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Culturally Diverse Children and Adolescents

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IN an increasingly multicultural society, clinicians must learn to work effectively with people from a variety of backgrounds. Culture is defined by shared attributes of a particular group, including a common heritage, set of beliefs, norms, and values (U.S. Surgeon General 2001). A number of cultural influences may play an important role in shaping an individual's identity, including membership in more than one cultural minority group. Race, ethnicity, nationality, religion, age, immigration status, gender, ability, sexual orientation, and income level are just some of the factors that may affect the therapeutic relationship, diagnosis, and treatment.

In this chapter, we discuss the importance of addressing cultural issues, examine the pros and cons of using cognitive-behavior therapy (CBT) with individuals from a variety of different groups, and identify overarching themes relevant to providing treatment to youth of varying backgrounds.

We also operationalize clinical recommendations for implementing culturally responsive CBT with children and adolescents.

Because a sizable body of literature on cultural competence already exists (see Sue and Sue 2003; Sue et al. 2009 for excellent reviews), this chapter will not focus on the particulars of achieving cultural competence. In general, a good CBT clinician will develop a case formulation and treatment plan specific to each client; thus, individual diversity issues should be a central component of the treatment process. Regrettably, inadequate training in multicultural issues is a well-documented shortcoming of mental health training programs (Iwamasa 1996) and may impede the CBT clinician in achieving both clinical and cultural competence. Furthermore, the assumption that clinicians of color or from other minority groups are free from cultural biases and have some inherent diversity expertise is without merit because minority clinicians receive the same training as therapists from majority cultural groups (Iwamasa 1996). Thus, clinicians from any cultural group would benefit from training in cultural diversity.

Because other chapters of this book outline disorder-specific strategies for cultural and ethnic minority groups, this chapter will focus on common themes to consider when working with diverse populations across disorders, rather than attempting to discuss specific interventions with every potential cultural group. Suggested readings are provided at the end of this chapter as resources for conducting CBT with particular populations.

Health Disparities and Evidence-Based Treatment

Why is it important to consider cultural issues in the delivery of CBT? According to the U.S. Census Bureau (2008), racial and ethnic minorities currently constitute one-third of the U.S. population and are expected to become the majority in 2042. However, for minors, this demographic shift will come much sooner: racial and ethnic minorities will account for more than half of U.S. children by 2023 (U.S. Census Bureau 2008). In contrast to this population shift, in 2006, the American Psychological Association reported that 85% of psychologists were of European American descent. As a result, it is inevitable that these clinicians will need to work with culturally different clients (Pantalone et al. 2010). Thus, the movement toward increasing cultural competence in the delivery of evidence-based treatment (EBT) is a timely one.

The Surgeon General's report on mental health disparities for racial and ethnic minorities (U.S. Surgeon General 2001) brought a number of

issues to light. These groups have less access to mental health services, are less likely to receive mental health services when needed, are likely to receive poorer quality of mental health care when they do receive services, and are underrepresented in mental health research (U.S. Surgeon General 2001). Even when treated, ethnic minorities often terminate prematurely, improve more slowly, and have poorer outcomes (Cooper et al. 2003). Ethnic minorities experience disproportionately more psychosocial stressors than do non-Latino white Americans (Bernal and Scharrón-del-Río 2001; U.S. Surgeon General 2001). These include social and environmental inequalities such as exposure to discrimination, violence, poverty, and limited access to education.

A disproportionate number of children of color are referred for mental health services (Kazdin et al. 1995; Manoleas 1996), yet they continue to be underrepresented in randomized controlled trials of EBTs, resulting in a relative absence of treatments that may be deemed well established for ethnic minority youth (Huey and Polo 2008). To date, no EBT (including CBT) has been tested in at least two independent, high-quality, between-group trials (with random assignment and adequate sample size) that demonstrate that the treatment is superior to placebo or alternative treatment or is equivalent to an already established treatment with ethnic minority youth. Similarly, underrepresentation of gay, lesbian, bisexual, and transgender (GLBT); differently abled; religious minority; ethnic minority; and low-income populations in the research has led some investigators to pose the following question about empirically supported treatment: "Empirically supported treatments…for whom?" (Pantalone et al. 2010, p. 452). More research is clearly needed to support the efficacy of CBT with ethnocultural minority youth.

Controversy About Adaptation of Evidence-Based Treatment

Given documented mental health disparities, there has been a call for the adaptation or modification of EBTs to be more culturally sensitive (Bernal et al. 2009; U.S. Surgeon General 2001). Proponents of such adaptations highlight the differences among cultural groups and suggest that interventions should be tailored to the characteristics of specific groups and consider language, values, customs, child-rearing practices, expectations of child and parent behavior, and distinctive stressors associated with certain cultural groups (Lau 2006; Vera et al. 2003). Some investigators suggest that the failure to make cultural adaptations may lead to miscommunica-

tion, value conflicts, low therapeutic engagement, and treatment failure (Huey and Polo 2008). Culturally adapted treatments can substantially improve engagement, perceived acceptability of the treatment, recruitment in clinical trials, and retention of ethnic minorities in treatment (Kumpfer et al. 2002). Suggested adaptations range from the creation of entirely new treatments for different ethnocultural groups to modifying treatment components of existing EBTs to address cultural factors (Whaley and Davis 2007).

Many experts have expressed reservations about undertaking the cultural adaptation of all EBTs. The inherent assumption that cultural groups are homogeneous entities that remain unchanged over time actually lends more support to stereotypes of cultural groups and neglects the possibility of plural cultural identities (socioeconomic status [SES], gender, religion, sexual orientation, and so forth) (Vera et al. 2003). These experts also argue that rigorous testing of EBTs with ethnic minority youth is limited, that the first priority should be the dissemination and examination of treatment outcomes with cultural minority populations, and that cultural adaptations to EBTs are premature or unwarranted and compromise the fidelity of the interventions and their effectiveness (Lau 2006). Also of concern is the possibility that the active core treatment elements would somehow be diluted or delivered later in the protocol if modifications were made to the original manualized therapy (Kumpfer et al. 2002; Schulte 1996). Finally, opponents to cultural adaptation of EBT stress the impossibility of adapting treatments for every possible cultural group and equipping providers with adequate information about each group, again reinforcing stereotypes and making clinicians believe they do not need to provide services to groups they have not "studied" (Lau 2006; Vera et al. 2003).

The limited existing literature on culturally adapted treatment protocols with ethnic minority youth does not indicate superiority of treatment outcomes beyond improvement in treatment engagement, and experts underline the methodological problems of these few studies, the dearth of randomized controlled trials of EBTs with cultural minorities, and the need for more research (Bernal et al. 2009; Huey and Polo 2008). For example, the lack of specific descriptions of cultural adaptations and wide variations in operational definitions of cultural adaptation make it difficult for researchers to replicate particular studies and make comparisons across trials. Some investigators suggest that EBT be maintained in its original form with all groups and that the intervention be culturally tailored to the individual client only when barriers or opportunities arise (Huey and Polo 2008). Lau (2006) suggested a model of selective adaptation of EBTs guided by empirical evidence. Adaptation should focus on the individual

and the presenting problem that have demonstrated inequitable response to EBT by contextualizing content and enhancing engagement (Lau 2006). Contextualizing content requires that clinicians use novel treatment components to target risk factors and mobilize protective factors specific to the client's cultural group or to respond to symptom presentation patterns that may require specialized intervention elements (e.g., somatic presentation of psychological distress). *Enhancing engagement* refers to adaptations that enhance the therapeutic alliance and retention of clients in therapy. Surface-level changes may include culturally relevant examples, translation into the preferred language of the client, and graphic material depicting ethnically similar families to improve perceived acceptability of the treatment. Structural changes may consist of provision of treatment in alternative settings and addressing logistical barriers and basic living needs to improve treatment engagement, but these changes also may require more substantial modifications to the intervention based on a more nuanced understanding of cultural, behavioral, and psychological attributes of a group (Lau 2006; Zayas 2010). A number of other cultural adaptation models have been proposed for specific ethnocultural groups (Bernal et al. 2009).

Caught in the ongoing debate about the need for and the particulars of cultural adaptation, clinicians find themselves in a difficult position when trying to serve diverse youth. The benefit of these discussions is that there is more pressure on training programs to produce culturally competent clinicians and on researchers to diversify participants in CBT trials. Cultural adaptations may be a critical step toward integrating cultural competence and evidence-based practice (Whaley and Davis 2007). However, we share the discomfort voiced by some that the word *adaptation* implies that culture can be an add-on item, usually occurring at the beginning stages of treatment (Falicov 2009). It is our belief that there are some feasible and empirically informed strategies for infusing culture into assessment, case formulation, treatment planning, engagement, and implementation of CBT with diverse youth.

Pros and Cons of CBT for Children of Diverse Backgrounds

To provide culturally competent CBT, it is essential to consider the advantages and limitations of using this type of intervention with youth who have been underrepresented in most randomized controlled trials. Despite the increasing popularity of multicultural therapy, there is a persistent dis-

interest in cultural and ethnic minority groups in the EBT and CBT literature (Hays 2006; Whaley and Davis 2007). In theory, the clinician would expect that the basic tenets of CBT would be universal (Hays 1995; Pantalone et al. 2010)—that is, behavior is learned and can be unlearned; thoughts, feelings, and behaviors are interrelated; and social learning and operant conditioning are processes that fit with the human experience across diverse populations (Hansen et al. 2000; Pantalone et al. 2010). This belief that CBT is universally applicable, culture-free, value-neutral, or color-blind, however, has come about from practice-oriented research that historically has focused on people of middle class, heterosexual orientation, and European American descent (Balsam et al. 2006; Hays 2006; Organista 2006; Pantalone et al. 2010; Vera et al. 2003). The idea that cognitions affect emotions may, indeed, be relevant cross-culturally. However, CBT's emphasis on cognition, logic, verbal skills, and rational thinking as therapeutic tools is influenced by American and European cultural values (Hays 2006; Hoffman 2006). Eastern cultures may attend more to context and relationships, rely on more experience-based knowledge instead of logic, and show more tolerance for contradiction (Hoffman 2006). In addition, CBT's emphasis on rational thinking may overlook the importance of spirituality, which may be as central and equally important as rational thinking among many cultural groups (Abudabbeh and Hays 2006; Hays 2006; Iwamasa et al. 2006a; Kelly 2006) and may detract from the credibility of cognitive-behavioral strategies for coping (Falicov 2009).

Consistent with collectivism, most ethnic minority groups value interdependence, family, harmony, and community (Nagayama Hall 2001). CBT's focus on the individual client may clash with these values and result in missed opportunities to capitalize on a potential source of strength for many ethnic minority groups (Kelly 2006). The U.S. mainstream cultural value of individualism (i.e., personal independence, self-control, verbal ability) informs the promotion of assertiveness skills and direct expression of thoughts in CBT (Hays 1995; Pantalone et al. 2010). This value may directly conflict with collectivist cultures that may view direct communication as disrespectful and that prefer nonverbal and indirect behavioral communication (Nagayama Hall 2001). Relatedly, assertiveness training's basis in egalitarian democratic principles runs counter to more traditional, hierarchical family structures (based on age and gender) in less acculturated ethnic minority families, where the person's "right" to express himself or herself is not a priority (Abudabbeh and Hays 2006; Organista 2006). The use of "I statements" in assertiveness training would be especially challenging for Native Americans whose preferred language does not have a word for "I" (McDonald and Gonzalez 2006). Thus therapists wanting to implement CBT with diverse populations should carefully con-

sider adherence to individualistic versus collectivist values for both the child and the parents.

A strength of CBT is that it is relatively clear, straightforward, and understandable to clients new to psychotherapeutic interventions. CBT's educational approach helps demystify psychotherapy and familiarizes clients with the roles of therapist and client (Organista 2006). Its focus on specific behaviors, thoughts, and emotions can be an important advantage for clients whose first language is not English (Vera et al. 2003). CBT's emphasis on changing negative thoughts to affect feelings and behaviors aligns well with ethnocultural groups, such as Native Americans, whose spiritual beliefs about wellness emphasize harmony or balance among mind, body, and spirit (McDonald and Gonzalez 2006). However, a downside to the educational approach often used in CBT is the reliance on written assignments and bibliotherapy, which may not be appropriate when working with clients whose native language is not English or immigrant populations with little formal education (Iwamasa et al. 2006a).

CBT's short-term, problem-focused, present-oriented nature also may be appealing to cultural and ethnic minority groups for a variety of reasons. For one, CBT's focus on current behavior, promotion of change (not underlying causes), directive nature, and goal-oriented and limited time frame are consistent with the expectations that many ethnic and religious minorities have for therapy (Abudabbeh and Hays 2006; Fudge 1996; Hansen et al. 2000; Huey and Polo 2008; Iwamasa et al. 2006a; Paradis et al. 2006; Rosselló and Bernal 1996). Likewise, these treatment aspects make CBT more appealing to those living in poverty, who have few resources and who may frequently be in crisis (Organista 2006). On the other hand, focusing exclusively on problem behaviors may neglect nonspecific factors important to the therapeutic alliance with diverse populations (Iwamasa et al. 2006a). Furthermore, a focus on the present and future may prematurely discount the client's history, such as the experience of racism, and neglect useful information about culture-based life experiences (Hays 1995). Thus, the present and future focus of CBT may be both a disadvantage and an advantage when working with diverse youth, and it is incumbent on the clinician to use good clinical skills in navigating these pros and cons.

CBT's action-oriented approach and focus on empowering the individual appear to be distinct advantages for cultural groups exposed to various types of oppression and stressors related to minority status (Balsam et al. 2006; Hays 2006; Kelly 2006; Vera et al. 2003). CBT recognizes that people have the ability to control their thoughts and emotions and develop skills to deal with life situations. Additionally, behavioral experiments and activation may help ethnocultural minority youth build strengths, expand

social supports, and acquire skills to meet goals more effectively (Kelly 2006). Despite the potential of CBT to address contextual factors, CBT proponents have not directly addressed the impact of racism and oppression on ethnic minority clients by creating explicit strategies to deal with these negative sociocultural influences. Critics suggest that CBT focuses too much on changing individual-level variables (thoughts and behaviors) in order to effect therapeutic change and adapt to current environmental conditions (Casas 1995; Organista and Muñoz 1996; Vera et al. 2003). This self-focus neglects unfair, discriminatory environmental factors that restrict an individual's ability to effect change (Hays 2006). As a result, therapists of the majority cultural group often overlook diversity issues and are inconsistent in focusing on problem solving in relation to the client's environment (Hays 1995).

There are a few potential advantages of using CBT with diverse youth:

1. *Directive and structured.* One such strength is that the directive, structured nature of CBT likely fits with diverse clientele's expectations of the nature of therapy. Because many ethnic minorities are accustomed to the traditional doctor-patient relationship in which the doctor (i.e., expert) recommends a course of action to improve health, they may have similar expectations of their therapist (Abudabbeh and Hays 2006; Organista 2006). Whereas other theoretical orientations' intrapsychic focus implicitly locate psychopathology within the individual, CBT does not view behavior as good or bad, but rather as functional or not functional given the context (Balsam et al. 2006). Further, culturally effective CBT emphasizes assessment throughout the course of treatment by examining social-environmental conditions that might contribute to the problems that minorities face and tailoring the intervention to the individual and his or her unique context (Balsam et al. 2006; Hays 2006; Kelly 2006). Likewise, the consideration of clients' perspectives on their progress demonstrates a respect for clients' opinions, as well as for their financial and time constraints; such consideration may be especially beneficial to developing and/or maintaining therapeutic rapport (Vera et al. 2003).
2. *Collaborative nature.* Another strength of CBT is its collaborative nature and determination of mutually defined goals. Such collaboration demonstrates respect for the client's values, abilities, and life circumstances and promotes a context in which cultural differences are recognized (Hays 1995; Vera et al. 2003). For clinicians working with children, such collaborative goal-setting often includes the parents. A collaborative relationship also implies that both the therapist and the client and parents possess valuable knowledge, which also may reduce

TABLE 3–1. Considerations in culturally responsive cognitive-behavior therapy

Intersection of development and culture
Individualism vs. collectivism
Oppression, -isms, and ethnic identity
Acculturation and immigration issues
Religion and spirituality
Distinctive symptom presentation and somatic symptoms
Contextual factors (e.g., socioeconomic status, environmental factors, school issues, access to services, and community involvement and solidarity)

the hierarchical distance between therapist and client (Abudabbeh and Hays 2006; Balsam et al. 2006; Fudge 1996; Kelly 2006).

3. *Empirical support.* Although there are no well-established treatments for ethnic minority children and adolescents, CBT has been found to be possibly (and probably, for some disorders) efficacious for such youth (Huey and Polo 2008). Compared to other types of therapies, cognitive-behavioral approaches have showed the strongest record of success with minority youth (Huey and Polo 2010). Furthermore, CBT has demonstrated effectiveness for a variety of problems in ethnic minority adults (Sue et al. 2009). Thus the use of CBT with ethnic minority youth has some preliminary support from the literature and appears to be a promising intervention for a variety of internalizing and externalizing disorders.

Overarching Themes Relevant to Culturally Responsive CBT

Table 3–1 lists the considerations of culturally responsive CBT, which are discussed in further detail throughout this section.

Intersection of Development and Culture

Culture influences many aspects of mental illness, including symptom manifestation, coping styles, family and community support, willingness

to seek treatment, diagnosis, treatment, and service delivery (Bernal and Sáez-Santiago 2006). Clearly, culture also plays a role in the creation, shaping, and maintenance of cognitions (Dowd 2003). The concept of contextualism suggests that an individual must be understood in the context of his or her family, and the family needs to be understood in the context of the culture in which it is immersed (Bernal and Sáez-Santiago 2006). Compared to adults, children are relatively powerless, dependent on parents and caretakers, school personnel, and other community leaders to make important decisions on their behalf. With respect to treatment engagement, the clinician must engage the adult bringing the child into treatment if the clinician hopes to retain the child in treatment (Crawley et al. 2010). When a clinician works with children, the clinician is working with the family (Hansen et al. 2000). Because Chapter 2 focuses more directly on developmental issues in CBT with children, in this section we highlight how culture may intersect with developmental issues.

Culture is strongly associated with child socialization. Harwood and colleagues (1996) demonstrated the centrality of *familismo* (strong identification with, and attachment to, family; importance of family solidarity, loyalty, and reciprocity) and *respeto* (respect and deference to authority figures and elders) to the socialization of Puerto Rican children by comparing non-Latino white and Puerto Rican mothers' responses to open-ended questions on positive and negative child qualities. Puerto Rican mothers consistently emphasized the importance of proper demeanor, such as respectfulness and obedience. In contrast, non-Latino white mothers highlighted self-maximization (that the child be self-confident, be independent, and develop his or her talents (Harwood et al. 1996). In traditional Arab families, the structure tends to be patriarchal, and children are expected to obey parents and not question authority (Abudabbeh and Hays 2006).

During middle childhood, ethnic minority youth become increasingly aware of their social milieu, discriminatory practices, inequities in the sociopolitical infrastructure, and (if applicable) limited economic resources for their cultural group (Ho 1992). These factors influence self-concept formation and may contribute to feelings of inferiority, frustrations, and resentment (Rivers and Morrow 1995). The issue of cultural identity is particularly relevant during adolescence, when the process of establishing an identity and a sense of autonomy while maintaining a positive relationship with parents are key experiences (Erikson 1968; Paniagua 1994). The Eurocentric expectation that adolescents separate from family during this stage, however, may conflict with collectivist cultures' ideas of normative adolescent development. For example, in many Latino and Arab cultures, the period of dependence and cohabitation with parents is extended, and clinicians may risk a serious breach in the therapeutic relationship if they

insist on adolescent autonomy (Abudabbeh and Hays 2006; Koss-Chioino and Vargas 1992; Rosselló and Bernal 1996).

Other important developmental issues in adolescence are the onset of puberty and emergence of sexual behaviors. Youth development may be further complicated by coming to terms with their sexual orientation and sexual identity (Safren et al. 2001). *Heterosexism* (an ideological system that denigrates and stigmatizes any nonheterosexual behavior, identity, or relationship) is a form of oppression common to many societies (Herek 1990). As a result, GLBT youth face several stressors, including confusion and internalized heterosexism as they come to terms with their sexual identity. Additionally, they often are exposed to overt acts of abuse, harassment, and violence (Safren et al. 2001). Social isolation is a major issue with these youth, as they may lack access to appropriate social venues where they could meet, develop support networks, and date same-age GLBT peers (Safren et al. 2001). GLBT youth who reveal their sexual orientation (i.e., "come out") are often met with punishment, rejection, criticism, and abuse (Balsam et al. 2006). In stark contrast to ethnic minority youth's identity development, many GLBT youth navigate the issues of sexual orientation and coming out without GLBT role models or family members who could potentially be sources of support (Safren et al. 2001).

Individualism Versus Collectivism

U.S. mainstream culture has been described as individualistic, valuing independence, self-confidence, self-reliance, competition, hard work, material success, and personal happiness (Dalton et al. 2001; Harwood et al. 1996). The collectivist worldview considers the well-being of others to supersede that of the individual and emphasizes respect (especially for elders), cooperation, obedience, self-control, politeness, family loyalty, dignity, and putting group interests first (Dalton et al. 2001; Pantalone et al. 2010; Paradis et al. 2006). Certainly all cultural groups value family, but ethnic and religious minority groups are more likely to give priority to the community's or family's needs over an individual's needs. Collectivist cultures also have expanded definitions of who is family. In addition to blood relatives, Latino families often include *compadres* or *padrinos* (i.e., godparents) in the definition of family. In African American culture, "fictive kin" (e.g., close friends of the family, members of the church community) often play critical roles in the upbringing and racial socialization of children, acting as mediators, judges, networkers, and caregivers as needed (Kelly 2006). Thus, when conducting therapy with ethnic and religious minority children, the clinician must evaluate the role of immediate and extended family when planning interventions.

Oppression, -Isms, and Ethnic Identity

When working with diverse youth, consideration of the effects of social oppression (discrimination against and antagonism toward a particular minority group) on the life of the child is crucial, and regrettably, often overlooked because clinicians fail to ask about it. As visible minorities, girls, children with disabilities, Orthodox Jews (adhering to traditional garb), and devout Muslim girls (wearing a hijab) may endure sexism, ableism (prejudice against individuals with disabilities), anti-Semitism, or anti-Muslim sentiment, respectively. GLBT clients often seek psychological services related to stressors related to the pervasive heterosexism and subsequent social rejection and conflict with mainstream culture and religious beliefs (Balsam et al. 2006). The type of oppression that has received the most attention in the psychological literature is that of racism and discrimination. Ethnic minority youth are often targets of racism and discrimination at an early age (Harper and Iwamasa 2000). Racism and discrimination have been shown to be potent risk factors for psychological and physical health problems (Kelly 2006; Sáez-Santiago and Bernal 2003). Experiences such as these will certainly affect the relationship with a therapist whose cultural background is the same as the group that the child views as oppressors (Harper and Iwamasa 2000).

One of the best predictors of resilience to the negative influences of racism and discrimination is the formation of a positive ethnic identity (Wong et al. 2003). Positive ethnic identity is associated with increases in self-esteem, coping, mastery, and optimism and is negatively correlated with loneliness, anxiety, and depression (Carter et al. 2001; Greene 1992). Ethnic minority children have to learn to be bicultural (i.e., able to negotiate the dominant culture successfully) in an often antagonistic environment. Children with underdeveloped cultural identities and long-term exposure to oppressive social environments often demonstrate signs of internalized oppression. Likewise, parents who themselves have internalized racist messages and beliefs in limited life options may pass these beliefs on to their children (Greene 1992).

Greene (1992) described the importance of racial socialization in teaching African American children how to deflect and negotiate a hostile environment. African American parents often strive to warn their children about racism and disappointments without being overprotective. Greene discussed how cultural paranoia (sensitivity to potential for exploitation by whites) evolved as an adaptive defense mechanism to decrease psychological vulnerability to racism. Positive racial socialization often involves providing children with strategies to manage specific problems, acting as role

models for handling discriminatory experiences, introducing African cultural values to increase cultural understanding and pride, having frank discussions with children about indirect and covert racism, and exposing children to accurate and positive messages about African American people and their history (Greene 1992). In short, racial socialization is an essential and underutilized parenting and therapeutic tool that promotes mental health in ethnic minority youth.

In an innovative Afrocentric parent training protocol, Neal-Barnett and Smith (1996) summarized an approach to behavior therapy that incorporates racial socialization to assist African American parents in preparing their children for the experience of discrimination. The Afrocentric approach takes into account strengths embedded in African American culture (e.g., extended family and kinship networks, unity, spirituality, flexibility, and respect for elders) and uses elder role models for younger parents, African American group facilitators, and ethnically similar models in clinical vignettes, tying discipline with building high self-esteem in African American children (Neal-Barnett and Smith 1996). This racial socialization component is typically lacking in other parent training programs, which may contribute to the high attrition rate of ethnic minorities from these types of programs.

Acculturation and Immigration Issues

The impact of immigration and acculturative stress on help seeking, treatment engagement, and family functioning for ethnic minority and immigrant youth cannot be overstated. *Acculturation*, the extent to which an individual adopts aspects of the dominant culture versus his or her indigenous culture, is a process pertinent to both immigrant and nonimmigrant ethnic minority populations (Klonoff and Landrine 2000). Nonimmigrant ethnic minority groups, such as Native Americans and African Americans, often struggle to maintain their indigenous cultural lifestyles and values while adopting the behaviors they need to function in the dominant culture (Kelly 2006; McDonald and Gonzalez 2006). Acculturation has been identified as a risk factor for depressive symptoms among ethnic minority groups (Sáez-Santiago and Bernal 2003), with some evidence indicating that more acculturated immigrants have worse mental health outcomes than less acculturated immigrants (Vega et al. 1998). Individuals who assimilate into the dominant culture (disregard their culture of origin's values and adopt dominant cultural values) may undergo a loss of traditional support systems coupled with feelings of self-deprecation due to exposure

to discrimination. Some investigators speculate that bicultural competency (balance between native cultural norms and those of the host culture) may lead to improved mental health outcomes (McDonald and Gonzalez 2006; Sáez-Santiago and Bernal 2003).

Immigration is often associated with stressful life events that affect child development. Family members may experience lengthy separations, loss of social support, and feelings of loneliness (Interian and Díaz-Martínez 2007; Suárez-Orozco et al. 2002). The reason for immigration is important: Immigrants who come voluntarily for economic, political, health, or educational reasons are usually more prepared to migrate, may have a support network in the host country, and may know the language or be familiar with the host culture (Pantalone et al. 2010). Refugees, on the other hand, are forced to leave their country due to war, persecution, or disaster. They may have been economically or educationally deprived in their home country and have experienced trauma before or during migration (Pantalone et al. 2010). Refugees often have little exposure to the dominant language or culture of the host country, whereas English proficiency is a distinct advantage for immigrants and is associated with lower levels of depression (Sáez-Santiago and Bernal 2003).

The legal status of both immigrants and refugees upon arrival to the new country will dictate the access they have to services and to educational and employment opportunities. Often legal status among family members may vary. For example, women who enter the United States illegally may give birth to children who are U.S. citizens and who receive corresponding services to which their parents are not entitled. These families are often in a constant state of anxiety about the possibility of deportation, and this undocumented status has been linked with increased vulnerability for socioemotional problems (Cavazos-Rehg et al. 2007). Despite high levels of psychological distress, these families often will not seek help for fear of deportation. In other cases, children are brought into the country without legal documentation by their caregivers and are limited after high school in accessing educational opportunities, employment, and medical care without a Social Security number. Upon reaching adolescence and gaining understanding of their predicament, these youth often experience poor mental health outcomes as a result of their severely restricted prospects (Mahoney 2008).

Another complicating factor in the familial acculturation process is that children tend to acculturate faster than adults, in part due to ease of language acquisition for younger children and sometimes because adults have more difficulty adjusting to major life changes (Gil and Vega 1996; Suárez-Orozco et al. 2002). As a result, families often experience an intergenerational gap in cultural values. Traditional cultural values imposed by

parents may contradict those of the dominant culture and cause identity confusion for ethnic minority youth (Ho 1992; Rivers and Morrow 1995) and conflict between parents and their children (Hansen et al. 2000). Also, traditional hierarchies in immigrant families can be disrupted by parents who must rely on children to translate and advocate for their families (Suárez-Orozco et al. 2002).

Religion and Spirituality

Clinicians should appreciate the central role of religion and spirituality and consider how to integrate such beliefs into conceptualization of the problem and treatment planning when working with culturally diverse individuals and families. African Americans demonstrate higher levels of religious devotion and spirituality compared to other ethnic groups, and their religious institutions often are involved formally and informally in child care, educational programming, and community leadership (Bernal and Scharrón-del-Río 2001; Kelly 2006; Neal-Barnett and Smith 1996). Native American spiritual traditions maintain that all things possess a spirit and that wellness is constituted by harmony between the three facets of a person: mind, body, and spirit (McDonald and Gonzalez 2006). Additionally, religious minorities, such as Orthodox Jews, may strive to separate themselves from mainstream American society to maintain group solidarity and their adherence to cultural and religious practices (Paradis et al. 2006). A culturally competent CBT clinician should demonstrate sensitivity to these issues and attempt to utilize the strengths they may present in order to support treatment outcomes. By collaborating with clergy and spiritual leaders (e.g., *curanderos*) and becoming familiar with sacred writings, the CBT clinician may improve treatment engagement and perhaps also the success of interventions.

Distinctive Symptom Presentation and Somatic Symptoms

Alternative manifestations of psychological distress have received increasing attention in the cross-cultural literature. The expression of psychological problems somatically is a common phenomenon in many ethnic minority groups. Arab and Latino clients often present with physical complaints, such as headaches, stomachaches, pain, and sleep disturbance (Abudabbeh and Hays 2006; Myers et al. 2002). It makes sense then that many ethnic minority individuals seek help from their primary care doctors instead of a mental health professional (Abudabbeh and Hays 2006;

Interian and Díaz-Martínez 2007). CBT clinicians may need to consider assisting their young clients with connecting somatic symptoms with psychological distress in order to increase the likelihood that the youth will adequately understand the rationale behind CBT interventions.

Contextual Factors

Ethnic and racial minority groups are often overrepresented in lower socioeconomic strata (U.S. Surgeon General 2001). Poverty and lack of resources often produce hopelessness and helplessness among ethnic minority clients and adversely affect their expectations for positive therapeutic outcomes (Bernal and Sáez-Santiago 2006; Koss-Chioino and Vargas 1992). Additionally, because of financial hardship, some parents need to work multiple jobs and, as a result, are less available to their children. While affluent, two-parent households may have the resources necessary to supervise children's out-of-session practice and therapeutic homework, single parents struggling to provide for their families may not have the energy or time to devote to such endeavors (Greene 1992). For these reasons, these parents are less likely to provide positive racial socialization to the children who most need it.

Low-income communities often are characterized by unsafe neighborhoods, gang activity, inadequate schools, poor housing conditions, limited access to quality health care and social services, and a number of other stressors. The ability of the family living in such conditions to follow through on therapy assignments (such as behavioral activation) may be significantly restricted due to these contextual factors. The limited literacy skills of many immigrant and some ethnic minority parents provide another potential barrier to compliance with written therapy homework and behavioral plans. The intersection of undocumented legal status and low SES creates another challenge for immigrant populations. Undocumented families may have difficulty regularly attending appointments scheduled during typical office hours because of the unpredictable nature of under-the-table day labor or repercussions of missing a day of work (e.g., no benefits and likely job loss for being absent).

Despite these barriers to compliance and treatment, diverse populations present with a number of strengths that can enhance treatment outcomes. Social affiliation, common in many collectivist cultures, has been found to be inversely associated with depression (Sáez-Santiago and Bernal 2003). Resources such as strong connection to family, religious involvement, and voluntary associations may be powerful therapeutic assets in promoting positive change in ethnic minority clients.

Clinical Recommendations

Suggestions for Beginning CBT

Therapist Self-Assessment

The therapeutic process needs to start with the therapist's own self-evaluation of his or her own cultural values, notions of acceptable behavior that may be culturally laden, personal experience with social oppression versus privilege, knowledge deficits, comfort in addressing and discussing issues of diversity and discrimination, and personal biases (Arredondo and Arciniega 2001; Hays 2006; Pantalone et al. 2010). To begin, therapists must be able to clearly identify their own cultural identity and the significance of belonging to that cultural group, including the relationship of individuals in that group with individuals from other groups institutionally, historically, and educationally (Arredondo et al. 1996). Therapists must examine differences between themselves and their clients and assess their level of comfort with working with culturally diverse clients who may have different values and beliefs. Such self-evaluation can make the therapist more attuned to social and environmental stressors that shape the client's experience, such as exposure to oppression, and further help the clinician to identify areas in which he or she needs more education and training (Arredondo et al. 1996; Vera et al. 2003).

Therapists must remember that they have a stimulus value (e.g., gender, race, dress) and that youth size them up the moment they meet regarding the therapist's ability to help and to recognize differences between them. Culturally skilled therapists are aware of their social impact on others in the form of communication differences or interpersonal style (Arredondo and Arciniega 2001). Therapists who have thought critically about how they will be perceived by ethnocultural minority youth will better prepare thoughtful questions and ways to recognize and address potential cultural differences.

Assessment

As discussed above, basic cultural competence calls for the therapist to find a balance between educating himself or herself about the sociocultural groups to which clients belong and recognizing that each client's experiences are unique and not necessarily dictated by group membership (Pantalone et al. 2010). At the same time, clinicians who overestimate the role of these issues, inadequately assess individual differences, and neglect to

consider other relevant factors affecting mental health will likely have poor treatment engagement and outcomes with diverse young populations (Sue et al. 2009).

The *Multidimensional Ecosystemic Comparative Approach* (MECA; Falicov 1998) balances the universalist (assumption that Western psychotherapeutic concepts are universally applicable across cultures) and culture-specific positions to help clinicians appreciate human similarities, consider cultural differences, and recognize the uniqueness of each individual. MECA maintains that culture develops over time through membership in a variety of domains (e.g., language, race and ethnicity, sexual orientation, religion, SES) and experiences in different contexts (e.g., discrimination or isolation where the individual lives and attends school). By adopting a culturally responsive approach to assessment, clinicians will be informed of cultural factors at each step of the CBT process, including case formulation, diagnosis, treatment planning, and therapeutic intervention.

Tanaka-Matsumi and colleagues (1996) outlined the *Culturally Informed Functional Assessment* to assist behavioral therapists who are culturally different from their clients in identifying the functional relationship between the client's presenting problem and the sociocultural environment. The underlying assumption is that good behavioral therapists assume that each individual's reinforcement history is unique (i.e., different from the therapist's and other individuals' from their cultural group). The two major tasks facing CBT therapists are 1) the need to evaluate the presenting problems using functional analysis and 2) the need to assess the larger context of the client's social network with attention to cultural influences (e.g., cultural definitions of problem behavior, knowledge of accepted behavioral norms, cultural acceptability of behavior change strategies, and culturally approved behavior change agents) (Okazaki and Tanaka-Matsumi 2006). Recommendations include the use of an interpreter or cultural informant and acculturation measures to examine the cultural identity, cultural match or mismatch with the clinician, and acculturative stress.

In addition to standard functional assessment with the client, the clinician should interview family members to explore how the presenting problem is viewed from the family's and sociocultural group's perspective (i.e., is this a culturally normative idiom of distress?), what the family perceives as the causes of the behavior, what characterizes traditional help-seeking in the cultural group, and how the family responds to the behavior in everyday situations (Tanaka-Matsumi et al. 1996). Assessment of cultural explanations for the individual's behaviors will reveal pertinent cognitive schemas that may be targeted by interventions (e.g., it is inappropriate for a child to challenge the authority of an elder family member). The clinician needs to

assess not only the quality of the child's self-image but also the life experiences of the parent to understand the role of racial pride, shame, or confusion and how these factors influence the parent-child relationship (Greene 1992). Ensuring that these areas of inquiry are covered in the assessment process will allow the clinician to entertain hypotheses to explain client behavior with a consciousness of what is culturally normative for this individual and the sociocultural groups to which he or she belongs.

The task of culturally responsive assessment may seem daunting because there are so many domains of diversity to consider and no clinician is bias-free. For this reason, a number of different models and tools have been developed to guide clinicians' assessment of both risk and protective factors in the individual's cultural environment. Hays (2008) proposed the **ADDRESSING** model to guide assessment and consideration of the various domains of diversity in case formulation:

A—Age and generation
D—Developmental and
D—Acquired disabilities
R—Religion or spiritual orientation
E—Ethnicity
S—Social status
S—Sexual orientation
I—Indigenous heritage
N—National origin and
G—Gender

To avoid overgeneralizing, clinicians need to consider the individual's level of acculturation compared with his or her level of involvement in the culture of origin (Balsam et al. 2006; Harper and Iwamasa 2000; Vera et al. 2003). Assessing cultural identity, language preference, English proficiency, acculturative stress, exposure to discrimination, and degree of internalized oppression is central to cultural case formulation (Bernal and Sáez-Santiago 2006; Vera et al. 2003).

Despite the documented importance of assessing for these diversity issues, Harper and Iwamasa (2000) found that a majority of therapists talk with clients about ethnicity when the presenting problem is clearly related but otherwise do not often broach the subject. Many dominant-culture therapists fear being considered racist for bringing up the subject of race or ethnicity if the client does not do so. However, young clients' fears of being dismissed or misunderstood may make it difficult for them to bring up such issues (Harper and Iwamasa 2000). By asking "What are aspects of your race or culture that are important for me to know about in working

with you?" or "What are your spiritual or religious beliefs?" the therapist communicates a willingness to discuss these issues (Kelly 2006). Often clients are relieved when the therapist asks this type of question, or they themselves have not previously considered how race and ethnicity contribute to their presenting problem (Harper and Iwamasa 2000). Culturally competent therapists should "do their homework" to inform themselves about what questions to ask and potential influences that the diversity issues may have on the presenting problem. Alternatively, if the clinician does not touch on such issues, the youth may perceive that the therapist is uncomfortable discussing the client's ethnic minority status, does not value the client's ethnicity, or truly cannot understand him or her (Harper and Iwamasa 2000). Some investigators maintain that failure to address ethnicity and cultural values contributes to dropout and treatment failure (Fudge 1996; Harper and Iwamasa 2000).

Considering that many individuals belong to more than one minority group, the clinician also should assess the degree to which the client's self-identity is tied to each of these diversity domains (Pantalone et al. 2010). For instance, in many cases, gay ethnic minority youth identify more with being a member of the GLBT community than with being an ethnic minority.

Case Example

Avery, a 14-year-old biracial (African American and white) adolescent presented for treatment with the primary concern of conflict with her father. After having been raised by her white mother, Avery had to move in with her African American Baptist father at age 10 when her mother died unexpectedly. Her father perceived that Avery had internalized racist messages and that her conflicted relationship with him was rooted in her struggling with her biracial identity. With further assessment, Avery revealed that in her opinion, her bisexual orientation and conversion from Christianity to Buddhism were the primary issues of contention between herself and her father.

Another consideration is that the child's identification will vary by context and level of exposure to oppressive and supportive social forces (e.g., school vs. home vs. religious events; Pantalone et al. 2010). A thorough understanding of contextual issues is crucial to being able to make clinical recommendations that are safe and have a good chance of being successful. For example, a clinician must be cognizant of the risks involved in a GLBT youth's cultural environment before encouraging him or her to come out (Balsam et al. 2006).

Culturally responsive assessment also involves inquiring about contextual risk and protective factors that will inform treatment. Conditions such as SES, educational level, safety of the neighborhood, adequacy of

housing, adequacy of health care and social services, legal problems, and exposure to trauma need to be well understood in order to develop effective recommendations for intervention (Crawley et al. 2010; Hays 2006; Vera et al. 2003). Additionally, clinicians may find useful outlets to enhance treatment engagement and effectiveness by fully understanding a family's cultural isolation versus access to a cultural community (e.g., availability of preferred foods or cultural art, music, and events), access to nature, participation in a religious community in their preferred language, interpersonal support (e.g., extended kinship, godparents, social networks), and involvement in political or social action groups (Hays 2006).

Framing treatment in a culturally acceptable way is crucial in promoting treatment engagement, retention, and compliance. If the assessment process has been truly culturally responsive, the diagnosis and treatment planning stages should be consonant with the family's perception of the problem and will reflect a collaborative effort between clinician, client, and the client's family (Vera et al. 2003). Clients' treatment goals may place less emphasis on cognitive and behavioral changes but rather may focus on having more involvement in a supportive faith community or having more balance in their lives (Pantalone et al. 2010).

Treatment Engagement and Orientation to Treatment

The debate is ongoing about whether factors specific to theoretical orientation or nonspecific factors in therapy (e.g., being understood, receiving unconditional positive regard or respect, and being accepted) are responsible for clinical improvement. Arguably, attention to nonspecific factors in therapy is central to effective treatment engagement with ethnic minority youth (Harper and Iwamasa 2000; Sue et al. 2009). Engagement of ethnic minority families may be particularly challenging given the stigma associated with mental health treatment and a history of exploitation, abuse, and disparities in mental health care that has created a deep-seated suspicion of mental health professionals of the dominant culture (e.g., Tuskegee experiment, conversion therapy for GLBT individuals). It is incumbent upon clinicians to understand how previous experiences and/or misconceptions about mental health service providers may influence the client's perception of them. As mentioned before, these misconceptions can be addressed by acknowledging cultural differences between clinician and client, thus signaling openness to further discuss the topic and sensitivity to the youth's cultural context. Clinicians may need to be prepared to do home visits or to reach out by phone to persuade reluctant family

members to join family sessions (Abudabbeh and Hays 2006). Attention to the therapeutic relationship cannot be overemphasized. For example, allowing time before and during sessions to engage the family in non-problem-related small talk and allocating additional time for standard rapport building may be necessary with culturally different clients (Falicov 2009).

Matching therapist-client characteristics (e.g., ethnicity and gender), language proficiency, and modes of expression (the use of easily understood lay terminology and culturally appropriate metaphors) may enhance the ecological validity of therapy (Interian and Díaz-Martínez 2007; Rosselló and Bernal 1996). Other techniques such as telephone and letter prompts immediately before a scheduled session, engagement interviews to problem-solve barriers to treatment, family therapy techniques to reduce resistance and increase engagement, and interventions designed to increase patient participation in care have been shown to improve treatment attendance and retention of ethnic minority youth (Huey and Polo 2010). Additionally, provision of explanations about the limitations of the therapist role early in therapy will help to avoid misunderstandings among ethnocultural groups who value warm interpersonal relations and expect that the provider will provide constant support and assistance (Barona and Santos de Barona 2003; Bernal and Sáez-Santiago 2006). A willingness to self-disclose often serves to relax the client, promote trust, and model how to discuss personal issues (Pantalone et al. 2010).

For example, when working with Latino families, I (RFP) utilize the formal form of "you" *(Usted)* and formal titles (Señor/Señora, Don/Doña) instead of first names of parents to demonstrate the cultural value of *respeto* and to decrease the hierarchical distance between myself and adult family members. To respond to the Latino cultural value of *personalismo* (warm interpersonal relations and personalized attention), I avoid an exclusively task-oriented orientation to therapy sessions and allow time for small talk and appropriate self-disclosure. This often includes discussion of where the parents of the child were raised. Usually, my clients are curious about my background and how I came to speak Spanish, so I take this opportunity to model self-disclosure by explaining my cultural and family background to increase their comfort level in discussing cultural differences and personal information.

Because of the stigma involved in pursuing mental health care among many ethnic minority and immigrant populations, psychoeducation during the treatment engagement phase is vital. Much of families' anxiety can be relieved by learning about the etiology of the presenting problem and learning that they are not alone (Iwamasa et al. 2006a). Nonthreatening psychoeducation about the purpose, course, and process of treatment has been shown to improve therapeutic alliance with African Americans (Kelly 2006). Early on, the clinician should explain how the cognitive-behavioral

clinician-client relationship differs from a traditional doctor-patient relationship to promote a collaborative treatment approach in which the client takes an active role in defining the problem, deciding on a plan, and negotiating homework (Hays 1995). A careful explanation of the CBT model and how it will specifically address the client's problems is important to treatment retention for ethnic minorities less familiar with therapy (Iwamasa et al. 2006a). This explanation should avoid jargon, particularly when the clinician is presenting the model to children, and should use developmentally appropriate lay language (e.g., "thinking mistakes" or "stinkin' thinkin'" instead of "cognitive distortions"). Pretherapy orientation videos for ethnic minority clients are available to enhance treatment engagement by depicting mock therapy sessions and including client testimonials by ethnically similar clients. These videos may be shown in waiting rooms or privately for individuals referred to therapy (Organista and Muñoz 1996).

Before commencing therapy, the clinician should take time to address potential barriers to treatment compliance. During the culturally responsive assessment, the CBT clinician will have identified logistical barriers as well as potential sources of support (e.g., extended family that can help with child care, expenses, or transportation). Helping the family problem-solve these issues will demonstrate a respect for the context in which families live and a willingness to discuss basic family needs. Barriers may also be attitudinal in nature. For example, it is not uncommon for ethnic minority parents to state that they do not "believe in therapy," that "therapy is for crazy people," or that "therapy is for rich white people." It will be necessary for the therapist to address these attitudinal barriers through psychoeducation and perhaps the use of the aforementioned therapy preparation videos. The willingness to discuss these issues nondefensively and the inclusion of important people, such as curanderos, extended family, clergy, and godparents, demonstrate a comfortable stance on cultural differences by the clinician and serve to build trust, improve attitudes toward treatment, and enhance compliance with homework for youth from ethnic and religious minority groups (Harper and Iwamasa 2000). Because premature termination is one of the major factors leading to poorer treatment outcomes among ethnic minority populations, attention to cultural factors in the treatment engagement phase is particularly crucial to building a therapeutic alliance and retaining the client in treatment.

Methods for Implementing CBT

Consideration of cultural and contextual factors must extend from assessment throughout treatment when working with diverse youth. This means not only adding cultural elements but also using traditional CBT skills to

address diversity issues. Creativity as a clinician is a great asset in flexibly implementing CBT with diverse youth. For example, the clinician may incorporate culturally appropriate metaphors and work cognitive restructuring into a child's affinity for writing raps, to improve the likelihood that the child will accept CBT strategies (Harper and Iwamasa 2000). Therapists also should ensure that the new behaviors learned in therapy are positively reinforced by the social environmental contexts in which youth live (Harper and Iwamasa 2000). This requires an awareness that a particular behavior may be considered adaptive in one context and maladaptive in another.

Family-Focused Interventions

Because of the emphasis on collectivism in many ethnic cultures, an emphasis on family-focused intervention may be most effective when working with ethnically and religiously diverse youth (Falicov 2009; Kumpfer et al. 2002; Organista 2006; Paradis et al. 2006). As part of culturally responsive assessment, the therapist should already understand family structures and backgrounds as well as how clients' behaviors affect the family and vice versa (Pantalone et al. 2010). In a trial of CBT for depressed Latino adolescents that demonstrated treatment effectiveness, *familismo* was considered in the assessment and treatment engagement phases by assessing and addressing parent goals in the treatment process (Rosselló and Bernal 1996). Additionally, family can be integrated into CBT sessions post–treatment engagement. The Treatment for Adolescents with Depression Study demonstrated that involvement of extended family supported compliance among African American youth in CBT (Sweeney et al. 2005). With Latino adolescents, the module of family communication was emphasized to address intergenerational gaps in values. Therapists normalized cultural differences to alleviate family stress and facilitated discussion about the values and beliefs of the host culture and culture of origin with the following goals: 1) promoting understanding between parents and adolescents, 2) teaching the family positive communication and negotiation skills, and 3) teaching the adolescent how to cope with negative feelings and cognitions (Sweeney et al. 2005). Encouraging families to share migration narratives has been a helpful adaptation to family therapy to reduce misunderstandings and to decrease silent suffering (Falicov 2009). When there is a clash between personal and family obligations (individualism vs. collectivism), the therapist should be careful not to impose his or her values, pathologize, or criticize. It is the therapist's role to help the youth anticipate the potential social consequences of certain decisions (Pantalone et al. 2010).

Case Example

Naomi, a 16-year-old Filipina girl raised in the United States, presented with conflict with her mother (a first-generation immigrant, single mother) about her mother's traditional belief that girls should not date until after college (consistent with the mother's upbringing). Due to the Filipino cultural taboo against discussing sexuality and intimate relationships and her mother's vehemence about her not dating, Naomi was unable to engage her mother in open communication and started dating behind her mother's back. Family therapy focused on allowing the mother to explain her values and express her concerns about dating while supporting Naomi to resist peer pressure. Parent-centered sessions provided psychoeducation about how difficult it is to bridge two cultures and the risks to Naomi if she did not have a parent to talk with about her challenges. These sessions included a discussion of the reality of the mother not being able to supervise her daughter 24 hours a day, the likelihood that Naomi might stop seeking her advice and would be more vulnerable to peer pressure if communication remained strained, the normalization that Naomi was likely attracted to the boy and he to her, and the possibility that Naomi might choose to defy her mother if she perceived the mother as being overly restrictive. Individual therapy helped Naomi weigh the pros and cons of continuing to deceive her mother versus choosing to be a nonconformist and not follow her peers' examples, as well as learn to evaluate relationships with peers and with potential boyfriends.

Cognitive Restructuring

As one of the core CBT skills, cognitive restructuring can be a powerful tool to use with youth to address diversity issues. A culturally competent CBT clinician will strive to integrate what is known about the child's cultural values and environment into the teaching and implementation of this skill. In many cases, cognitive restructuring with diverse youth parallels its use in majority populations. For example, youth with disabilities often need assistance in decatastrophizing the impact of their disability (Mona et al. 2006). Cognitive restructuring can focus on personal strengths that were unaffected by the disability to dispute the belief that "Nothing will ever be the same."

For diverse youth, clinicians may want to simplify the **A-B-C-D-E** method (based on Albert Ellis's work), which teaches the client to identify the

Activating event,
Beliefs about the activating event,
Consequences (feelings and behaviors),
Disputation of irrational beliefs, and
Effects of disputation.

Organista and Muñoz (1996) described how **A-B-C-D-E** can be difficult to master and as a result discarded by Latino clients. They suggested that instead of labeling cognitions as irrational or distorted, the "Yes, but…" technique may be presented as a way to challenge clients to consider more realistic alternatives, to see more positive situational elements that have been overlooked, and to make half-truths into whole truths (Organista and Muñoz 1996). For example, a first-generation immigrant adolescent from the Sudan struggling to learn English might say, "Yes, my English language skills are not so strong now, but I'm learning more every day. One day I might be fully bilingual, and this will give me an edge in getting a job!"

A common misconception is that CBT is less helpful with diverse youth because of its emphasis on individual-level variables—that is, on challenging distorted cognitions about negative events in order to help the individual adapt to the environment (Casas 1995; Organista and Muñoz 1996; Vera et al. 2003). When ethnocultural minority youth experience injustice in an antagonistic environment (e.g., exposure to oppressive societal factors), adjusting their mind-set to fit the environment might be seen as maladaptive for their mental health. The challenge for the CBT clinician is to help the youth question whether a cognition is rational before engaging in cognitive restructuring. Culturally responsive CBT clinicians recognize the injustices facing diverse youth and acknowledge that distorted cognitions are not always the source of the problem; thus other skills, such as problem solving, might be more appropriate to alleviate distress. For example, a Latino student thinking "It's not fair that the teacher gives me detention when I speak Spanish in school" is not experiencing a distorted cognition but rather is accurately labeling an experience of oppression.

Even when there is no distorted cognition, however, cognitive restructuring can be used to assign responsibility and positively affect mood. A parallel can be drawn to youth exposed to trauma. By focusing on cognitions, the therapist is not laying blame on the child for the traumatic event but rather equipping the child with a coping skill that will allow him or her to react to the situation in the healthiest way possible (e.g., meaning making). In the case of youth who have experienced trauma or uncontrollable environmental circumstances (as is often the case for cultural minority populations), clinicians can use cognitive restructuring to reframe the impact of these undeniably negative events and help the youth generate more productive self-talk (e.g., "I am not responsible for the teacher being racist. Being bilingual is an ability I have that will be valuable to me in other settings.").

Cognitive restructuring is particularly useful for ethnocultural minorities because it can be used to challenge cognitions stemming from internalized oppression. Many GLBT youth and their families are troubled by heterosexist thinking, such as "Gays and lesbians are more promiscuous and are not ca-

pable of having a stable, committed relationship with one partner." GLBT youth may experience some relief through systematic analysis and correction of cognitive errors and adaptation of more constructive self-talk, including messages from a gay-affirmative therapy approach (e.g., homosexuality is not an illness, same-sex attractions are normal variants of sexual orientation, same-sex relationships can be fulfilling) (Balsam et al. 2006; Glassgold 2009; Safren et al. 2001). In the case of exposure to racial discrimination or harassment, African American youth are at risk of adopting beliefs such as "Being black means I'll never be good enough"; "Being black means acting in a particular way"; and "Black men don't do school; therefore, doing well in school means that I'm not a black *man*." Clinicians can assist ethnic minority youth in challenging these beliefs and developing more realistic and positive self-statements to combat the internalization of negative messages (Fudge 1996; Kelly 2006; Kuehlwein 1992).

Knowing that religion and spirituality are central to the culture of many ethnocultural youth, the clinician can use scriptures and religious anecdotes to challenge maladaptive cognitions (Neal-Barnett and Smith 1996). Such religious disputation of disturbance-creating beliefs can be a potent catalyst for religious clients and is a strategy used by some clergy in the Christian, Jewish, and other faiths (Ellis 2000). Such disputation when carried out by clinicians working with young children, however, needs to be done in a respectful way so as not to alienate the young person or his or her family. Research has shown that devout individuals who believe in an angry, punitive God and perceive a lack of support from their religious community tend to suffer more psychological distress in contrast to those who believe in a loving God, who enjoy more positive mental health (Pargament 1997). Clinicians are encouraged to inquire what the youth's and parents' religious beliefs are in relation to the situation at hand, determining whether these beliefs are exacerbating or relieving the youth's distress (Walker et al. 2010). Psychoeducation about the clinician's role can highlight the intention to help the youth (and sometimes the family) feel better by adopting adaptive and hopefully religiously congruent thinking. This approach may require consultation with a clergy member to provide the family with the necessary reassurance that the treatment is acceptable (Walker et al. 2010). In the cases that young clients or the parents present with views that conflict with the clinicians' beliefs, clinicians are encouraged to focus on the well-being of the youth as a way to guide therapeutic intervention.

Case Example

José, a 17-year-old gay Catholic adolescent from Mexico, presented for individual therapy for depression. He was struggling to reconcile his Catholic identity with his sexual orientation. He had internalized negative messages,

such as "Homosexuality is a sin," and therefore felt as though he was a bad Catholic. Recognition that much of his distress emanated from this punitive belief that an integral part of identity was abhorrent to his God and religion guided my (RFP) decision to use scriptures to counteract this internalized oppression, common to Christian GLBT older adolescents. I engaged José in collaborative research into same-sex relationships in the Bible, alternative theories and interpretations of biblical passages, and contradictions in Scripture. Cognitive restructuring helped José adapt beliefs based on Scripture that emphasized his compliance with Christian ideals. Additionally, to help him cope with some of his family's rejection as he disclosed his sexual orientation, José utilized religious readings, such as "When my father and my mother forsake me, then the Lord will take me up" (Psalm 27:10). He also was able to critically analyze and generate positive self-talk, such as "If nonheterosexual orientation is so completely unacceptable, then why is there not one mention of sexual orientation in the Ten Commandments or in all of Jesus' teachings?"

Often cognitive restructuring with diverse youth is most effective in combating the effects of oppression when the therapist is able to access and enhance the client's strengths (be they developing a positive ethnic identity or a belief in a loving God) and use them in therapy.

Behavioral Activation

When designing behavioral activation for diverse youth, the clinician should attend to contextual factors such as income, safety of neighborhoods, gender roles, and other cultural norms. A clinician who recommends that a child living in the inner city exercise regularly by walking or running around the neighborhood, going to the park, or working out at the gym without thoroughly assessing such contextual factors may inadvertently put the child in danger of crossing gang lines and exposing himself or herself to violence, assumes access to parks, and presumes that the family has the resources to pay for private gym membership, respectively (all of which demonstrate the clinician's lack of skill, knowledge, and understanding of the client). Clinicians need to help children identify activities that are congruent with their environment, do not require payment, or are readily available to low-income families (e.g., free admission days at museums, visiting friends, mall walks) (Organista 2006).

Follow-through on behavioral activation may be highly dependent on how it is viewed by the family. For Latinos, focusing on themselves and improving their own moods may cause problems for more traditional families who value *familismo*. Therefore, activity schedules that include activities for the youth to do with and without family are more likely to be well received (Organista 2006). Additionally, traditional gender roles dictate that Latinas take on a caretaking role in the family by helping around the house

with child care, cleaning, and chores. In these cases, behavioral activation might be more well received if instead of framing it as a way for the client to take care of herself, the clinician proposes the rationale that when the client takes care of herself, she is better able to care for her family (Organista 2006). For children who manifest psychological distress primarily in somatic symptoms, behavioral activation (e.g., physical exercise, distraction) in conjunction with relaxation techniques may be an intervention that is easily understood by the family (Interian and Díaz-Martínez 2007).

Behavioral activation may also serve as a useful complement to cognitive restructuring to buffer youth from oppressive influences by connecting them to culturally specific networks and religious institutions (Hays 1995). For African American and Latino youth, clinicians can connect youth with church communities, local cultural organizations, English classes (for those whose first language is not English), and mentoring as part of their behavioral activation interventions (Interian and Díaz-Martínez 2007; Sweeney et al. 2005). GLBT youth, in particular, benefit from assistance in identifying appropriate agencies and organizations that will allow them to build social support networks and experience more positive events (Safren et al. 2001). Such culturally attuned behavioral activation interventions may decrease social isolation, enhance positive ethnic identity development, and improve overall mental health.

Case Example

Ming is a 13-year-old girl who emigrated from China at age 11 and recently relocated to a new city in the United States. She feels isolated and different at her new school because most of the students are African American. She reported that the only other Asian students were "Gothic" (an offshoot of punk culture), a group with which she did not identify. In order to increase her social activity level, I (RFP) found a Chinese American agency near where Ming lived and suggested that she and her mother investigate some of the classes and recreational activities. We discussed how classes on Chinese cultural heritage might lead Ming to meet other youth with whom she would feel more connected. We also discussed that the youth group field trips could help her get to know her new city. To address her mother's concern that Ming was not serious enough about academics, I explained that the agency also provided academic assistance such as tutoring and English-language classes, which might help Ming improve her writing for standardized testing.

Problem Solving

Problem solving is another useful complement to cognitive restructuring when there is an environmentally based problem (Hays 2006). Problem solving is especially relevant to ethnocultural minority youth's contextual

experiences that may negatively influence their mood and behavior because of the focus on effecting change on the environment. Therapists can help youth (already disempowered because of their age) draw on community and family resources to address unjust treatment. For example, using family problem-solving to address discriminatory practices at the child's school can empower parents to file complaints, request to speak to someone's supervisor, seek out a new school, or consult an attorney. Helping ethnocultural minority children (and at times, their parents) successfully change their environment may serve to increase their self-efficacy and willingness to implement learned coping skills in subsequent situations.

CBT with ethnic minority youth may require a higher level of intervention in the larger community than CBT with dominant cultural groups. Effecting change on the community level and healing a community of oppressive influences resonates with Afrocentric values of responsibility and self-determination, empowers clients to use more active coping styles, and strengthens positive ethnic identity (Kelly 2006). Problem solving can promote external change in the contingencies in the environment that may maintain child symptoms (Kelly 2006). This intervention may entail empowering the child or family to start an ethnocultural youth group at the school or in the community when one does not already exist (e.g., Latino Student Association, Gay-Straight Alliance).

Case Example

Kadija is a 13-year-old African American girl who was having significant difficulty getting along with a particular teacher at school. She and her mother viewed this teacher as often discriminating against Kadija (e.g., blaming only her for something a group of students did). Her mother attempted to advocate for her daughter by talking to the teacher, but she had a strong emotional reaction to the teacher and would end up raising her voice, which only seemed to exacerbate the teacher's discriminatory behavior. Through the use of problem solving and a review of communication skills in different cultural contexts during therapy, the family was able to enlist the help of an African American teacher who was willing to facilitate this discussion and identify assertive, rather than emotional, methods of opening discussion of the issue with school staff.

Exposure Therapy

Traditional exposure therapies for anxiety and panic disorders have included interoceptive exposure to somatic symptoms evoked during a panic attack. Panic attacks brought on by stressors related to the client's minority status, however, may need additional culturally relevant exposures coupled with relaxation training and problem solving to decrease chronic

stress levels. For GLBT youth, coming out to specific individuals can be planned as clinicians would plan any other exposure—using a hierarchy of how difficult it would be to come out to particular individuals (Glassgold 2009).

When engaging the client in exposure therapy, CBT clinicians need to be mindful of cultural factors that may alter effectiveness. For example, clinicians may need to address the role of shame with Asian American clients by weighing the pros and cons of the client experiencing short-term embarrassment while completing exposures versus the long-term consequences of not doing the exposures (Iwamasa et al. 2006a). For religious clients, the therapist needs to be careful not to engage the client in something that is specifically prohibited by religious law (Paradis et al. 2006).

Case Example

Nicolas, an 8-year-old Dominican boy and observant Jehovah's Witness, presented with obsessive-compulsive disorder (OCD). He was experiencing blasphemous obsessions about swearing at or hating God that were highly embarrassing and distressing to him and his family. I (RFP) worked with the family in psychoeducational sessions to help them understand the nature of OCD and how obsessions were often ego-dystonic and not stemming from a budding rebellion or defiance. We worked collaboratively to externalize OCD and separate it from Nicolas' identity by making OCD the "bad guy" who bothered Nicolas with the most personally distressing thoughts it could generate. With a solid understanding of OCD and the rationale for exposure and response prevention, he and his mother were willing to proceed with exposures to acting out his obsessions (e.g., swearing at God).

Assertiveness Training

Traditional assertiveness training stresses the rights of the individual, which may pose problems for youth from more collectivist cultural backgrounds. A breach in the therapeutic relationship may occur if the CBT clinician is perceived as trying to impose his or her cultural value system on a child or family by empowering the child to put his or her needs above those of the family or community. Organista and Muñoz (1996) suggested that instead, clinicians should frame assertiveness training as a way to help children develop bicultural competency. Assertiveness may be described as an effective communication skill in mainstream America that will serve the youth well in school and in pursuing a professional career. At the same time, the clinician may help youth recognize that assertive communication is inappropriate or may need to be used sensitively in other contexts, such as at home or in religious communities (Hays 1995; Koss-Chioino and Var-

gas 1992). This approach to assertiveness training avoids devaluation of traditional communication patterns in particular cultural contexts (Organista and Muñoz 1996). By discussing cultural values, expectations, and family roles, the therapist may assist more acculturated adolescents in negotiating a looser attachment to the family without completely abandoning traditional cultural values (Koss-Chioino and Vargas 1992).

For African American youth, assertiveness training can help them anticipate situations and generate and rehearse appropriate responses that focus on desired outcomes instead of the oppressive script of "acting black" (Fudge 1996). In combination with cognitive restructuring to challenge negative internalized messages, assertiveness training can present youth with alternatives to the extremes of either aggression and hostility or passivity and withdrawal. Through role-play and examples from role models, ethnic minority youth can strengthen assertiveness skills and effectively anticipate and manage problematic situations (Fudge 1996).

A good deal of attention in the literature has been given to conducting assertiveness training with Latino populations. The therapist needs to be mindful of culture-based protocols of communication, *respeto*, and *simpatía* (i.e., warmth, kindness, emphasis on positive interactions and avoidance of conflict) in Latino cultures (Interian and Díaz-Martínez 2007; Organista 2006). Comas-Díaz and Duncan (1985) were the first to write about how Latinas could communicate assertively without seeming confrontational. Culturally sensitive framing of assertive communication may include prefacing statements, such as "With all due respect…," and/or asking permission—for example, "Would you permit me to express how I feel about that?" (Comas-Díaz and Duncan 1985). When using assertiveness training in Latino family therapy, clinicians can ask the father's permission to allow the wife and children to state their opinions or express feelings, which demonstrates *respeto* for his role as head of the family and to appeal to his *machismo* (i.e., male pride, man's role as protector of the family) (Koss-Chioino and Vargas 1992; Organista 2006). When such cultural adaptations are made, assertiveness can be a useful tool for diverse youth.

Interventions to Promote Positive Ethnic and Cultural Identity Development

Despite consistent findings that experiences of oppression and discrimination have adverse effects on mental health, there is a remarkable lack of emphasis in the CBT literature on techniques to develop self-efficacy and positive ethnic and cultural identity. Bandura (1982) discussed that central to the development of a sense of positive self-worth and effectiveness is

the individual's acquisition of skills necessary to master the environment. In the case of some ethnic minorities, internalization of racism contributes to difficulty accurately assessing personal competence and resisting negative behaviors that are reinforced by peers (Fudge 1996). Positive ethnic identity would alter expectations regarding personal competency and would give children the courage to engage in more adaptive behaviors even if not reinforced by some members of their peer group.

Because of the emphasis on behavior change, behavior therapy is especially well suited to increasing youth's sense of control and self-efficacy in disempowered young minority populations (Fudge 1996). Behavior change can result in empowerment and an increased ability to alter the environment. By exposing youth to positive role models of their own group through bibliotherapy (e.g., *The Autobiography of Malcolm X*), therapists can help youth learn vicariously about positive ethnic identity development (Fudge 1996). Through involvement in political activity or ethnoculturally based youth groups, youth can appreciate the interdependence between their own needs and those of the larger cultural community, gain a sense of belonging and solidarity, and strive collaboratively to modify systems-level problems and repair injustices, leading to increased self-confidence and self-esteem. Therapists can teach youth behavioral analysis to help them analyze antecedents and contingencies that are capable of being altered (Fudge 1996). For example, therapists can discuss with African American boys the negative behavior that is often reinforced by peers who have internalized racist messages. Therapists can appeal to these youth's responsibilities as black men to help others with similar problems by changing the contingencies (e.g., label academic achievement as a positive, desirable quality) (Fudge 1996).

Racial socialization has been identified as a therapeutic tool for clinicians to use when interested in promoting positive ethnic identity development in diverse young clients (Greene 1992). Although racial socialization is not a suitable treatment focus for all forms of psychopathology, Greene (1992) recommends that it be used proactively to promote self-esteem and not solely in response to discrimination. The first phase of racial socialization educates children to label racism accurately, identify when it occurs, and understand the experience. In the second phase, the parent is used as a role model to demonstrate to children how to handle certain situations (e.g., advocating for the child at school). The third phase of racial socialization is to provide emotional support for the expected angry emotional reaction to injustices. The final phase assists parents in not reinforcing negative racial stereotypes by showing them how to provide more positive racial images by sharing family folklore and other stories and symbols of racial pride (Greene 1992).

Case Example

Esmeralda is a 12-year-old Guatemalan girl exhibiting oppositional behavior at home, poor self-esteem, and academic decline. In addition to parent training and school consultation, I (RFP) engaged Esmeralda in a variety of activities meant to bolster positive ethnic identity development. Every week, I had Esmeralda read a printout from a Web site featuring successful, famous Latinas in the United States and answer questions about them to help her draw connections between their ethnic backgrounds and hers. I recommended seminars at the nearby university that were open to the community, focusing on Latino leadership and higher education, so that Esmeralda was exposed to role models, such as Latino politicians and college students. I also helped the family find ethnic minority college students at the local university who were willing to donate time to tutor Esmeralda after school to help increase her self-efficacy in her classes.

Hence, therapists may foster positive ethnic identity development in their young clients through a combination of CBT techniques, including cognitive restructuring, behavioral activation, and problem solving, as well as racial socialization.

Future Directions

The topics covered in this chapter illustrate the need for a coherent approach to integrating cultural competence and CBT. To accomplish this goal, a number of changes must occur in the fields of mental health training, service provision, and research. Training programs for all types of mental health professionals need to improve preparation of clinicians to work with culturally diverse populations in addition to training them in EBTs (Vera et al. 2003). Diversity and cultural competence training has been demonstrated to increase knowledge about ethnocultural populations among trainees, improve client perceptions of therapist sensitivity, and enhance treatment outcomes (Yutrzenka 1995). Clinical CBT supervisors need to be willing to examine their own values, beliefs, attitudes, and worldviews to build the foundation of self-awareness (Iwamasa et al. 2006b). Likewise, cultural issues need to be raised in supervision to promote the competence of clinicians in training (Iwamasa et al. 2006b). Additionally, culturally responsive assessment in clinical practice is inconsistent in part because of the lack of training, but also because of the deemphasis of culture in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association 2000) by relegating cultural formulation to an appendix as opposed to inclusion of such issues as an inherent part of multiaxial assessment (Hays 2008).

Research must focus on culturally sensitive assessment and treatment response of minority populations to traditional CBT as well as culturally adapted protocols. Specifically, future research should integrate hypothesis-testing and discovery-oriented research and move away from cross-cultural comparisons, instead focusing on mediators and moderators of treatment outcomes for one specific ethnic group at a time (Bernal and Scharrón-del-Río 2001; Huey and Polo 2010). Discovery-oriented research on how to modify treatments with culturally diverse youth, including both quantitative and qualitative methods, would inform the development of culturally adapted protocols. Hypothesis-testing research with specific ethnocultural groups may then examine questions of efficacy and effectiveness of traditional CBT as well as culturally tailored protocols (Bernal and Sáez-Santiago 2006; Bernal and Scharrón-del-Río 2001). In addition to research that tests cultural adaptations of CBT strategies and manuals, there is a need for mainstream manuals to demonstrate applications of standard modules with diverse populations (Huey and Polo 2010).

In the meantime, it is possible for CBT clinicians to provide culturally responsive interventions using the resources we have outlined in this chapter. CBT's ongoing assessment and tailoring of the interventions to the individual make it particularly useful with clients from a wide variety of cultural backgrounds. CBT clinicians, however, should commit to incorporating cultural diversity issues into their treatment plans by educating themselves about the cultural groups to which their clients belong and using the tools and resources available to them.

Key Clinical Points

Tips for Culturally Responsive Assessment

- Conduct a cultural self-assessment and assess differences between yourself and your client.
- Use a form of cultural assessment such as ADDRESSING (Hays 2008) or the Culturally Informed Functional Assessment (Tanaka-Matsumi et al. 1996) to avoid your own blind spots and incorrectly estimating the importance of diversity issues.
- Assess the primary cultural identity of the client and consider how this might vary depending on context.
- Focus on risk and protective factors in the cultural and contextual environment.
- Arrive at treatment goals collaboratively and frame treatment goals in culturally congruent language.

- Understand the complexities of expectations about relationships between the child and his or her family members.

Tips for Culturally Responsive Treatment Engagement

- Pay attention to nonspecific factors and work to reduce the hierarchical distance between you and the client to promote a collaborative therapeutic relationship.
- Provide psychoeducation in easy-to-understand language to address common misconceptions, normalize help seeking, and make explicit how treatment will help.
- Address logistical and attitudinal barriers to treatment engagement.
- Recognize and address cultural differences between you and the client.
- Communicate hope and willingness to assist the child and parents with addressing the presenting problem.

CBT Interventions With Diverse Children and Adolescents

- Develop interventions that are likely to be successful and culturally acceptable in the context in which the child lives.
- When appropriate, inclusion of family in treatment may support treatment compliance and improve outcomes for ethnocultural minorities.
- Directly address diversity issues using CBT tools such as cognitive restructuring, behavioral activation, problem solving, and exposure.
- Be careful with competing cultural values when conducting assertiveness training and make sure that your client uses the skill in culturally appropriate ways and only in appropriate contexts.
- Target somatic symptoms when they are the idiom of distress and explain how CBT strategies will impact physical well-being.
- Support the development of positive cultural identity and racial socialization.

Self-Assessment Questions

3.1. Which of the following is NOT a strength of CBT when implemented with ethnocultural minority youth?

A. It is time limited and problem oriented.
B. It is focused on the present and future.
C. It is focused on intrapsychic, unconscious processes.
D. It involves collaboration in defining treatment goals.

3.2. Parent training protocols with ethnic minority youth may improve treatment retention and outcomes by including an emphasis on

A. Time-out.
B. Physical discipline.
C. Natural consequences.
D. Racial socialization.

3.3. Antoine is a 9-year-old African American boy who is struggling in school. One of his core beliefs is that "only white kids do well in school." This belief is an example of

A. Acculturation stress.
B. Internalized oppression.
C. Feelings as facts.
D. Ableism.

3.4. CBT with an Iraqi (Muslim) 12-year-old girl with externalizing problems might be enhanced by

A. Family-focused sessions.
B. Individual-focused sessions.
C. Emphasis on assertiveness training in all contexts.
D. Behavioral activation.

3.5. The clinician must be especially cautious in implementing which CBT skill because of its cultural acceptability in different settings (e.g., home vs. school)?

A. Behavioral activation.
B. Problem solving.
C. Assertiveness training.
D. Cognitive restructuring.

Suggested Readings and Web Sites

Population-Specific Information

American Psychological Association: Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. August 2002. Available at: http://www.apa.org/pi/oema/resources/policy/multicultural-guidelines.aspx. Accessed April 19, 2011.

American Psychological Association: Practice guidelines for LGB clients: guidelines for psychological practice with lesbian, gay, and bisexual clients. February 2011. Available at: http://www.apa.org/pi/lgbt/resources/guidelines.aspx. Accessed April 19, 2011.

American Psychological Association, Office of Ethnic Minority Affairs home page: www.apa.org/pi/oema/index.aspx

Council of National Psychological Associations for the Advancement of Ethnic Minority Interests: Psychological treatment of ethnic minority populations. November 2003. Available at: http://www.apa.org/pi/oema/resources/brochures/treatment-minority.pdf. Accessed April 19, 2011.

Hays PA, Iwamasa GY: Culturally Responsive Cognitive-Behavioral Therapy: Assessment, Practice, and Supervision. Washington, DC, American Psychological Association, 2006

Additional resources such as peer-reviewed journals are also an excellent source of current literature on treatment with culturally diverse populations. Examples include *Cultural Diversity and Ethnic Minority Psychology*, *Asian American Journal of Psychology*, and *Journal of Black Psychology*.

Assessment

Hays PA: Addressing Cultural Complexities in Practice: Assessment, Diagnosis, and Therapy, 2nd Edition. Washington, DC, American Psychological Association, 2008

Tanaka-Matsumi J, Seiden DY, Lam KN: The Culturally Informed Functional Assessment (CIFA) Interview: a strategy for cross-cultural behavioral practice. Cogn Behav Pract 3:215–233, 1996

Multicultural Training and Supervision to Promote Cultural Competence

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Research on Cultural Adaptations

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