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Adapting Cognitive–Behavioral Therapy for Mexican American Students With Anxiety Disorders: Recommendations for School Psychologists

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Mexican American students are the fastest growing group in U.S. public schools. There is a growing body of research indicating that Mexican American families underutilize mental health services and are more likely to drop out of care prematurely when they do seek help. These findings may indicate that our health care system is not providing ethnic minorities with culturally competent care. Although cognitive–behavioral interventions are considered to be evidence-based treatments for child anxiety disorders, previous protocols have not taken cultural factors into account. This article discusses how to adapt cognitive–behavioral therapy (CBT) for Mexican American students with anxiety disorders. Working within the Psychotherapy Adaptation and Modification Framework (PAMF), this article offers adaptation principles that may guide school

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psychologists in implementing CBT strategies when working with Mexican American youth and their families. A case study is provided illustrating how cultural modifications of CBT can lead to positive outcomes for Mexican American students.

Keywords: Mexican Americans, youth, anxiety, cognitive–behavioral therapy, school interventions

Mexican Americans are the largest and fastest growing Latina/o group in the United States, comprising a total of 20.6 million individuals (U.S. Census Bureau, 2002). In California, over one third of all public school students are Mexican American. Furthermore, 25% of all California students are English learners, and three quarters of those are Spanish speaking (e.g., Rumberger & Gandara, 2004). Mexican American youth living in the United States are more likely than European Americans to face a number of social inequities, including high rates of poverty and poor medical coverage (Halfon, Wood, Valdez, Pereyra, & Duan, 1997; U.S. Census Bureau, 2001). There is also a severe lack of needed mental health services for Mexican American youth (Kataoka, Zhang, & Wells, 2002; Vega, Kolody, & Aguilar-Gaxiola, 2001). School psychologists are uniquely positioned to help rectify this disparity in the provision of mental health services to Mexican American students with significant mental health needs and promote social justice by offering evidence-based services. However, current empirically supported intervention protocols require adaptation to fit the cultural values and practices of Mexican American students and their families. The focus of this article is the development of a model for bridging established evidence based practices with the needs of Mexican American students and their families.

Because there are many ethnic subgroups categorized as Latina/o or Hispanic, greater cultural specificity is likely to lead to more relevant practice recommendations for school psychologists. Hence, this article focuses on Mexican American students in light of their high level of representation in the western United States. However, much of the cross-cultural child mental health literature focuses on nonspecific Latina/o or Hispanic samples that include Mexican American students as well as other Latina/o ethnic groups. Therefore, when possible, only literature specific to Mexican American students will be cited; otherwise, the general literature on Latina/o or Hispanic samples is presented. Terms reflecting the nature of the samples included in previous studies are used as appropriate (i.e., Mexican American samples vs. nonspecific Latina/o samples).

Social Justice and Culturally Competent Practice

The concept of social justice, which is frequently used to understand inequity in American education along the dimensions of race and ethnicity, refers to fair treatment and a just share of the benefits of society for all (cf. Lalas, 2007). When a group systematically receives fewer or lower quality public services, such as school mental health care, social justice has been impeded and corresponding corrective action may need to be taken. It is the goal of this article to offer a framework for adapting evidence-based psychosocial interventions for working with Mexican American families to increase the quality of care and to reduce barriers to accessing services.

Culturally competent and sensitive practice is different from traditional notions of "good practice" because practitioners need to be flexible and adaptive when implementing therapeutic interventions that were originally developed for European Americans (Sue, Ivey, & Pedersen, 1996). Similar to Western cultures, traditional therapy approaches tend to be individually oriented and less focused on group dynamics and social interactions, and as a result, may be less appropriate for individuals from more collectivistic cultural backgrounds (e.g., Hwang, Wood, Lin, & Cheung, 2006). Some practitioners may balk at the need to make cultural adaptations to their services, feeling that they are good clinicians and that good treatment inherently involves adapting to the individual, hence leading them to treat all of their clients equally. Given the diversity of the U.S. population, it is unlikely that health care providers can provide

equitable services when they do not know about their ethnic minority clients' cultures (Hwang, 2006). Furthermore, cumulative knowledge demonstrating that ethnic minorities are more likely to do worse in treatment or drop out of treatment prematurely continues to suggest that inequity of services persists (Bein, Torres, & Kurilla, 2000; Kataoka et al., 2002). Therefore, school psychologists need to learn about the cultures of the children they will be treating and how to alter the implementation of evidence based practices based on this knowledge. Culturally competent practice requires nuanced reflection on how the client's background might affect treatment, how the clinician's own biases impede their ability to provide effective services, and how to flexibly apply treatments so that culturally salient issues are addressed. This article uses the treatment of school-related anxiety disorders as an organizing framework to present guiding principles for cultural modifications to current evidence-based treatments.

School Interventions For Child Anxiety Disorders

Anxiety disorders, defined as a persistent pattern of high anxiety accompanied by significant distress or impairment in school, social, or family functioning, are a form of emotional disturbance recognized under federal special education law. Anxiety disorders are common mental health problems among American schoolchildren, including Mexican American students, and they can have an adverse effect on school performance and adaptation (e.g., Ginsburg & Silverman, 1996; Wood, 2006). Anxiety disorders are often associated with significant educational problems such as school refusal (Kearney, 2003). However, the impact of mental health services for anxiety disorders is diluted by many structural, institutional, and cultural factors that pose barriers to access and engagement in care for Mexican American clients (e.g., Vega & Lopez, 2001). Although cognitive–behavioral therapy (CBT) is considered probably efficacious for the treatment of child anxiety disorders (Kendall, Aschenbrand, & Hudson, 2003), current evidence-based CBT protocols have not taken the cultural background of the client into account. Little attention has been given to the cultural factors relevant to the implementation of CBT by school psychologists and counselors working with Mexican American students.

While CBT is the only well-established, evidence-based intervention for childhood anxiety disorders, original studies validating CBT for children with anxiety disorders (e.g., Barrett, Dadds, & Rapee, 1996; Kendall, 1994) were conducted on primarily middle-class Caucasian children. As noted earlier, these standard intervention approaches may not suit children from other cultural groups. One approach in the development of culturally appropriate interventions is to begin with extant evidence-based treatment manuals, modifying them as necessary to meet the needs of children from specific cultural groups. A second approach would be to develop and test a novel culturally relevant intervention that differs from current evidence-based practices (i.e., a non-CBT intervention). While the latter approach is potentially worthwhile, developing novel psychosocial interventions for each cultural group could be a costly and ultimately unnecessary endeavor (Hwang, 2006); adapting and modifying existing manuals is likely a more cost-effective and pragmatic solution to the need for cultural specificity in evidence-based treatments.

Although there is some evidence of clinical success for nonadapted CBT for Mexican American youth with anxiety disorders seen in university settings (e.g., Pina, Silverman, Fuentes, Kurtines, & Weems, 2003), it is unclear whether this approach would meet the needs of practicing school psychologists and the Spanish-speaking immigrant families referred to them in urban school settings. The inclusion of small samples of Mexican Americans in other studies examining the efficacy of CBT for youth with anxiety disorders provides equivocal evidence for the appropriateness of CBT for Mexican American families in school mental health settings, particularly with regard to cultural fit. Given the current impetus to disseminate evidence-based intervention practices into public schools (cf. The Evidence Based Intervention Work Group, 2005), consideration of culturally appropriate modifications of such practices in schools serving a high proportion of ethnic minority students is an important initial step.

Although prevalence rates of anxiety disorders appear to be similar for Mexican American and Caucasian children, youth of Mexican ori-

gin are nonetheless *underrepresented* in the population that uses counseling and other mental health services, despite a similar level of mental health need (McCabe et al., 1999; Vega et al., 2001). In general, Latino families (including Mexican Americans) also *seek* counseling from agencies and professionals less often than do Caucasian families (McMiller & Weisz, 1996). When Latino families do seek counseling for mental health disorders, studies of both adults and youth suggest that about 60% to 70% of clients discontinue services before adequate treatment effects have been achieved (i.e., premature termination/treatment dropout) (e.g., Bein, Torres, & Kurilla, 2000).

Low mental health service utilization patterns and poor retention rates in counseling among Mexican Americans and other Latina/os raise concerns that despite the prevalence and consequences of anxiety disorders in these cultural groups (e.g., Ginsburg & Silverman, 1996; Willig, Harnisch, Hill, & Maehr, 1983), mental health needs are not being addressed in schools or community clinics for this population of students. These research findings have also increased awareness about the need to develop culturally responsive intervention practices for this population. Difficulties retaining ethnic minority families in counseling have raised questions about whether intervention approaches that were originally developed and tested primarily with Caucasian families are culturally sensitive to the needs of other ethnic and racial groups (Hwang, 2006).

School psychologists and counselors are often the only mental health service providers available to families in urban settings (e.g., Farmer, Stangl, Burns, Costello, & Angold, 1999). Many parents are unfamiliar with how to navigate the mental health care system, may not have adequate health insurance coverage, and may be influenced by a host of cultural, language, and structural barriers that impede help-seeking and attainment of mental health services for children. Previous research suggests that the school system plays an important role in initiating services for Mexican American children (Takeuchi, Bui, & Kim, 1993). Due to the substantial unmet mental health needs among Mexican American youth, school psychologists can play a pivotal role in promoting social justice for students in need by brokering access to the school mental health system and offering culturally appropriate services (Williams & Butler, 2003).

Early research in the area of child anxiety treatment in other Latina/o populations (though not Mexican Americans specifically) has shown some promise in cultural adaptations for children's outcomes. For example, the use of a culturally adapted prevention program for Puerto Rican adolescents at high risk of mental health disorder significantly increased adolescents' ethnic identity and self-concept, and reduced anxiety (Malgady, Rogler, & Costantino, 1990). This intervention enlisted the use of adult Puerto Rican role models to facilitate pride in ethnic heritage, self-concept, and adaptive coping skills. These findings suggest that properly adapted techniques could enhance outcomes for Mexican American students as well.

Given the consensus in the field that CBT is the modality of choice for childhood anxiety disorders, this approach would appear to be the most suitable for the development of cultural adaptations. Before understanding how to modify this modality, it is important to review standard CBT procedures, especially those that have been found to be efficacious. Based on the work of our research group, the University of California, Los Angeles (UCLA) Consortium for Evidence-Based Treatment in Schools (CETS) the following recommendations are offered for adapting CBT for Mexican American students in the school mental health context. A case study illustrating the application and cultural adaptations of CBT for a Mexican American family in an elementary school setting is also presented.

Standard (Non-Adapted) CBT Techniques For Childhood Anxiety Problems

CBT is a developmentally appropriate treatment modality that has been found to be successful with children as young as 5 years of age; treatment of children below age 7 years typically involves a high level of family involvement to support the new skills (e.g., King et al., 2000; Rapee, Kennedy, Ingram, Edwards, & Sweeney, 2005; Wood, Piacentini, Southam-Gerow, Chu, & Sigman, 2006). Approximately 50% to 80% of children in traditional CBT programs no longer meet criteria for an anxiety disorder at the end of treatment (Barrett et al., 1996; Kendall et al., 2003; Wood et al., 2006).

Some CBT programs have applied these techniques to anxiety-related problems in the school setting such as school refusal (e.g., Kearney, 2003). Specific fears associated with going to school (e.g., something bad will happen to mom/dad or to me when I am at school) are identified and more realistic coping thoughts are developed (e.g., nothing bad has actually happened to mom when I went to school in the past—how likely is it to happen now?) And in the application and practice phase, a series of steps are enumerated that lead to the child returning to school full-time. In short, several evidence-based CBT programs have been developed that can be helpful for anxiety-related problems among children.

Our research group has developed a manualized, family-based CBT program for child anxiety disorders that would meet American Psychological Association criteria for being probably efficacious (e.g., Chambless & Hollon, 1998) because it outperformed another active treatment condition in a high quality randomized, controlled trial (Wood et al., 2006). This program and other recognized CBT interventions for child anxiety disorders are comprised of two phases: (a) skills training and (b) application and practice (i.e., graded exposure) (i.e., Kendall, 1994). During the first phase, children are taught numerous techniques for coping with anxiety, such as relaxation, reappraisal of the danger of feared situations (cognitive restructuring), and self-reward (usually lasting 4–8 sessions). In the second phase (usually involving at least 8 sessions), a hierarchy is created in which feared situations are ordered from least to most distressing. Children work their way up the hierarchy and are rewarded as they attempt increasingly difficult (fearful) activities. Children and psychologists work together to devise plans for coping at each step of the hierarchy. Parents are taught communication techniques to facilitate children's mastery of new skills such as giving choices when children are indecisive, allowing children to struggle and learn by trial and error rather than taking over for them, labeling children's emotional responses, and promoting children's acquisition of novel self-help skills. Parents also help plan tasks involving facing feared situations in their children's daily lives. This clinical trial, like other CBT approaches, has not been proven in school-based settings with Mexican American students and likely needs revision to be culturally appropriate and meet student needs.

Adapting and Modifying CBT For Mexican American Students

Our research group has been working on adapting our original evidence-based CBT program for use with Mexican American families of students in urban public elementary schools. One of the first steps in making these adaptations is to use theory and one's knowledge of the specific population to guide changes. This step is followed by the use of a clinical approach where the modified program is applied to sample cases and careful attention is paid to those areas that might need further adaptation. Our initial efforts have been met with an enthusiastic response by the several families who have received the cultural adaptation of this treatment in an urban school setting. This response is encouraging and provides a basis for further research. We present one case where this adapted approach was used and highlight those areas where changes from the standard protocol were followed. These adaptations are presented below as recommendations to school psychologists planning to modify existing intervention programs for Mexican American students.

According to a multicultural counseling perspective, each cultural group likely requires a different set of skills and emphases for counseling to be effective (Patterson, 1996; Pedersen, 1976; Sue, 1977; Suzuki, Alexander, Lin, & Duffy, 2006). Specifically, counseling techniques need to be adapted to the needs, values, and characteristics of specific cultures being served (Hwang, 2006; Hwang et al., 2006; Kumpfer, Alvarado, Smith, & Bellamy, 2002; Turner, 2000). Beginning with the emic notion that all people experience mental health problems, the multicultural perspective emphasizes the etic notion that how such problems are experienced, expressed, and defined within a particular cultural group may vary (Triandis, 1978; Varjas, Nastasi, Moore, & Jayasena, 2005). According to Varjas and colleagues, "using this integrated approach one can construct. . . interventions specific to each cultural (local) setting, thus ensuring cultural specificity while maintaining focus on universal elements" (p. 244).

Unfortunately, few frameworks have been developed to guide cultural adaptations to coun-

seling and psychotherapy. In adapting CBT for Chinese Americans, Hwang and colleagues (2006) recommended developing principles for adaptation that are targeted and theory driven. Hwang (2006) later developed the Psychotherapy Adaptation and Modification Framework (PAMF), which provided a set of recommendations that could be applied across multiple cultural groups. He suggested that those trying to tailor interventions for different groups begin by developing principles of adaptation and categorizing them under specific domains. These principles should be theory driven and supported by a strong clinical and cultural rationale. The PAMF cultural adaptations are grouped into six domains, including: (a) dynamic issues and cultural complexities, (b) orienting clients to psychotherapy and increasing mental health awareness, (c) understanding cultural beliefs about mental illness, its causes, and what constitutes appropriate treatment, (d) improving the client-therapist relationship, (e) understanding cultural differences in the expression and communication of distress, and (f) addressing cultural issues specific to the population. Based on this framework, we have developed a number of adaptation principles intended to help school mental health providers deliver more culturally competent and sensitive care when working with Mexican American students.

Principles For Adapting CBT For Mexican American Students

Principle 1. Spend Time Learning About Each Family's Cultural Practices, Acculturative Status, Migration History, Language Proficiencies and Preferences, and Other Relevant Background History

Acculturation, defined as "the changes in behaviors and values made by members of one culture as a result of contact with another culture" (Burman, Telles, Karno, Hough, & Escobar, 1987), has received attention as one of the primary factors that may influence mental health service use and retention among Mexican Americans. Acculturation involves adopting the cultural practices of the dominant culture, including its language, values, and customs. Mexican American clients who are less acculturated (e.g., who are more likely to speak primarily in Spanish, to interact mostly with other Mexican Americans, and to have maintained many of the values and customs from their country of origin) are six times less likely to use mental health services in comparison to more acculturated Mexican Americans (Wells, Hough, Golding, Burnam, & Karno, 1987).

CBT is a technical language-based intervention, and its subtleties would likely be lost upon children and parents who are obliged to speak in a language with which they have limited or emerging proficiency. Therefore, if family members have limited experience with English, it is crucial to assign practitioners who are capable of conversing in Spanish to work with the family, or, if Spanish-speaking psychologists are not available, efforts must be made to enlist a good translator from the school staff.

Understanding each family member's level of acculturation can aid the school psychologist's conceptualization of the family and potentially strengthen the working relationship between the family and psychologist. It can be beneficial to ask about the family's background, when they immigrated to the United States, why the family decided to come to the United States, and hardships that the family may have encountered during the migration process and after their arrival. During early discussions, it may be helpful for school psychologists to self-disclose personal experiences aimed at increasing a sense of commonality and normalizing the family's experiences (Hwang et al., 2006). The psychologist may share information about being from the same country (if relevant), having similar family backgrounds or having gone through the same difficulties learning English. Spending some extra time talking about these issues helps family members feel understood and sets the stage for a collaborative relationship.

Similarly, by learning about a family's cultural beliefs and practices, school psychologists are in a better position to adopt appropriate metaphors and modalities for implementing CBT (e.g., play, art, music) that will prove meaningful to the family (e.g., Suzuki et al., 2006). While these topics diverge from common introductory topics in most child CBT treatment manuals, they are important for establishing a strong early alliance with the family and collecting information about types of modifications to the treatment manual that may be needed for the remainder of the intervention.

Principle 2: Actively Collaborate with School Staff to Alleviate Parental Apprehension

Experiences of discrimination may negatively impact help-seeking behaviors among some Mexican Americans. Some research suggests that anti-immigrant attitudes and policies have created wariness among some Mexican Americans about the U.S. health care system (Fenton, Catalano, & Hargreaves, 1996). These feelings may also extend to the school environment. Tinkler (2002) proposes that some Latina/o parents are less involved in their children's schools because they have had negative personal experiences with schools in the past. If parents have been discriminated against in the schools, they may be less likely to trust programs and personnel associated with their children's schools, including school psychologists. Consequently, it can be useful to address feelings of apprehension with the school system in early conversations to ease concerns and correct misperceptions (e.g., that a child with anxiety is "in trouble" or that the parents have failed in some respect). Before making initial contacts with the family of a student referred for evaluation, school psychologists should consult with the student's teacher and determine whether the parents have developed positive ties with any faculty or staff at school. When feasible, such individuals should serve as a liaison for initial contacts with the family to increase their comfort and to help explain the situation to them in culturally appropriate terms. While this additional step of using a liaison may exceed the standard practices of many school psychologists, the role it can play in increasing accessibility to services should not be underestimated.

Principle 3: Provide an Orienting Session Early on to Increase Family Understanding and Participation

Client expectations in counseling are thought to be powerful predictors of treatment success. Mexican Americans, particularly recent immigrants, may have less knowledge than more acculturated clients about mental health services (Bein et al., 2000; Keefe & Casa, 1980) and about how to navigate the mental health system. While lifelong U.S. residents may be well aware of the basic premise of mental health services and need little introduction to the fundamental concepts (e.g., that talking represents the "cure"), less acculturated immigrants may benefit from an introductory presentation and discussion. Evidence suggests that orientation programs prior to the start of counseling increases knowledge and positive attitudes toward counseling among Latina/o clients (Yamamoto, Acosta, Evans, & Skilbeck, 1984). Therefore, it is advised that school psychologists orient families to the structural aspects of therapy, such as what is discussed in sessions and what the goals of treatment are, to help demystify the process and to facilitate client buy-in. In orientation sessions, the school psychologist should review the goals and methods of therapy, establish clear roles and the level of involvement of each family member, discuss projections about the amount of work both inside and outside sessions, and discuss realistic expectations for improvement.

Attitudes toward the psychological problem are postulated to be influential in the utilization of and retention in mental heath services (Alvidrez, 1999), offering further evidence of the need for a motivating orientation to counseling. It has been hypothesized that Latina/o clients who view mental health services as stigmatizing or shameful may be more likely to terminate counseling before presenting problems have been addressed (Bein et al., 2000; Levine & Padilla, 1980). It is therefore also advised during orientation sessions that school psychologists respect and validate family attitudes about mental health problems by addressing feelings of stigma, shame, and apprehension about counseling and offering a benign, culturally appropriate alternative (e.g., that childhood anxieties are common, and that counseling makes families stronger and allows parents to give their children what they need to grow emotionally).

Strong views of self-reliance or of the ability to handle the problem within the family may promote feelings of ambivalence about seeking services and have been found to affect the length of stay in counseling (McCabe, 2002). Some Mexican Americans have also been described as valuing parental authority, and Mexican American families who view strict discipline as the solution to their children's psychological problems are more likely to terminate counseling prematurely (McCabe, 2002). These

culture-related issues should also be addressed during the therapy orientation.

Principle 4: Respect the Family's Conceptualization of Mental Illness and Its Treatment to Increase Acceptance of CBT Techniques

Some Mexican American families prefer to turn to medical doctors rather than psychologists or counselors for emotional and psychological problems (e.g., Vega et al., 1999); several reasons have been proposed to explain this pattern. Rogler, Malgady, and Rodriguez (1989) note that some Latina/o clients harbor feelings of shame about having mental disorders and about needing treatment and suggest that they may also be unaware of available mental health services. While the role of religiosity and the supernatural in the family's understanding and description of presenting problems has been considered, there is little evidence of greater use of traditional healers such as *curanderos* among Mexican Americans compared to other cultural groups (Keefe, 1978). A possible explanation for the tendency to use physicians for emotional problems is that psychological distress is often manifested through somatic symptoms among Mexican American youth with anxiety (Pina & Silverman, 2004; Varela et al., 2004). These findings suggest that some Mexican American parents and children may be prone to attribute physiological expressions of anxiety as an illness requiring medical attention rather than a psychological problem warranting help from a mental health specialist. These views, if present, could impact family beliefs about the efficacy of CBT for anxiety.

For families that attribute anxiety to medical illness, validating their conceptualizations of illness, framing anxiety as a biopsychosocial illness (with physical as well as psychological components), presenting CBT techniques as a means for coping with the illness (Kirmayer & Young, 1998), and providing education about how CBT strategies may help to alleviate somatic expressions of illness can enhance the acceptance of treatment. This approach stands in contrast to the standard psychoeducation in CBT manuals that describes anxiety as a result of genetics, neurobiology, and environmental factors. Rather than adhering to these "explanations" of the origins of anxiety, clinicians working with Mexican Americans are advised to listen carefully to the family's understanding of the problem's origins and to validate this understanding, finding connections between this understanding and the goals of treatment.

Principle 5: Establish CBT Goals that are Valued by the Family to Improve the Working Relationship

If the goals of CBT do not match the goals of the family, parents will be less likely to employ the techniques prescribed by school psychologists. Therefore, it is important for the psychologist to collaborate with the family when establishing goals to ensure that they are congruent with the family's cultural values and practices. In many cases, it may be necessary to modify traditional goals to ones that are more culturally relevant. Adjusting goals to ones that are valued by families will allow school psychologists the opportunity to retain effective CBT strategies while aligning themselves with family members. For example, one of the common targets in treatment described in child CBT manuals for separation anxiety is cosleeping (with the goal of having children sleep alone; e.g., Wood & McLeod, 2008). This goal may be difficult to address in some families because while in all cultures children eventually sleep in their own beds, the specific age at which this individuation process is expected to occur may differ (Welles-Nystrom, 2005). Therefore, older children cosleeping with family members can represent common cultural practices, and not separation anxiety per se. If families do not feel it is necessary for their children to sleep alone in their own beds, the school psychologist should work toward applying CBT techniques to help children cope in situations when their parents think it *is* important for their children to be independent (e.g., attending afterschool activities without being accompanied by a parent; attending Sunday school with peers while parents are in church). Modifying goals so that they are valued by parents but still relevant to the goals of CBT may enhance treatment acceptability for families with varying cultural norms and values.

Principle 6: Learn about the Cultural Context of Parenting to Facilitate Engagement in CBT

Family relationships are often strongly valued among many Mexican American clients and the success of any intervention is believed to be dependent on the extent to which family members are involved in treatment (Santisteban, Szapocznik, & Rio, 1993). When working with families, clinicians need to be aware of and sensitive to the cultural practices and beliefs that influence parenting due to the importance of parental engagement for facilitating treatment success (Forehand & Kotchick, 1996). With respect to CBT for anxiety, considering the effect of culture on beliefs about parenting roles and responsibilities may help to elucidate interactions that contribute to the development and maintenance of anxiety symptoms related to separation (Ginsburg & Silverman, 1996). As an example, a Mexican American boy we worked with experienced a great deal of anxiety and wanted to be picked up by his mother directly from his classroom at the end of each school day. He constantly asked questions and thought about whether she would be on time. In investigating the parents' perceptions of this symptom, we discovered that they felt it was the role of a parent to reliably pick up their child from school in this manner, and they affirmed that this was a culturally congruent practice in their community. They were simply concerned about the child's excessive anxiety surrounding his pick-up from class. Understanding these cultural norms for parenting practices helped us select an appropriate goal (anxiety reduction in the context of maintaining this daily routine, rather than eliminating the routine itself, which is a common goal in CBT for this type of symptom) that we could collaborate on with the family.

It is the responsibility of the school psychologist to become knowledgeable about the family's specific cultural beliefs and practices in addition to how culture may influence caregiving practices and parenting techniques. Viewing members of the family as experts on their own cultural experiences and asking them about their own backgrounds, family structure, beliefs, values and traditions can help to increase engagement in CBT because it encourages students and their families to perceive the school psychologist as understanding and competent.

Principle 7: Engage the Extended Family in the Child's CBT Treatment

Mexican American families are often characterized by a multigenerational organization, with extended family members living in the same household or in close proximity to each other (Alvirez & Bean, 1976; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). Often, child-rearing responsibilities are shared by parents, grandparents, older siblings, and other extended family members (Forehand & Kotchick, 1996). Thus, school psychologists should explore the family structure and level of reliance on extended family for childcare and ask extended family members to collaborate in the treatment process when appropriate. Enlisting extended family may be particularly useful when working with parents who are initially hesitant about certain CBT techniques. For example, in traditional CBT for children who experience difficulties separating from their parents, students are assigned tasks such as sleepovers with friends to help them overcome fears about being away from their parents (e.g., Wood & McLeod, 2008). If parents do not feel comfortable allowing their children to sleep over at houses outside of the family network, we recommend modifying the standard procedures in child CBT manuals and instead engaging the extended family for these kinds of tasks. Instead of sleeping at a friend's house, a student might sleep over at an aunt's or grandparent's house as an exposure task. In this way, extended family members can become an asset to the school psychologist and permit appropriate adaptations to CBT that suit both the family's cultural practices and the goals of the treatment.

Principle 8: Align CBT Techniques with Family Cultural Beliefs and Traditions to Enhance Commitment to Treatment

Several common cultural values and beliefs may also affect the implementation of CBT with Mexican American families, including the concepts of collectivism and simpatia. Collectivism is a broad cultural value in which one's behaviors and self-concept are defined in reference to

the greater good of the family and community rather than the needs of the individual (Shkodriani & Gibbons, 1995; Varela et al., 2004). For instance, in some Mexican American families we have worked with, parents have chosen very uncomfortable sleeping arrangements for themselves (e.g., sleeping on the floor next to the child's bed) to ensure their child feels comfortable and safe.

The cultural value of simpatia refers to "a sense of empathizing with others, respecting them, and remaining agreeable even if this means making personal sacrifices" (Varela et al., 2004, pp. 238–239). This may include not complaining to others about one's problems (i.e., adopting a "grin-and-bear-it" attitude), as well as sacrificing individual needs for the needs of the many. Bridging this cultural notion of simpatia with CBT concepts may improve family buy-in to therapy (cf. Hwang et al., 2006). Initially, many parents experience sympathetic responses to children's fearfulness when supervising their exposure tasks and often feel unwilling to push their child. Parents naturally avoid exacerbating children's distress in such situations, even though exposure to fears is often the only effective intervention for the child. When conducting CBT and exposing children to their fears, it is important to help parents understand their simpatia and underscore why the "grin-and-bear-it" attitude (defined in this case as *limiting* one's sympathetic reaction) is an important facilitator of change and a worthwhile sacrifice that benefits children in the end, even if it is difficult in the short run.

Principle 9: Consider Whether Culturally Based Conversational Norms are Masking Poor Adherence to Treatment

Marin and Marin (1991) describe the importance of social harmony and respect for authorities among some Latina/o cultural groups, such as Mexican Americans. They suggest that some clients may refrain from disagreeing with others in an effort to maintain cordial relationships and to respect authority figures. If a family is hesitant to disagree with a school psychologist's views during sessions, there may be little chance for the family's concerns to be addressed and a modified plan of action to be made. In such cases, families may be more likely to have poor adherence to assigned tasks. As an example, school psychologists may sometimes suggest that a child with separation anxiety be picked up slightly late from school, or that s/he attempt to remain in school rather than go home early even if experiencing physical symptoms of anxiety such as stomachache. However, these recommendations are not always feasible—some working families do not actually pick up their children from school, and other families may not feel comfortable coming late to pick up their children. In trying to maintain harmony and respect for the school psychologist, parents may not raise concerns about such practical constraints, but in the end not comply with his or her recommendations.

Psychologists should, therefore, entertain the hypothesis that family noncompliance with homework assignments may be a warning sign signifying the incongruence of the task with the cultural practices of the family and the realities of the family's daily life. School psychologists should also monitor for indicators of familial concern and disagreement, including nonverbal cues such as changes in eye contact and facial affect during discussions of goals and assignments, and respectfully address the possibility that the family may find particular assignments challenging. Rather than turn such interactions into confrontations (e.g., over a failure to complete an assignment), school psychologists are advised to convey an empathic desire to ensure the family is finding the assignments manageable and useful, and remain flexible in modifying tasks to suit the family's needs.

Principle 10: Remain Attuned to the Role of Acculturation Gaps in Children's Adjustment Problems, But Consult with Cultural Experts before Addressing this Topic with Families

When working with immigrant families, Hwang (2006) highlights how therapists may exacerbate family problems by remaining oblivious to acculturative issues. Extending upon the theory that acculturation gaps between parents and children lead to intergenerational family conflict (Szapocznik, Santisteban, Kurtines, Perez-Vidal, & Hervis, 1984), he proposed that acculturative family distancing (AFD) sets the stage for the development of adjustment problems. The concept of AFD consists of two di-

mensions, a breakdown in communication and incongruent cultural values that become exacerbated as parents and children acculturate at differential rates. Therapists can sometimes help externalize the blame for family distress and discord on acculturation issues, thereby helping children and parents develop mutual understanding and empathy. However, consistent with good clinical practice, it is recommended that school psychologists always consult with cultural experts when working with a population that they may be less familiar with, especially before addressing sensitive topics such as the role of acculturation gaps in the child's presenting problems.

Case Illustration: Julien

The following case study describes the application of the modified CBT protocol of the evidence-based program, *Building Confidence* (Wood & McLeod, 2008), with a Mexican American student who participated in our current clinical trial. The above principles have been used in adapting this program for use in urban elementary schools serving Mexican American students. This intervention consists of 12 conjoint sessions with the child and parents. The therapist meets weekly with the family for 1.5 hours. The adaptations are intended to offer culturally competent care to increase acceptance of treatment, comfort and rapport, and, ultimately, clinical outcomes.

Julien, a 5-year-old Mexican American male kindergartener, was referred to the school psychologist by the school nurse who expressed concern about his frequent visits to her with complaints of stomach aches and worry. He is an only child who lives with his mother and father in a major metropolitan area of the western United States. Both parents work in semiskilled jobs and his father had been taking time off from work to deal with Julien's recent problems.

In the initial evaluation, Julien and his parents were each administered the Anxiety Disorder Interview Schedule for *Diagnostic and Statistical Manual of Disorders, Fourth Edition* (*DSM–IV*)—Parent and Child versions (ADIS-C/P; Silverman & Albano, 1996) by a trained diagnostician who was unaware whether Julien had received treatment or was on a waiting list. The ADIS-C/P, when administered by a diagnostician blind to treatment condition, represents the gold standard for the assessment of child anxiety disorders and is used as the primary outcome in most clinical trials (e.g., Barrett et al., 1996). At pretreatment, Julien met *DSM–IV* (via the ADIS-C/P) diagnostic criteria for Separation Anxiety Disorder (SAD). Using the ADIS-C/P scoring convention in which diagnoses are rated on a 0–8 Clinician's Rating Scale for severity, in which 0 connotes *no disorder*, 4 represents the *threshold for clinical criteria*, and 8 connotes *a very severe (and disabling) case of the disorder*, Julien was rated a 5. For point of comparison, none of the children in our clinical trial (Wood et al., 2006) had a CRS score higher than 6. Hence, Julien had a moderately severe case of SAD at intake.

Per the diagnostician's ADIS-C/P report, Julien reported significant distress when leaving his parents. He complained of stomach pains on the way to school and throughout the day. He often refused to go to school, crying and begging his parents not to leave. Feeling empathy for his son, Julien's father often accompanied him in school for at least part of the day. Julien also went to the nurse multiple times per day for extended periods, sometimes resulting in his parents picking him up early from school. Even when he was in class, Julien was unable to participate fully because he was preoccupied with being separated from his parents. In addition, his parents reported that his worries about separation limited him from making new friends because he preferred to be with his parents than play with peers.

Julien's mother reported that he also preferred to be near his parents at home and either periodically checked (by calling out) to make sure they were close by or shadowed them around the apartment. In addition, Julien's mother had to turn on the lights for him before he entered a room because he was afraid of the dark. Julien also avoided using bathrooms alone because he believed that he would be kidnapped by monsters. Julien refused to fall asleep unless his mother was with him, which resulted in a strict bedtime routine. Every night, she bathed Julien, read to him, and they fell asleep together in Julien's bed at 8:30 p.m. Julien's parents both reported that their freedom was restricted by Julien's anxieties. His mother noted that she had little time to herself as she went to sleep early with Julien every night. His father noted disrup-

tions in his employment due to Julien's anxiety because he often missed work to remain with Julien. Clearly, Julien and his family were adversely affected by his heightened anxiety.

According to the school nurse, Julien's father felt uncomfortable about seeking treatment for mental health problems. She mentioned that he viewed Julien's somatic complaints as an expression of a physical illness. Julien had already received two full medical exams from a physician, both of which were unable to identify a medical cause to explain Julien's stomach pains. The school nurse reported that Julien's father appeared frustrated that Julien's school recommended psychotherapy because he felt Julien required further medical attention.

The therapist assigned to the case was a masters-level, 24-year old, first-generation Chinese American female who spoke little Spanish. She had minimal experience working with Mexican American families. Recognizing that a substantial difference in cultural backgrounds may exist between she and the family, she sought consultation with a cultural expert (Principle 10). The cultural expert advised her to first assess the need to enlist the help of a translator. The cultural expert also suggested that she (1) devote time toward thinking about how her own cultural background differed from the family's background and history, (2) consider how language issues and preexisting biases might affect rapport-building and the ability to deliver effective services, (3) express interest in and learn about the family's views, values, and practices, and (4) consult with the expert on sensitive issues as necessary throughout the intervention.

Because there was clear discomfort with the mental health implications of the school's recommendation to the family, care was needed in establishing an initial dialogue with them, and the school nurse—who was trusted by the family—was asked to make the first phone call with the therapist to add legitimacy to the CBT program (Principle 2). This offered the therapist an opportunity to develop positive initial ties with the family. With this goal in mind, her initial objective was to conduct an assessment of the family's level of acculturation and specific cultural practices and beliefs that might be relevant to CBT (Principle 1). Following the cultural expert's recommendation, the therapist spent time learning about the family's acculturative status, migration history, and other relevant background history during the initial session.

Both Julien's father and mother were immigrants from Mexico and had been living in California for over 20 years. They came to the United States voluntarily hoping to provide their family with better lives and access to quality education. They spoke primarily Spanish at home, but all family members were proficient in English and spoke English at work and at school—hence, they declined the offer for a translator to attend sessions (Principle 1). They ate both traditional Mexican and American foods, enjoyed attending various sporting activities, and were actively involved in their church. Both of Julien's parents reported that the health of their family was most important to them. Julien's father regarded his son as the most valuable part of his life and felt that the happiness of his son was his first priority. He noted that although it was a sacrifice for him to miss so much work to accompany Julien during school, he had no doubt that this was the right thing to do. Unfortunately, family finances had been adversely affected by these demands on his time. These sentiments resembled *simpatia* in certain respects and required consideration in the subsequent development of the treatment plan (i.e., Principles 6 and 8).

After learning about the family, the therapist considered similarities and differences between her own upbringing and the family's background. In contrast to Julien's parents, the therapist was less affiliated with the church and was born in the United States. However, she noticed several shared experiences and values as well. Much like the family, she was bilingual, speaking her native language at home while conversing in English with friends and at work. Although she had no personal experience with immigration, the therapist's parents emigrated from Hong Kong to the United States in the late 1970s with a similar hope of securing better educational opportunities. The therapist was also raised to value and respect family relationships. After noting these differences and commonalities, the therapist considered how her life experiences might influence rapport and the course of treatment. For example, she might have preconceived views about the family's knowledge of the structure and purpose of therapy. In addition, perhaps her lack of experience working with Mexican American families

might bias her conceptualization of treatment-related issues such as treatment compliance. Given the impact of potential biases, the therapist made a conscious decision to evaluate the impact of cultural factors on the course of treatment after each session, to continually entertain multiple hypotheses that might explain questions when they arise, and to invest time monitoring and assessing the family's acceptance of her therapeutic approach throughout the intervention.

Following Principles 3 and 4, an orientation to therapy was provided in the first session and Julien's somatic symptoms were identified as a key target of change. CBT was described as a technique often useful in addressing such problems. Psychoeducation about the common reports of somatic complaints among youth with anxiety was also provided to normalize Julien's symptoms and offer a rationale for the "counseling solution" to an apparently physical symptom. Given the time commitment inherent in CBT, the therapist problem-solved with the family about any foreseeable logistical complications. During this discussion, Julien's mother indicated that her work schedule was not very flexible. Although she wished to attend sessions, only Julien's father was available to come consistently. The therapist then addressed realistic expectations about Julien's rate of improvement and encouraged the family to raise any concerns (Principle 9). This orientation to CBT was intended to build rapport and identify any obstacles that might arise.

Julien's parents expressed concern about two issues: First, they continued to wonder if Julien's complaints of stomach aches were an indication that he was suffering from a medical condition and not merely anxiety. Second, they were worried about the academic implications of Julien's resistance to attending school. In an effort to set goals valued by the parents (Principle 5), the therapist informed them that she agreed that stomach aches were a real concern and that since physicians had ruled out a medical cause, CBT could likely help address the problem (Principle 4). Furthermore, the connection between anxiety reduction and greater school participation—and hence, learning—was described. Reassurance was provided about the efficacy of CBT in addressing school avoidance. Also following Principle 5, eliminating cosleeping was not emphasized as a treatment goal because the family noted that it was culturally normative for children to sleep with parents, and that the only problem they saw was Julien's rigidity in insisting on an identical routine each night. With these efforts to set culturally relevant goals and spell out how the treatment process could attain them, the parents gradually became more connected with the therapist and expressed approval of the treatment plan.

A primary component of culturally adapting CBT was providing information about the factors that cause and maintain anxiety in a manner that was respectful of the family's cultural values and view of mental health (Principle 4). The therapist first tried to see the situation from the father's perspective and validate his point of view. It was evident that the most important issue for him was his son's physical discomfort and that treatment goals and plans should be framed in terms of Julien's physical symptoms rather than in purely psychological terms. In layman's terms, the therapist explained the physiology of anxiety as a part of the fight/flight reflex (the connection between anxious feelings triggered in the brain and subsequent changes in the gastrointestinal system, producing symptoms such as nausea). In order to achieve a culturally appropriate metaphor of CBT for the family, the therapist asked about Julien's favorite books or stories, focusing especially on ones containing anxiety-related themes. She discovered that one book Julien enjoyed was *When This World Was New* (Figuerdo, 1999), which is about an immigrant family in New York City with a young son who is initially fearful of all the unfamiliar elements of urban life, but confronts the fears through bravery and trust in his family. This book was used to exemplify the CBT principle of exposure (facing fears to reduce fears) in a culturally congruent manner, and to reemphasize the important role Julien's parents could play. The family reacted with much enthusiasm when CBT was explained this way and often cited the story themselves in future sessions when making plans for exposure tasks.

Furthermore, Julien was taught basic CBT concepts about how "feeling scared can cause tummy aches even when you're not really sick." He was encouraged to think of himself as being brave like the little boy in *When This World Was New*. He developed simple positive self-

statements comparing himself to this character, focusing on his ability to remain safe when away from his family ("I can be brave too!"). Subsequently, a series of exposure tasks were planned to gradually decrease the amount of time Julien's father spent in the classroom, to limit the frequency and length of visits to the nurse, and to stay at school the entire day.

With the hopes of minimizing the likelihood that these tasks would prove too difficult for Julien, the therapist explored cultural influences that affected the development and maintenance of the father's protective parenting behavior (Principle 6). As discussed earlier, one of the cultural concepts hypothesized to play a role in Julien's family was the value of *simpatia*. The therapist emphasized her recognition that Julien's father was making great sacrifices to ensure Julien felt safe at school. A primary goal for the therapist was to focus Julien's father's caring, selfless attitudes in a direction that would buttress the exposure therapy plan, not hinder it. Given the father's initial perspective on how to best help his son (i.e., to stay with him at school when he seemed upset), it was necessary to find a way to illustrate that the most caring thing he could do now was to allow Julien to learn *on his own* (i.e., without parental help) that he was safe at school even if he felt scared.

Given the sensitive nature of this point, a consultation was made with the cultural expert to discuss appropriate ways of illustrating this concept productively (Principle 10). Key issues that arose in this consultation were the need to affirm that the family had already been very *helpful* by staying with Julien to calm him in the past, but that now with Julien's emerging self-confidence stemming from his work in CBT, the most helpful thing they could do was to give Julien a chance to conquer his fears. The emphasis here was avoiding statements that might suggest poor parenting practices had been employed at any time, which could clearly have a counterproductive effect. Instead, the therapist's appreciation of the father's sacrifice on behalf of his son was emphasized. By framing the act of allowing Julien to exhibit his bravery as the next positive step for the family to take, there appeared to be a sense of comfort and even relief on the father's part. He began to make an increased level of self-disclosures to the therapist (about his hopes and fears for Julien) and appeared to genuinely adopt the therapist's framework and recommendations. For this family, illustrating CBT principles with culturally congruent concepts produced higher levels of parental buy-in and treatment adherence.

Once Julien's father began to implement the exposure therapy plan, behavioral improvements began to manifest at school. The family first set limitations on the amount of time the father would spend with Julien at school, beginning with half the day, and over the course of several weeks reduced this to 10 minutes total per day. Limitations on use of the nursing office were then added, and Julien also agreed to stay at school all day unless he was running a fever or otherwise medically ill. Julien was rewarded with praise, stickers, and small privileges at home when he met his daily goals for "being brave at school." Although Julien made his best effort to be courageous and use positive self-statements, he still would plead and cry on some days when his father was set to leave.

This "standoff" proved to be a real test of the family's confidence in the CBT program. Julien's father expressed ambivalence and guilt about the days he left Julien crying, and agreed when the therapist suggested that this felt like letting his son down and failing in his paternal role (again, referring to culturally relevant parenting themes; e.g., Principle 5). However, the father was also able to reflect on the fact that Julien had reportedly recovered quickly and participated well in class on these days (according to the teachers). When looking at it this way, he admitted that he was pleasantly surprised to hear that Julien could handle these seemingly upsetting days. Therefore, he continued to implement the plan most of the time. Soon, Julien was attending school daily with little complaint and few stomachaches, and the frequency of his nursing visits declined to an occasional trip once or twice a week. In addition, Julien's father was able to leave him in class after only a brief farewell, and he remained engaged with class activities throughout the day, substantially improving his participation compared to the days when his father had stayed with him.

As progress was being made on Julien's independence at school, Julien's parents became interested in applying CBT principles to Julien's bedtime routine as well. Following a similar procedure to the school-refusal plan de-

scribed above, it was fairly straightforward to help him become more flexible about whether or not his mother fell asleep with him every night. To further improve Julien's self-confidence about brief separations from family, overnight sleepovers away from home were proposed to the family. However, rather than remain strictly adherent to traditional CBT in which overnights with nonfamily members are preferred, the therapist agreed to the family's suggestion that they solicit the involvement of the extended family (his uncle and aunt) in this sleepover task (Principle 7). Because of this modification, any possible conflict with the therapist over the appropriateness of the task was avoided, yet the task was still beneficial for anxiety reduction (Principle 5); the sleepovers were successful and resulted in a sense of pride and autonomy for Julien and his family.

At the termination of the 12-week intervention, a posttreatment ADIS-C/P diagnostic interview (which, as described above, had been performed at pretreatment as well) was conducted by a clinician unfamiliar with the case or the family's assignment to treatment or waitlist. According to the ADIS-C/P results, Julien no longer met criteria for SAD or any other anxiety disorder. His ADIS-C/P SAD score dropped from 5 (on the 0–8 ADIS-C/P severity scale) at pretreatment to 0 at posttreatment. Furthermore, all of Julien's parent-report scores on the Multidimensional Anxiety Scale for Children-parent version were below the clinical cutoffs established in a recent psychometric study (Wood, Piacentini, Bergman, McCracken, & Barrios, 2002), suggesting his anxiety was in the normal range. According to the ADIS-C/P report, Julien's parents reported that they had noticed several salient changes. Most important was Julien's reduced stomach aches, increased participation in class, and decreased absences, tardiness, and nursing visits. They also noticed that Julien no longer shadowed them around the apartment and that they could stay in different rooms at home for about an hour without his needing to check-in. Julien also reported that his stomach was not hurting as much and that he was no longer scared of wandering around the apartment without knowing where his parents were. Julien's parents were pleased and agreed that the CBT strategies did, in fact, address Julien's presenting problems.

Overall, this case illustrates a successful cultural adaptation of CBT for a student with separation anxiety disorder. The therapist implemented several modifications that helped to facilitate the family therapist relationship and adherence to treatment. Recognizing that cultural concepts, values, and practices may influence the family's acceptance of CBT principles proved useful in this case. Adopting a culturally sensitive stance helped the therapist establish CBT goals that were important to both the family and the school. Having a trusted school staff member broker the initial contact with the family helped provide a point of entry for the mental health care provider that might have otherwise been difficult to attain. Engaging extended family members in the treatment was also helpful because Julien was able to practice coping with feared situations with different caregivers (i.e., on the overnight visits). Respecting the family's conceptualization of mental illness and reframing treatment as a means to address physical symptoms and school engagement (i.e., outcomes valued by the family) served to increase the parents' acceptance of CBT techniques and reduce their initial skepticism. Lastly, consulting with an expert when tackling difficult topics was useful in obtaining additional assistance on how to intervene appropriately.

Summary and Conclusion

In summary, evidence-based CBT programs for Mexican American students and other diverse clients may be enhanced by making culturally appropriate adaptations. School psychologists should entertain working hypotheses about how culture influences the treatment process for each family and continually refine these hypotheses as more information about the family unfolds. Cultural sensitivity requires conscientious effort on the part of the school psychologist to learn about a student's background, value systems, beliefs, and traditions (Hwang, 2006). It is important to note that the case illustration provided is just one example of a cultural adaptation of CBT for school-related problems. School mental health providers should keep in mind that there are many ways to use the above principles for cultural adaptations of CBT for Mexican American students. Providers need to consider which adaptations are relevant in working with individual students

and families with different values, beliefs, and customs. We encourage school psychologists to think creatively about how to apply these principles in an effort to strengthen the cultural appropriateness of evidence-based CBT protocols for Mexican American youth seen in the school setting.

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