handbook [4], as well as in the recently released National Fire Academy's Youth Fire setting Prevention and Intervention (YFPI) Manuals for training certification levels 1 and 2 [5]. The purpose of these manuals and the associated training program is to instruct and guide communities in the development and implementation of a juvenile fire setter intervention program.

The FEMA endorsed model ostensibly designed for lowering the future risk of juvenile fire setting was first published in 1979. The model is "a formal process for fire setting behavior that includes an intake, interview, education, referral, and evaluation…[and]…a comprehensive strategy that addresses safety issues via educational means" [6]. The stated goal of the JFS modeled program is "early identification and intervention to prevent and control fire setting and arson" [4]. The version of the program published in 2002 remains a primary model for the implementation of juvenile fire setting intervention programs conducted through the fire service in the United States. These juvenile fire setting programs are all educational in nature and the academic backgrounds of the individuals implementing them is bachelor level or lower. In this case, minimum academic and practicum requirements often found in mental health trainings are not found in the aforementioned practice guides. More problematic, there is a dearth of relevant research to support the effectiveness (i.e., reducing recidivism) of these educational programs for achieving public safety much less their cultural responsiveness. In addition, a major difference probably needs to be stressed (i.e., ethical informed consent to participants) between the proliferation of JFS programs versus the less than 10 national JFSB clinical forensic services provided by qualified professionals (i.e., minimum a state mental health license) that attempt to address the public safety risk assessment and intervention issues stemming from these cases.

In addition, conceptualizing JFSB is further compounded by the fact that there is wide variation in the psychometric properties of various tools used with JFSB, which have clear implications for confidence in the accuracy of the risk assessment relevant information they provide [1,7]. For example, dissertation investigation published in 2000 examined the primary instrument used in the implementation of the FEMA model. This investigation found both the instrument and the theory utilized in the construction of the FEMA model lacking in validity [8]. A third study, conducted in 1997 on a group of children referred to the Portland Fire Department, found less than 42% of the children whose parents

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endorsed clinical levels of psychopathy on a well-respected, empirically sound screening instrument were referred to mental health providers after being screened by firefighters using the FEMA model [9]. The average age of these three studies is 19 years old. The foundational work responsible for the development of the instruments the studies investigate is 36 years old. Despite its lack of validity as an empirically supported method, the FEMA modeled practice of screening juvenile fire setters may be assessed by some as a gold standard in the United States. A review of the manuals and documented training procedures from 1979 to 2013 reveal an absence of substantial revisions to the theoretical model, standards of training, or implementation of FEMA's procedures for identification and disposition of juvenile fire setting cases in 35 years. The 2014 printing of the new YFPI manuals provide updated references for mental health related summaries. However, it fails to make substantial connections between the information and the applicability to the use of the FEMA model of categorizing juvenile fire setting typology. A widespread use of any model lacking validation, reliability, and strong empirical evidence of efficacy is concerning as a public safety matter.

Basic risk assessment concepts and public safety matters for JFSB

One thing that is clear, JFSB constitute a realistic potential threat to public safety that by default requires a relevant public safety risk assessment. Risk assessments are an accepted standard of practice in forensic psychology and in other disciplines [1,3,7,10,11]. The current advances in risk assessment for criminal behavior are supported by important findings in regards to the applicability of treatment components for individuals being evaluated. A study conducted by Andrews et al. in 2006 [12] demonstrates that risk assessments, which are paired with appropriate treatment, compliance management, and reassessment at regular intervals, provide strong evidence for accurate prediction of recidivism. Risk assessments without these elements were negatively correlated with accurate predictions, meaning they were statistically more likely to be wrong than right [12].

The FEMA model is a combination of first and second generation models of risk assessment, as defined by the work of Andrews et al. [12]. The first generation models relied ostensibly on the unstructured judgment of the evaluator to identify the presence or absence of risk for re-offending. This type of judgment includes gut feelings, anecdotal knowledge, personal and professional experience, and common sense. A statistical analysis of the predictive validity, in this case the likelihood of correctly identifying a future fire setting behavior, for the first generation risk assessment design was shown to be extremely poor [12,13]. As an assessment tool, the FEMA Model also fails to include ethnoracial factors or other developmental features that are particularly relevant for JFSB post risk assessment family therapy cases.

DSM-5 quadrant, public safety and treatment

Diagnosis is central to public safety and treatment. Diagnostically, the DSM-5 Quadrant uses four of the most commonly occurring disorders to create a clinical portrait of a JFSB that is helpful during interventions [14,15]. Interventions aimed at moderate to extreme high risk JFSB are designed to reduce those public safety threat levels. In this case, once the risk assessment levels have been reduced, based on a second forensic evaluation, then the JFSB could be ethically referred to a health care provider (i.e., family therapist) between recidivism and address the post-risk assessment treatment issues. The public safety framework for working with these cases necessitates the need to recognize the relationship between recidivism and addressing these residual clinical concerns. Treatment of a DSM-5 clinical disorder does not mitigate the public safety risk posed by the JFSB [14,16]. The primacy of public safety means that a juvenile must be stable enough to productively participate and complete an evidenced based intervention program (e.g. Forensic Assessment Therapeutic Jurisprudence Model or FATJAM; [14,17]) that is aimed at harm reduction issues associated with the actual incident.

Perhaps the most important distinction that makes a difference with regards to public safety is between a clinical versus a forensic work in JFSB cases. The clinical work with a JFSB takes on a direct psychotherapeutic outcome that often starts with a DSM-5 diagnosis [14]. However, forensically assessing and culturally responsive conceptualizing factors stress the priority of public safety that must remain central to legal and clinical decision making with respect to all JFSB cases [15,17]. Forensically, there is a much greater concern with recidivism with respect to fire setting or bomb making because of the obvious public safety ramifications. Among mental health professionals, many practitioners acknowledge being inadequately prepared in many areas specific to JFSB including comorbid behavioral or relevant DSM-5 psychiatric conditions [15]. Therefore, JFSB are more likely than not to receive inappropriate and inadequate interventions. Perhaps even more problematic from a potential harm perspective, these juveniles are often excluded from receiving an accurate public safety risk identified.

FEMA recognizes both of their models as individual treatments that are appropriate for use with disparate groups of juvenile fire setters; however, FEMA does not offer any guidance for determining the qualifications of forensic mental health service providers or post-risk assessment family therapist. The FEMA model identifies these groups of juveniles by the presumptive risk of future fire setting behavior. FEMA considers the educational model to be appropriate for the group classified as 'little risk.' The primary model of juvenile fire setter risk for the purpose of identification and referral for treatment is achieved through a screening conducted by non-mental health fire service personnel. No current study adequately measures the efficacy or effectiveness of this practice. On a professional level, can a substantial case be made that a person with BA or lower be sufficiently trained to competently conduct such complex risk assessments? Correspondingly, FEMA states the group of juvenile fire setters classified as 'high risk' is most appropriately treated by referral to a qualified mental health provider. Despite the obvious lack of relevant professional guidance for such a referral, the reduction of juvenile fire setting behavior is a multi-systemic or a collaborative effort involving at least three primary disciplines. These disciplines are the fire service, mental health, and juvenile justice. Each of these groups has methods used uniquely within their discipline.

The family therapy literature is emerging in a number of clinical and forensic areas (e.g. primary care or as fact witnesses). A logical question to ask is to what extent can culturally responsive family therapy be used within a post-risk assessment JFSB context? There is a developing understanding of the family psychological processes required for intervening with JFSB. This article frames support for six areas that may address the aforementioned question. First, there is a review the significance JFSB, which elaborates on the prevalence and priority of these public safety cases. Second, the making of a JFSB family therapy referral is discussed. Third, ethical issues in JFSB family therapy are reviewed. Fourth, there is an exploration of the forensic adaptations required for family therapy with respect to JFSB. Fifth, culturally responsive post-risk assessment family therapy for JFSB is reviewed. Finally, implications for research, practice, training, and supervision are discussed.

Prevalence of the Problem of JFSB

A major part of the reason for the added attention to fire setting and bomb making is its wide-ranging prevalence rates. For example, the reported rates of adult perpetrated violent crime incidents in the United States have lowered steadily over the twenty years. In contrast, the rate of all crimes perpetrated by juveniles is rising. Most crimes committed by juveniles fall into the arena of property crimes [18]. The category includes burglary; theft; motor vehicle theft; forgery, check and access card offenses; and arson. According to the latest available research, the rates of juvenile arson have mirrored the increased rate of other juvenile crime over the last two decades [19].

Between 2005 and 2009, an average of 56,300 child-playing fires reported to U.S. municipal fire departments per year. These incidents caused, on an annual average, 110 civilian deaths, 880 civilian injuries, and $286 million in property damage [6]. Juveniles accounted for 40.4% of all arson arrests in 2010 [20]. Almost half of these arrests are children under the age of 15, and nearly 7% were under the age of ten [21]. A Federal Emergency Management Agency (FEMA) report, which accounts for federally reported and tracked fire incidents, indicated 44% of home structure fires were caused by children aged four to six playing with a heat source.

It is important to note that these statistics are for only the federally report incidents; the actual number of juvenile set fires are known to be higher**.** A recent review of the National Fire Incident Reporting System (NFIRS) public data set established 354,513 arson incident reports of juvenile involved fires from 2006 to 2011. These statistics may also be misleading, as there are incidents which are reported more than once, or incidents filed as a juvenile involved fire in which the juvenile was simply present in the home and not an active participant in the fire setting [22]. What is certain is that, as noted over three decades ago in the 1974 Fire Prevention and Control Act, arson is both costly and dangerous (Federal Bureau of Investigation [23]). The costs and injuries stemming from the prevalence of JFSB speak volumes about the need for attention to making proper forensic assessments and therapeutic referrals.

Making a JFSB Family Therapy Referral

Referring JSFB to other mental health professionals is a sine qua non for clinical forensic practice. To be appropriately referred, a JFSB must achieve a low public safety risk assessment rating as a standard of practice precondition for termination subsequent psychological treatment [24]. A post-risk assessment and intervention referral for continued treatment can have a two-fold benefit for a JFSB. First, it can help solidify or seal the progress made at the time of termination in the area of public safety, as well as, extend time to explore in more detail previous but perhaps inadequately addressed family circumstances or other issues [25-27]. Second, since a licensed a qualified mental health JFSB provider is making the referral, their awareness of the clinical forensic situation strategically places them (i.e., assuming previously obtained valid and written permission to communicate with providers) in an important gatekeeper and resource role to influence any subsequent treatment or concerns about recidivism [28-31]. It this case offering support to the post-risk assessment service provider in a way that is likely to help reduce recidivism risks.

Challenges in deciding to make the post-risk assessment family therapy referral

The decision about whether to refer appears to be impacted by both individual and family factors. For example, there may be repeated episodes of non-compliance while the JFSB is in the process of receiving the risk assessment and related interventions. During these interventions an examiner may have observed dynamics (e.g. rigid denial of the seriousness of the JFSB incident, inaccurate reporting, or parental psychopathology) in the family that were of considerable concern but not the focus of the previous sessions in any major way [14]. A post risk assessment family therapy referral can also be made as a malpractice risk management strategy if a forensic examiner has reason to question the gains made by a JFSB. In terms of choosing who to make a referral for family therapy, the licensed mental health professionals chosen to be recommended (i.e., at least three) should have some experience with working with forensic cases and feel reasonably comfortable with possible court appearances (i.e., as a fact witness) if it is required (reference for forensic family therapy). The post-risk assessment referral should be thoroughly discussed with the JFSB and their parent, as there are additional costs and time commitments. In addition, the referring provider must assess the pros and cons of any potential hardship to the family and JFSB (e.g. driving distances, culture, school or language factors) possibly stemming from subsequent family therapy.

There are reasonable challenges that must be kept in mind as these JFSB referrals take place. The post-risk assessment referral requires coordinating attention to the communications between the referring forensic examiner and family therapist. It is also important for the family therapist selected to remain sensitive to the public safety issues that can reemerge during the course of post risk assessment treatment. The standard of practice must include a signed release that authorizes sending a termination summary report that contains a pre and post-risk assessment ratings for the JFSB [14,22]. The report would also include supplying the therapist with all relevant clinical information and specify the purpose of the referral. A forensic examiner may also include a DSM-5 Quadrant rating which clarifies the diagnostic picture for the JSFB [14,15]. A review of the literature reveals minimal training and guidance available with regard to how to determine the appropriateness of a particular case for mental health referral for JFSB. Much of the reviewed literature tailored to US fire service recommends that the interviewer rely on subjective judgment and the self-reported responses of the juvenile fire setters and their families in order to determine the appropriate disposition of the case. This can be problematic in assessment of fire setting risk, even for seasoned mental health professionals, as there is also limited knowledge of fire setting within the general mental health profession [32]. Family therapy with JFSB requires the service provider to make forensic adaptations with respect to these cases.

Forensic Adaptations in Family Therapy Practices with JFSB

There are several forensic areas where family therapy can be used (e.g. family unification, custody disputes, divorce, etc.). The construct of forensic adaptation refers to the legal proceedings adjustments that are associated with JFSB. A forensic adaptation is the application of family therapy for a criminal justice system issue [33-35]. In this case, a JFSB has been charged with a fire setting or bomb making incident such that they have reached a point in the process where at least an empirically guided treatment is applied to mitigate public safety risks for recidivism while address residual family issues.

Family therapy is one of the clinical services that can be provided to post risk assessment JFSB. Unlike the risk assessment and intervention, post-risk assessment family therapy is not likely to be mandated by

the courts or probation. The JFSB and their families participate in this treatment on more of a voluntary basis. As such, the focus on family issues may evoke significant resistance to treatment or perceptions of a less psychologically-minded patient [36]. Hence, there are caveats associated with the family therapy role.

Forensically, family therapy with JFSB is a part of a larger therapeutic culture with four adaptive practice caveats. First, a forensic adaptation in family therapy practices with JFSB means that each session must include a documented assessment of what can be an outstanding public safety feature signaled by a reoccurrence of fire setting or bomb making behaviors [1,15,37]. Second, this brief assessment should be performed separately with the JFSB and the parent/legal guardian. Third, from an interdisciplinary perspective, a consultation with the previous forensic examiner may be advisable depending on the exact nature of recent incidents. Finally, it is important to be mindful that JFSB and their families can flexibly deny, distort, or minimize subsequent problematic behaviors.

Forensic cautions and a family therapist's role in work with JFSB

As family therapists, the treatment with JFSB must be conceptualized as a forensically-related mental health activity. Why? Fire setting and bomb making perpetrated by juvenile has received increased legal attention over the past decade [14,38]. The literature also indicates that a large percentage of juvenile offenders have mental disorders but only limited access to appropriate services to treat the diversity of family issues that can present during their contacts with the justice system. As part of their public safety risks, JSFB often present an additional constellation of interpersonal difficulties surrounding their family of origin or home culture. The course of any multisystemtic approach involving family therapy is expected to include a blend of emotional disturbances and occasional setbacks [33,39,40]. Many family therapists are less familiar with the behavioral characteristics, prevalence and public safety threats associated with JFSB. A caution for a sharpened awareness of these risk factors is critical for family therapists, who can almost predictably become more focused on some of the highly charged family interactions and thus may overlook forensic warning signs stemming from these cases [41-44].

As post-risk assessment service providers, therapist's primary role is to provide care for the JFSB family. Given the legal nature of these cases, it must be assumed that the work of the family therapist functions as forensic evidence in the broad context of these JFSB legal cases.

Forensically, post-risk assessment family therapists working with JFSB cases would be designated as a fact witness as opposed to an expert witness (i.e., paid independent professional). In theory, the family therapist over time has collected critical information that makes them eligible for being compelled to appear via subpoena where they would provide sworn testimony. As a fact witness, a family therapist would be expected to provide professional evidence of their post risk assessment treatment with the JFSB. The evidence would include the clinical records as a result of the various sessions. The family therapist's direct contact with the JFSB in this context is invaluable. In this case, during the course of family treatment, the therapist has secured facts (i.e., fact witness) and developed culturally relevant opinions regarding the case [17,45].

How to be a more effective fact witness in JFSB family therapy cases

Daubert is one of the standards used by several states to gauge the scientific credibility of the work of professionals in various legal contexts. In the application of the Daubert standard in practice, a family therapist's testimony is ostensibly designed to assist the "trier of fact (i.e., usually a judge)" to understand the therapeutic evidence or other clinical facts in the JFSB case. Historically, family therapist comparatively receive a paucity of training for developing the skills required for providing testimony [21,32,46,47] To little surprise, the thought of providing testimony in open court can be quite anxiety provoking and daunting for most therapists. There are at least four practices that a family therapist can do to prepare for the testimony in these JFSB cases. First, carefully study the circumstances surrounding the original referral. Second, make sure all the documentation is appropriately completed for the case. Third, define and deliver services within a specified area that allows circumscribed testimony only for what was observed during contacts with the JFSB. This means avoiding offering opinions or speculations that go outside the scope of the actual clinical work that the family therapist was initially charged to perform (i.e., do not offer opinions about future fire setting or bomb making). Fair warning, the attorneys on both sides of the case, may attempt to get the therapist to opine on a host of other matters that support their perspective on the case or refute the opposing counsel. Finally, obtain legal consultation as necessary. The overall view that emerges is that despite the public safety risk challenges, family therapy seems to be an appropriate option for JFSB. There are ethical issues to consider when working with JFSB cases.

Ethical Issues in JFSB Family Therapy Work

Mental health professional associations (e.g. American Psychological Association, American Counseling Association and National Association of Social Workers) are packed with ethical standards usually written as codes. For example, the AAMFT includes eight principles (American Association for Marriage and Family Therapy [AAMFT] [48]). These standards guide how service providers should ethically structure their practice and each of the aforementioned professional associations share several codes in common (e.g. confidentiality and competence). From an interdisciplinary standpoint, a family therapist that is aware of the various ethical codes has an informational and clinical practice advantage in understanding how they may apply to JFSB. At a minimum, the ethical standards serve the purpose of reducing malpractice risk when working with JFSB. There are wide ranges of ethical issues that are of significant practical importance to family therapy; however, confidentiality, informed consent, diagnosis, diversity and competence are probably the most prominent ethical-related issues that a family therapist may be expected to regularly confront in their work with JFSB. An example of the public safety relevance of applying the ethics for a family therapist is noted by a case where repeated fire setting behavior was not reported to group home staff despite being disclosed in several sessions (i.e., with signed permission to share information). The rooms of the two groups home sustained major damage stemming from the fire set by this juvenile. The hard conclusion here that is difficult to disagree with, there is public safety risks associated with JFSB work. In other words, there is an overarching concern about non-malfeasance (i.e., do no harm).

Public safety has the prevention of harm as a core element in defining it. Based on the prevalence of JFSB, harm avoidance (i.e., non-maleficence) is a justified metric that can be ethically and legally applied to JFSB cases whenever behaviors reflecting underlying principles (e.g. beneficence justice, and respect for autonomy) of a family therapist's work have been called into question. These concerns are dependent on the competence of the therapist with respect to JFSB work. In terms of

competence, the AAMFT third ethical principle is competence. This principle clearly indicates in Principal 3.1 that "Marriage and family therapists pursue knowledge of new developments and maintain competence in marriage and family therapy through education, training, or supervised experience." To "maintain competence" implies that a therapist upholding this principal will be able to treat each client effectively [48]. The emphasis on competence assessment has been a part of the mental health profession for several decades [49,50]. While there is no ubiquitous definition, competence in this JFSB context refers to the knowledge, skills, attitudes, values and judgment needed to implement and use them appropriately with these cases.

The applications of ethical standards are expected to evolve as an outcome of the professional work performed in various clinical and forensic areas like JFSB. It could be argued that one of the greatest ethical tensions in practice with respect to JSFB is the mental health provider's incapacity to recognize self-deceptions around their competence [32]. A competency self-audit is recommended in consideration for the other issues attached to these cases [51]. An ethical analysis or decision making framework may be of some assistance [52,53]. Since JFSB work is not usually a primary area of expertise for many family therapists, by default it carries with it an extra public safety burden for a family therapists to exercise scientific responsibility (i.e., understanding the applied clinical forensic science). Too often, competence in working with these cases can be confused with how much general education or training one has received in the distant past, instead of how much targeted experience or specific training can be documented recently that they have learned and are able to demonstrate through effective JFSB work [14].

On the upside, the AAMFT guidelines do provide ethical scaffolding for family therapist's decision making analysis. These codes focus on providing reasoned and coherent ways for finding answers to the questions associated with JFSB. The awareness and judgments around these ethical matters are critical in this safety sensitive treatment process. A family therapist is also ethically expected to manage the ethnoracial factors present in various JFSB cases. That means they have integrated ethical, professional and societal obligations in order to ensure that their work is culturally responsive (i.e., exploring a wide range of ethnoracial, social, cultural, linguistic), strives to be objective, reliable and is at least empirically guided [16,17,44].

Culturally Responsive Family Therapy for JFSB

Being culturally responsive means that a mental health provider can assess a range of clinical forensic issues and then appropriately introduce at least empirically guided interventions that are congruent with the life experiences of the patient. There are four reasons why culturally responsive family therapy can be useful with JFSB. First, is the universal recognition that culture is embedded in the context and practice with JSFB [34]. Second, families of origin are preloaded with home cultural factors that function as a significant etiological agent during course of any treatment [54,55]. Third, an analysis of the fire setting and bomb making behaviors are laden with stressors that fuel adaptation challenges unique to the family. Finally, research reinforces a combination of needs for cultural continuity in the treatment of mental health issues that can function as aggravators or mitigators for recidivism. In addition, there are family therapy methods that have empirical support (e.g. BSFT, FFT, MST) that underscore their use in working with family characteristics found in offenders [11,28,56-58].

Family characteristics of JFSB

No pattern or psychological profile of an actual incident can be constructed that distinguishes various JFSB. Family structures are also not found to have predictive features substantially suggestive of JFBS behavior. Yet, decades of research reveal that problematic behaviors like JFSB can arise from a personal past or current emotional situation which is byproducts of family life [59]. Juvenile arsonist families have been assessed as disorganized and dysfunctional [60,61]. Family life is at least a double-sided psychological coin that can have a negative or positive impact on a JFSB. In this case, a family system can increase the likelihood of JFSB or contribute in substantial way such that reoccurrences are reduced.

A JFSBs larger sociocultural environment contains interpersonal tendencies (e.g. bad boundaries, poor adaptability to stress) and cognitive schemas that shape how they function in the world (i.e., make decisions or exercise judgment). For example, parental practices, levels of rigidity, style and psychopathology can impact multiple levels of a juvenile's functioning [47,62] Parents can sometimes be described as not psychologically available or unresponsive [37]. The level of supervision is often poor with little emotional connectivity to their children [63,64]. Other research focuses on family and parenting factors as important correlates for "troubled" fire setters [14,38,60,63,65]. These factors may include variables of the parents themselves, such as alcoholism, presence of psychopathology, or absenteeism. They may also cover parenting behaviors such as ineffective or inconsistence discipline, domestic violence in the home, modeling of inappropriate uses of fire, or lack of supervision. There is very little research on the protective parental factor of fire setting reduction or cessation. Several studies have found heightened parental awareness through education can reduce the number of fire sets in the home for some cases [14].

To little surprise, the aforementioned family structures were also found to have influence on the development of antisocial tendencies in juveniles. In terms of JFSB, whatever conditions are assessed as operating within a family, they have not functioned in a way that follows a predictable trajectory to judgments leading to fire setting or bomb making. Ethnoracially, a JFSB family may present with a host of dynamics (denial, distorting, or minimizing) surrounding the fire setting incident and the other circumstances resulting in actual family therapy referral. The legal and psychological attention stemming from a JSFB incident can significantly alters family functioning and may draw attention to other historical events that may be not openly discussed but can nonetheless function as treatment obstacles [66-69].

Family therapy obstacles within an ethnoracial context with JFSB

Ethnoracial factors create the need for a meta-framework that can be used in the practice of family therapy with JFSB cases. Different kinds of JFSB can exert diverse influences on the family therapy practice. It cannot be assumed that the current evidence based models (e.g. MST) methods or techniques can be appropriately applied in a culturally responsive manner. The application is hindered by a comparatively paucity of existing information that make it difficult to apply some of these methods. There are at least four obstacles with respect to family therapy in JFSB cases. First, can the documented competencies (i.e., cross-cultural and clinical deficiencies) of the service provider sufficiently meet an independent review? In other words, the service provider must be able to provide clear and convincing evidence of their competence in implementing a culturally responsive approach to family therapy that meets the diverse ethnoracial needs [70]? Second, to what extent do current evidence based family therapy models invalidate or get applied mechanistically in the absence of a cultural psychohistorical

context (e.g. acculturation, cultural mistrust, denial of mental health issues, help seeking dispositions, language, stigma and differing world views) with every service provider for the group it is being used [69,71-76]? For example, biracial and multiracial backgrounds are predictably relevant to treatment but a search on several databases (e.g. PsychInfo, FamilyTherapyResources.Net, etc.) failed to result in a substantial body of literature for guiding family therapy with the aforementioned racial backgrounds [77].

Third, to what extent is the post-risk assessment family therapy plagued by diagnostic problems [78,79]. Finally, a general scarcity of empirical investigations reveals a failure to engage the complexity and variability found in ethnoracial diverse families that results in another flaw any subsequent cultural analyses. Despite the aforementioned obstacles, being culturally responsive is the cornerstone of family therapy that can offer a more nuanced analysis and informed intervention strategy for the specific challenges in these cases.

A culturally responsive approach to JSFB

A culturally responsive approach to family therapy in JFSB case requires four elements at a minimum (Figure 1). First, an accurate and defensible self-assessment of competencies associated with being culturally responsive [50]. Second, an ability to conceptualize the case from the ethnoracial prism of the family [16,17,80]. Third, familiarity with at least empirically guided approaches that have demonstrated some efficacy with the clinical forensic issues presented in the case [81]. Finally, familiarity with the legal requirements attached to the case [48].

In terms of practice and training, no assessment, diagnosis, or treatment can appropriately take place without significant inclusion of ethnoracial and cultural factors [22,71,82-84]. For example, while identified as relevant to both practice and training, the construct culturally responsive is not comparatively well represented in family therapy.

Baily et al. [54] found some positive cultural theme movement in the Journal of Marital and Family Therapy from 1990 to 2000. However, the topics of culture, ethnicity, and race are more noticeable by their relative neglect in key professional resources used by MFTs. For example, ethically, there are 87 AAMFT Codes but less than 1% of those codes actually speak to issues of culture and race [48]. The Commission on Accreditation for Marriage and Family Therapy Education's [85] who sets standards for MFT programs encourages a commitment to multiculturally-informed education. There are 128 AAMFT core competencies for marriage of family therapy and less than 1% of them are actually devoted to being culturally responsive [48]. There are four domains where these competencies are listed. A summary of the descriptors used for those competencies includes cultural, culturally sensitive approaches, culture/race/ethnicity and vulnerable populations. Domain 4 (therapeutic interventions) contains the largest number of MFT core competencies (i.e., 3) that are specifically related to cultural responsiveness.

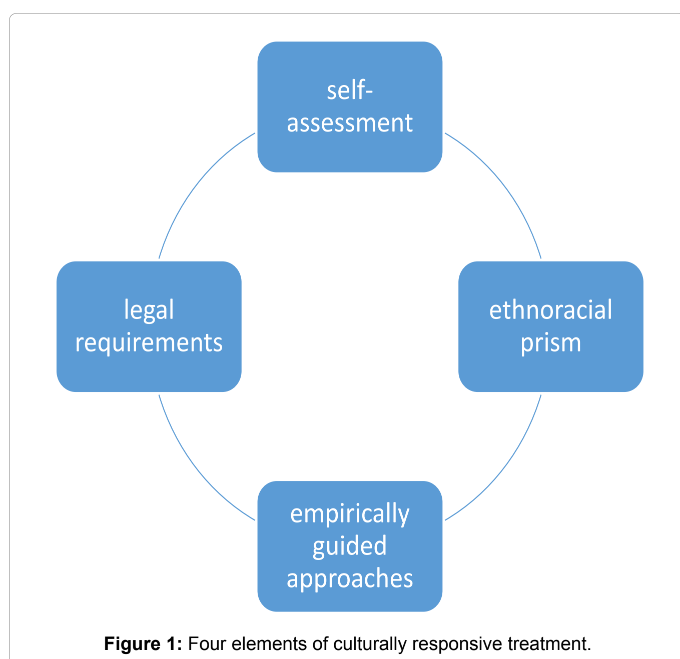

Figure 1: Four elements of culturally responsive treatment.

Towards a culturally responsive framework

In JFSB practice, being culturally responsive requires examining and questioning several unchallenged assumptions about the therapeutic process. Among the questions yet to be comprehensively answered for some service providers are:

- If an independent ethnoracial audit were made of your work in this case, what would be the most vulnerable competency points?
- What cultural or ethnoracial factors did I consider in this case?
- How did those factors impact how I approached working with this case?
- Ethnoracially, every theoretical approach has caveats and limitations. How are these factors expected to impact the work required in this case?

Few of the traditional theories were originally crafted to address the full range of clinical issues presented by historically underserved ethnoracial groups in the United States [16,73,86-90]. That is, many of these theories have not been systematically tested in order to create a solid empirical foundation for their application with diverse patients [16,91-93]. In this case, systematically testing cultural utility hypotheses would permit us to evaluate where these theories have ethnoracial strengths and deficiencies. In the end, it would improve the cultural responsiveness of these theories. Many family treatment issues presented by JFSB can be initially evaluated clinically by prioritizing a combination of three criteria, although these criteria are far from exhaustive of the important clinical issues raised by any family therapy that aspires to be culturally responsive. The criteria are: (a) ethnoracial acumen; (b) cross-cultural problem solving; and (c) the ability to empathically conceptualize as the other.

Ethnoracial acumen means the service provider takes to the time to learn about the ethnoracial history of the family across generations and the complexities of culture that was shaped by their experiences in the world [16,36,94,95]. It is nearly impossible to escape the fact that ethnoracial factors are embedded organizing principles for family therapy with JFSB. In order to effectively work with these families, it is important to understand how psychohistorical events have come to shape the formation of their varying cultural contexts. Post-risk assessment therapy challenges families to understand how their own functioning can affect their relationships with each other and can link to JFSB. There are some cross-cultural norms that are ingrained in the psychological fabric of diverse ethnoracial groups that must be learned and used in the delivery of services (e.g., African-Americans [96]; or

Latinos). In other words, there are some critical assumptions that should guide treatment. Cross-cultural problem solving uses knowledge of diverse groups to listen, interpret, and the make decisions. Empathically conceptualizing as the other means the ability to completely divest and refashion experiences, training and ways of being in a manner that enters the affective and cognitive or world view framework of the patient (i.e., become the other [97]). Culturally responsive in this expanded context does not mean the provider agrees with or endorses the patient's view of the world. Yet, instead of reflexively dismissing or marginalizing issues presented by diverse families, a culturally responsive provider has developed the ability to understand (i.e., flexible and responsive framework) the logic of behaviors and seemingly misplaced emotions (e.g. critical race theory [98]).

The end result is the experience of the JFSB family is they tend to feel affirmed by the provider. For example, Kossak [99] suggested that Hispanic clients are more willing to consider and comply with the treatment regimen when they have a sense of being understood and have developed trust in the service provider while consistently address issues of power, privilege, racism, and oppression. A JFSB incident coincides with resulting contacts with legal authorities and mental health professionals which are often assessed as a stressful life event that clearly present challenge for children and their families. The home ethnoracial culture of the family means the family therapist is deeply connected to an objective of contextualizing interventions aimed at salient post-risk assessment JFSB issues by temporarily losing their own sense of self long enough to be effective or approach understanding the families distinct world view.

It may be somewhat naïve to assume that being culturally responsive in family therapy with JFSB can be achieved through a single theoretical orientation. It is also not recommended to artificially inject ethnoracial into any traditional family therapy approaches in an effort to somehow make it culturally responsive. The intent here was to address some of the gaps, misconceptions, and incomplete knowledge about post-risk assessment family therapy with JFSB. For example, Szapocznik et al. [100] has demonstrated the effectiveness of Brief Strategic Family Therapy (BSFT) with troubled Latino youth. Similarly, Bernal and Saez-Santiago [101] crafted eight element scaffolding for interventions that can be used with diverse families. Admittedly, culturally responsive can be a rather nebulous clinical term. Still, there is growing empirical and practical evidence that speak to the advantages of considering its importance within the provision psychological services to diverse families.

Implications for Practice, Research, Training and Supervision

Despite the prevalence of JSFB, comparatively little is known about this complex issue within the context family therapy. As an essential part of the post-risk assessment treatment, the competencies of a culturally responsive family therapist working in conjunction with a forensic psychologist can fill a critical practice role in working with JFSB [26,55,102]. The ethnoracial context of therapy with JFSB varies from case to case but is largely driven by a patient's known risk assessment [1,12] The hallmarks of culturally responsive family therapy includes an ongoing assessment of public safety issues, collecting, analyzing, interpreting and intervening in the context of the families multigenerational cross-cultural life experiences [103,104]. Public safety is a major area of concern when it comes to JFSB and family therapy represents another way to facilitate it in practice. For example, the family therapist plays a central role in monitoring JFSB behaviors that possibly signal deterioration in their functioning in a way that might lead to recidivism. Culturally responsive post-risk assessment family therapy means knowing how and when to shift into back and forth between the lingering clinical issues and the priority-setting for safety needs in JFSB cases.

There is a gap between the practice and science in JFSB that poses a perplexing dilemma. On the one hand, there is an ever-expanding list of treatment evidence that has demonstrated to be efficacious for a number of mental disorders and clinical issues. On the other hand, these interventions are not well represented in the post risk assessment treatment of JFSB. In fact, there is a paucity of investigations that examine family dynamics and post-risk assessment culturally responsive treatment with JFSB. Future studies in these areas would have the potential of offering additional insight into the family structure and functioning as it pertains to the precursors and residual responses in the aftermath of a fire setting or bomb making incidents. Investigations could also explore the role that family members would play in the process of the post-risk assessment treatment as well as the differences between JFSB and non-JFSB subjects. Similarly, within cultural group differences in JFSB is also a worthy area of subsequent research.

There are three considerations that merit attention when examining the implications for culturally responsive family therapy training and supervision. First, it would be a mistake to underestimate importance of the ongoing need for public safety assessment with supervisees working with these cases. Second, it can be reasoned that supervision must to be adapted to complexity of the JFSB case and competence of the family therapist who may use ill-advised customary approaches without sufficiently considering the public safety elements of the case. For example, it is probably more advisable that at a minimum, licensed mental health professionals with forensic expertise should be used in these post-risk assessment family therapy cases due to the potential of court involvement. Since many family therapists do not have substantial experience with JFSB cases, supervision would need to change in accordance with the growth of a supervisee [46,47,105]. Finally, forensic training issues probably need to be more intentionally incorporated in an already crowded MFT curriculum. Overall, this article has helped initiate a family therapy dialogue that aimed to clarify the breadth and multifaceted nature of culturally responsive work with JFSB.

References

1. Dolan M, McEwan TE, Doley R, Fritzon K (2011) Risk factors and risk assessment in juvenile fire-setting. Psychiatry, Psychology and Law 18: 378-394.
2. Fritzon F, Dolan M, Doley R, McEwan TE (2011) Juvenile fire-setting: A review of treatment programs. Psychiatry, Psychology and Law 18: 395-408.
3. Johnson R, Jones P (2014) Identification of parental endorsement patterns: An example of the importance of professional attunement to the clinical-forensic risk markers in juvenile fire-setting and bomb-making. American Journal of Forensic Psychology 32: 25-42.
4. Gaynor J (2002) Juvenile fire setter Intervention Handbook. United States Fire Administration, USA.
5. United States Fire Administration (2014b) Youth fire setting prevention and intervention 1 Student Manual. Fema, USA.
6. Hall JR, Association NFP (2010) Intentional fires: National Fire Protection Association. NFPA, USA.
7. Hempel I, Buck N, Cima M, van Marle H (2013) Review of risk assessment instruments for juvenile sex offenders: What is next? Int J Offender Ther Comp Criminol 57: 208-228.

8. Slavkin ML (2000) Juvenile fire setting: An exploratory analysis. Indiana University, USA.
9. Pierce JL, Hardesty VA (1997) Non-referral of psychopathological child fire setters to mental health services. J Clin Psychol 53: 349-350.
10. MacKay S, Henderson J, Del Bove G, Marton P, Warling D, et al. (2006) Fire interest and anti-sociality as risk factors in the severity and persistence of juvenile fire setting. J Am Acad Child Adolesc Psychiatry 45: 1077-1084.
11. Monahan J, Steadman H, Silver E, Appelbaum P, Robbins PC, et al. (2001) Rethinking risk assessment: The MacArthur study of mental disorder and violence. Oxford University Press, New York.
12. Andrews DA, Bonta J, Wormith JS (2011) The risk-need-responsivity (RNR) model: Does adding the good lives model contribute to effective crime prevention? Criminal Justice and Behavior 38: 735-755.
13. Andrews DA, Bonta J (2010) Rehabilitating criminal justice policy and practice. Psychology, Public Policy and Law 16: 39-55.
14. Johnson R (2014) Towards a forensic psychological evaluation of juvenile fire setters: Parent power. Journal of Forensic Research 5:214.
15. Johnson R (In press) Towards an evidence base forensic diagnostic assessment framework for juvenile fire setting and bomb making: DSM-5 quadrant. Journal of Forensic Psychology & Practice 15: 275-293.
16. Johnson R (2013b) Using the DSM-5 and ICD-11 in forensic and clinical applications with children across racial and ethnic lines. In: Koocher GP, Norcross JC, Greene BA (Edr) Psychologists' Desk Reference (3rd Edition). Oxford University Press, New York.
17. Johnson R (2013a) Forensic and cross-culturally responsive assessment using the DSM-5: Just the F.A.C.T.S. Journal of Theory Construction and Testing 3: 18-22.
18. Miller L (2014) Juvenile crime and juvenile justice: Patterns, models and implications for clinical and legal practice. Aggression and Violent Behavior 19: 122-137.
19. Stadolnik RF (2000) Drawn to the flame: Assessment and treatment of juvenile fire setting behavior. Professional Resource Exchange, USA.
20. Puzzanchera C, Kang W (2013) Easy Access to FBI Arrest Statistics. National Center for Juvenile Justice, USA.
21. Cassel E, Bernstein DA (2013) Criminal behavior. Psychology Press, USA.
22. Johnson R, Jones P, Said C, Walker S (2013) Juvenile Arson and Explosives-Use Research and Intervention Center. San Diego, California.
23. Federal Bureau of Investigation (2009) Crime in the United States, by State, 2009. FBI - UCR. Federal Fire Prevention and Control Act of 1974. UCR, USA.
24. Terrell F, Terrell S (1984) Race of counselor, client sex, cultural mistrust level, and premature termination from counseling among Black clients. Journal of Counseling Psychology 31: 371-375.
25. Trupin EJ, Kerns SEU, Walker SC, DeRobertis MT, Stewart DG (2011) Family integrated transitions: A promising program for juvenile offenders with co-occurring disorders. Journal of Child & Adolescent Substance Abuse 20: 421-436.
26. Waites C, Macgowan MJ, Pennell J, Carlton-LaNey I, Weil M (2004) Increasing the cultural responsiveness of family group conferencing. Soc Work 49: 291-300.
27. Weiler LM, Lyness KP, Haddock SA, Zimmerman TS (2015) Contextual issues in couple and family therapy: Gender, sexual orientation, culture, and spirituality. In: Wetchler JL, Hecker LL (Edr.) An introduction to marriage and family therapy. Routledge/Taylor & Francis Group, UK.
28. Draine J, Solomon P (1994) Jail recidivism and the intensity of case management services among homeless persons with mental illness leaving jail. The Journal of Psychiatry and Law 22: 245-261.
29. Kennedy PJ, Vale ELE, Khan SJ, McAnaney A (2006) Factors predicting recidivism in child and adolescent fire-setters: A systematic review of the literature. Journal of Forensic Psychiatry & Psychology 17: 151-164.
30. Lovell D, Gagliardi GJ, Peterson PD (2002) Recidivism and use of services among persons with mental illness after release from prison. Psychiatr Serv 53: 1290-1296.
31. Theurer G, Lovell D (2008) Recidivism of offenders with mental illness released from prison to an intensive community treatment program. Journal of Offender Rehabilitation 474: 385-406.
32. Schwartzman P, Fineman K, Slavkin M, Mieszala P, Thomas J, et al. (1999) Juvenile fire setter mental health intervention: A comprehensive discussion of treatment, service delivery and training of providers. Juvenile Firesetter Intervention Project, USA.
33. Ashmore Z, Fox S (2011) How does the delivery of multisystemic therapy to adolescents and their families challenge practice in traditional services in the Criminal Justice System? The British Journal of Forensic Practice 13: 25-31.
34. Baglivio MT, Jackowski K, Greenwald MA, Wolff KT (2014) Comparison of multisystemic therapy and functional family therapy effectiveness: A multiyear statewide propensity score matching analysis of juvenile offenders. Criminal Justice and Behavior 41: 1033-1056.
35. Lehmann P, Jordan C, Bolton KW, Huynh L, Chigbu K (2012) Solution-focused brief therapy and criminal offending: A family conference tool for work in restorative justice. Journal of Systemic Therapies 31: 49-62.
36. Spira M, Wall J (2006) Issues in multigenerational families: Adolescents' perceptions of grandparents' declining health. Child & Adolescent Social Work Journal 23: 390-406.
37. Davis JA, Lauber KM (1999) Criminal behavioural assessment of arsonists, pyromanics and multiple fire setters. Journal of Contemporary Criminal Justice 15: 273-290.
38. Campagna A (2010) Review of juvenile fire setting: A community guide to prevention and intervention. Elsevier Science, Netherlands.
39. Martens WHJ (2004) Multisystemic therapy for antisocial juveniles: Suggestions for improvement. International Journal of Offender Therapy and Comparative Criminology 48: 389-394.
40. Painter K (2009) Multisystemic therapy as community-based treatment for youth with severe emotional disturbance. Research on Social Work Practice 19: 314-324.
41. Grunebaum H (2006) On wisdom. Fam Process 45: 117-132.
42. Holmes SB (2006) Becoming "the best possible" family counselor of family mediator: What expertise research has to say. Journal of Family Studies 12: 113-122.
43. Holmes SB (2009) On the nature of expertise in family therapy. Swisburne University, Melbourne, Australia.
44. Scher S, Kozlowska K (2011) The clinician's voice and the limist of bioethics. Austrailian and New Sealand Journal of Family Therapy 32: 15-32.
45. Koss-Chioino JD, Vargas LA (1992) Working with culture. Jossey-Bass, San Francisco.
46. Larner G (2013) Teaching, training and supervision in family therapy. Australian and New Zealand Journal of Family Therapy 34: 281-282.
47. Liddle H (1991) Training and supervision in family therapy: A comprehensive and critical analysis. In: A. S. Gurman & D. P. Kniskern (Eds.), Handbook of family therapy.
48. American Association for Marriage and Family Therapy (2012) AAMFT code of ethics.
49. Fouad NA, Grus CL, Hatcher RL, Kaslow NJ, Hutchings PS, et al. (2009) Competency benchmarks: A model for understanding and measuring competence in professional psychology across training levels. Training and Education in Professional Psychology 3: S5-S26.
50. Kaslow NJ, Grus CL, Campbell LF, Fouad NA, Hatcher RL, et al. (2009) Competency assessment tool kit for professional psychology. Training and Education in Professional Psychology 3: S27-S45.
51. Dunning D, Heath C, Suls J (2004) Flawed self-assessment: Implications for health, education and the workplace. Psychological Science in the Public Interest 5: 71-106.
52. Sukut ME, Trathen DW (2002) Ethical decision making in marriage in family therapy. A Christian Journal 5: 179-190.
53. Zygmond MJ, Boorhem H (1989) Ethical decision making in family therapy. Fam Process 28: 269-280.
54. Bailey CE, Pryce J, Walsh F (2002) Trends in author characteristics and diversity issues in the Journal of Marital and Family Therapy from 1990 to 2000. J Marital Fam Ther 28: 479-486.

55. Bean RA, Perry BJ, Bedell TM (2001) Developing culturally competent marriage and family therapists: Guidelines for working with Hispanic families. Journal of Marital and Family Therapy 27: 43-54.

56. Beck AJ, Maruschak LM (2000) Mental Health Treatment in State Prisons (Report No. NCJ188215). Retrieved from Bureau of Justice Statistics.

57. Dixon A, Howie P, Starling J (2004) Psychopathology in female juvenile offenders. J Child Psychol Psychiatry 45: 1150-1158.

58. Solomon P, Draine J, Meyerson A (1994) Jail recidivism and receipt of community mental health services. Hosp Community Psychiatry 45: 793-797.

59. Fossion P, Leys C, Vandeleur C, Kempenaers C, Braun S, et al. (2015) Transgenerational transmission of trauma in families of Holocaust survivors: The consequences of extreme family functioning on resilience, Sense of Coherence, anxiety and depression. Journal of Affective Disorders 171: 48-53.

60. Dadds MR, Fraser JA (2006) Fire interest, fire setting and psychopathology in Australian children: A normative study. Aust N Z J Psychiatry 40: 581-586.

61. Epps K, Hollin CR (2005) Understanding and treating adolescent fire setters. In: G. Boswell (Ed.), Violent children and adolescents: Asking the question why? Wiley Publishing, Indianapolis, IN.

62. Hunsberger B, Pratt MW, Pancer SM (2002) A longitudinal study of religious doubts in high school and beyond: Relationships, stability and searching for answers. Journal for the Scientific Study of Religion 41: 255-266.

63. Kazdin AE, Kolko DJ (1986) Parent psychopathology and family functioning among childhood fire setters. J Abnorm Child Psychol 14: 315-329.

64. Kolko DJ, Kazdin AE (1990) Matchplay and fire setting in children: Relationship to parent, marital and family dysfunction. Journal of Clinical Child and Adolescent Psychology 19: 229-238.

65. Kolko DJ, Kazdin AE, Meyer EC (1985) Aggression and psychopathology in childhood fire setters: Parent and child reports. J Consult Clin Psychol 53: 377-385.

66. Messent P (1992) Working with Bangladeshi families in the East End of London. Journal of Family Therapy 14: 287-304.

67. Minuchin S (1974) Families and family therapy. Harvard University Press, Cambridge, MA.

68. Minuchin S, Fishman HC (1981) Family therapy techniques. Harvard University Press, Cambridge, MA.

69. Perlick DA, Nelson AH, Mattias K, Selzer J, Kalvan C, et al. (2011) In our own voice—Family companion: Reducing self-stigma of family members of persons with serious mental illness. Psychiatric Services 62: 1456-1462.

70. Pedersen PB, Leong FL (1997) Counseling in an international context. Counseling Psychologist 25: 117-112.

71. Carpenter-Song E, Chu E, Drake RE, Ritsema M, Smith B, et al. (2010) Ethno-cultural variations in the experience and meaning of mental illness and treatment: Implications for access and utilization. Transcultural Psychiatry 47: 224-251.

72. Hardy KV, Laszloffy TA (1998) The dynamics of a pro-racist ideology: Implications for family therapy. In: M. McGoldrick (Ed.), Re–visioning family therapy. Guilford Press, New York.

73. Hardy KV, Laszloffy A (2002) Couple therapy using a multicultural perspective. In: A. Gurman (Ed.), Clinical handbook of couple therapy. Guilford Press, New York.

74. Ida DJ (2007) Cultural competency and recovery within diverse populations. Psychiatric Rehabilitation Journal 31: 49-53.

75. Kravetz S, Faust M, David M (2000) Accepting the mental illness label, perceived control over the illness and quality of life. Psychiatric Rehabilitation Journal 23: 324-332.

76. Link BG, Phelan JC (2001) Conceptualizing stigma. Annual Review of Sociology 27: 363-385.

77. Milan S, Keiley MK (2000) Biracial youth and families in therapy: Issues and interventions. J Marital Fam Ther 26: 305-315.

78. Nelson TS, Chenail RJ, Alexander JF, Crane DR, Johnson SM, et al. (2007) The development of core competencies for the practice of marriage and family therapy. J Marital Fam Ther 33: 417-438.

79. Gehart D (2010) Mastering competencies in family therapy: A practical approach to theories and clinical case documentation. Brooks and Cole, Pacific Grove, CA.

80. Primm AB, Vasquez MJT, Mays RA, Sammons-Posey D, McKnight-Eily LR, et al. (2010) The role of public health in addressing racial and ethnic disparities in mental health and mental illness. Preventing Chronic Disease 7: A20.

81. Sue DW, Sue D (2003) Counseling the culturally diverse: Theory and practice. Wiley, New York.

82. Alverson HS, Drake RE, Carpenter-Song EA, Chu E, Ritsema M, et al. (2007) Ethnocultural variations in mental illness discourse: Some implications for building therapeutic alliances. Psychiatric Services 58: 1541-1546.

83. Kleinman A (1988) The illness narratives: Suffering, healing, and the human condition. Basic Books, New York, NY.

84. Sam DL, Morreira V (2012) Revisiting the mutual embeddedness of culture and mental illness.

85. Commission on Accreditation for Marriage and Family Therapy Education (2015) Manual on accreditation.

86. Hardy KV (1989) The theoretical myth of sameness: A critical issue in family therapy training and treatment. Journal of Psychotherapy and the Family 6: 17-33.

87. Hardy KV, Laszloffy AT (1992) Training racially sensitive family therapists: Context, content and contact. Families in Society: The Journal of Contemporary Human Services 73: 364-370.

88. Hardy KV, Laszloffy AT (1995) Therapy with African Americans and the phenomenon of rage. In Session: Psychotherapy in Practice 1: 57-70.

89. Hardy KV, Laszloffy TA (2000) The development of children and families of color: A supplemental framework. In: W. Nichols, D. Becvar & A. Napier (Eds.), Clinical handbook of individual and family development. John Wiley and Sons, New York.

90. Interian A, Lewis-Fernández R, Dixon LB (2013) Improving treatment engagement of underserved U.S. racial-ethnic groups: A review of recent interventions. Psychiatric Services 64: 212-222.

91. Nickerson KJ, Helms JE, Terrell F (1994) Cultural mistrust, opinions about mental illness and Black students' attitudes toward seeking psychological help from white counselors. Journal of Counseling Psychology 41: 378-385.

92. Szapocznik J, Scopetta MA, King OE (1978) Theory and practice in matching treatment to the special characteristics and problems of Cuban immigrants. Journal of Community Psychology 6: 112-122.

93. Terrell F, Terrell SL (1981) An inventory to measure culture mistrust among Blacks. Western Journal of Black Studies 3: 180-185.

94. Gay G (2000) Culturally responsive teaching: Theory, research, and practice. Teachers College Press, New York, NY.

95. Szapocznik J, Kurtines WM, Foote F, Perez-Vidal A, Hervis O (1983) Conjoint versus one person family therapy: Some evidence for the effectiveness of conducting family therapy through one person. Journal of Consulting and Clinical Psychology 51: 889-899.

96. Sealey-Ruiz Y (2007) Wrapping the curriculum around their lives: Using a culturally responsive curriculum with African American adult women. Adult Education Quarterly 58: 44-60.

97. Bernal G, Bonilla J, Bellido C (1995) Ecological validity and cultural sensitivity for outcome research: Issues for the cultural adaptation and development of psychosocial treatments with Hispanics. Journal of Abnormal Child Psychology 23: 67-82.

98. Patton MQ (2002) Qualitative research and evaluation methods. Sage, Thousand Oaks.

99. Kossak SN (2005) Exploring the elements of culturally relevant service delivery. Families in Society 86: 189-195.

100. Szapocznik J, Hervis OE, Schwartz S (2003) Brief strategic family therapy manual [NIDA therapy manuals for drug addiction series]. National Institute on Drug Abuse, Rockville, MD.

101. Bernal G, Saez-Santiago E (2005) Towards culturally centered and evidence-based treatments for depressed adolescents. In: WM Pinsof & J. L. Lebow (Eds.), Family psychology. Oxford University Press, New York.

102. Weaver HN, Wodarksi JS (1995) Cultural issues in crisis intervention: Guidelines for culturally competent practice. Family Therapy 22: 213-223.

103. Durodoye BA (2002) Preparing counselors to dialogue about race. Texas Counseling Association Journal 30: 18-23.

104. Dwairy M, Achoui M (2010) Adolescents-family connectedness: A first cross-cultural research on parenting and psychological adjustment of children. Journal of Child and Family Studies 19: 8-15.

105. Celano MP, Smith CO, Kaslow NJ (2010) A competency-based approach to couple and family therapy supervision. Psychotherapy: Theory, Research, Practice, Training 47: 35-44.