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Enhancing the Responsiveness of Family-Based CBT Through Culturally Informed Case Conceptualization and Treatment Planning

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Family-based CBT has been shown to be effective in controlled settings for an array of youth mental health difficulties, yet disparities in treatment engagement and outcomes across culturally diverse groups remain. In practice, cultural minority families are less likely to reap the demonstrated benefits of supported programs. Although there have been tremendous advances in case conceptualization, leading models have largely ignored cultural factors, contributing to observed disparities. The present paper reviews recent advances in science-informed case conceptualization and highlights how such advances nonetheless have failed to provide guidance on systematically incorporating cultural formulation into assessment and treatment planning. We then build upon Christon et al. (2015) useful 5-stage model of science-based case conceptualization in an effort to move the field toward culturally informed case conceptualization. We highlight how leveraging cultural assessment—such as with the use of the Cultural Formulation Interview (CFI)—can facilitate the incorporation of cultural factors into each of the five stages of science-based case conceptualization. A case example is utilized to illustrate key opportunities for strategically incorporating relevant information gleaned from the CFI into culturally responsive care with youth and families.

FAMILY-BASED cognitive behavioral therapy (CBT) has garnered strong support in the treatment of a wide range of child and adolescent mental health problems such as anxiety, depression, OCD, eating disorders, behavioral problems, and substance misuse (Comer et al., 2019; Hogue et al., 2014; Kaminski & Claussen; 2017; Le Grange et al., 2015). Such family-based CBT typically includes considerable caregiver involvement in treatment to optimize engagement, improve family communication and problem solving, facilitate cohesion, target problematic family patterns and structures, bolster natural supports for the child or adolescent, and promote generalization and maintenance of gains. Directly involving caregivers and considering child problems within the broader context of the family can yield improved outcomes, enhance the caregiver's ability to support their child, and address a wider array of impairments that impact the entire family.

Despite the demonstrated efficacy of family-based CBT for treating a range of youth mental health problems, in practice not all families in need have been able to benefit from such care. Cultural minority youth—i.e., those from various intersecting demographic, social, and economic backgrounds that have been historically marginalized—remain less likely to engage in, and benefit from, mental health services (Alegría et al., 2010; Alegría et al., 2015; Kataoka et al., 2002; La Roche, 2020; Marrast et al., 2016; Maura & de Mamani, 2017; Merikangas et al., 2012). Moreover, studies show that cultural minority families, compared to their non-Hispanic White counterparts, receive fewer and lower-quality mental health services in general (Alegría et al., 2015; Alegría et al., 2010; Kataoka et al., 2002).

Research supporting the efficacy of family-based therapies for mental health problems in cultural minority youth has lagged considerably behind research supporting such treatments in majority White populations (Pina et al., 2019). Despite historic under-

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representation in the empirical literature, cultural minority youth collectively account for a very large, and growing, proportion of youth in need of services. While there is a rich evidence-base of treatments with strong effectiveness in child psychology, there is clear need to improve cultural responsiveness of services. By cultural responsiveness we are referring to both the understanding of the cultural background of the client followed by the intentional use of strategies that incorporate their cultural backgrounds, beliefs, and values into treatment (Jones et al., 2020; Sue et al., 1992).

To date, most literature on culturally adaptated treatments (CATS) has focused on adapted protocols for entire cultural groups; these protocols may fail to meet the individualized needs of youth by not addressing intersecting cultural identities (e.g., race/ethnicity, gender, SES, immigration status, education) that influence their experiences.

To date, researchers have offered very little process-oriented guidance for improving the cultural responsiveness of evidence-based family-based therapy. As such, there is a critical need for person-centered strategies for infusing relevant cultural factors within evidence-based care models, without requiring wholesale modified treatment protocols. The current paper provides practice guidance for systematically incorporating relevant cultural factors into case conceptualization in the context of family-based therapy. We begin by further underscoring the urgent need for more culturally responsive treatment approaches and then highlight how leading case conceptualization models fail to systematically incorporate cultural formulation into assessment and treatment planning. Further, we discuss cultural assessment as an important tool in gathering relevant cultural information to inform case conceptualization and treatment planning. Last, we build upon Christon et al. (2015) 5-stage model of science-based case conceptualization in an effort to move the field toward *culturally informed case conceptualization* and highlight how cultural factors can be specifically incorporated into each of the five stages of science-based case conceptualization. A case example is used to illustrate our model of culturally informed case conceptualization. We conclude with a discussion of challenges and recommendations to improve the cultural responsiveness of mental health services.

The Urgent Need for Culturally Responsive Care

Most evidence-based treatments have been developed mostly within the majority White culture and largely by White clinical innovators and researchers, leading to a lack of systematic consideration of cultural factors relevant to mental health care (Benish et al. 2011; Sue et al., 1992). Despite the explicit focus in CBT on contextual factors that shape and reinforce behavior, and despite the central emphasis in CBT on attitudes and beliefs, until relatively recently, leading CBT approaches have largely ignored the influences of cultural contexts and cultural values in the conceptualization and treatment of patients. Indeed, increasing research highlights how cultural context can deeply affect the way in which individuals and families view mental health and interact with mental health services (Kirmayer, 2006; Lewis-Fernández et al., 2020). Notably, the current definition of "evidence-based practice" explicitly requires that the therapist integrate the best available research with clinical expertise "in the context of patient characteristics, culture, and preferences" (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006). It is now considered unethical for therapists to conduct treatment without the assessment and incorporation of the patient's cultural context. With growing awareness of the influence of a patient's culture within the psychotherapeutic process, researchers are increasingly calling for more culturally responsive services (Georgiadis et al., 2020; Graham-LoPresti et al., 2017; Kirmayer & Jarvis, 2019; Sue et al., 2009; Zigarelli et al., 2016).

Calls for more responsive mental health care for cultural minority communities have led to the development of culturally adapted treatments (CATs). CATs entail systematic modifications to consider language, culture, and context in ways that are compatible with the patient's cultural patterns, meanings, and values (Bernal & Domenech Rodriguez, 2012). During the last decade a growing number of CATs have been developed and tested with racially and ethnically diverse samples (for a review see Rathod et al., 2018; Sue et al., 2009; Zane et al., 2016). Meta-analyses of the literature have found that CATs indeed lead to better treatment outcomes among racial and ethnic minority groups, relative to interventions that are not culturally adapted (Griner & Smith, 2006; Hall et al., 2016; Smith & Trimble, 2016; Soto et al., 2018).

Despite these promising outcomes, CATs also have some important limitations. For example, most CATs only include one or two cultural modifications (Smith & Trimble, 2016). The most frequent cultural modification is language, where the CAT is delivered in patients' first language. The second most common cultural adaptation entails racial and/or ethnic "matching," following from an assumption that racial and/or ethnicity minority patients will show greater treatment engagement and response when working with racial and/or minority therapists than when work-

ing with Non-Hispanic White American therapists (Zane et al., 2005). Such frequent and exclusive reliance on these two cultural modifications suggests a tacit assumption that delivering an intervention in the patient's dominant language and by a racial and/or ethnic minority therapist—irrespective of level of therapist skills or cultural values—qualifies as a CAT (Smith & Trimble, 2016). This operationalization of CATs not only simplifies multicultural guidelines (APA, 2002, 2017, 2019), but also ignores the considerable heterogeneity within racial/ethnic groups. It suggests that being of a particular race or ethnicity determines which CAT is applicable, irrespective of patients' unique characteristics, experiences, and values. This misguided reduction is at odds with the aims of multicultural guidelines, which emphasize complex and heterogeneous cultural characteristics (APA, 2002, 2017, 2019). Too often, race and ethnicity are used as proxies of underlying cultural characteristics, without further scrutiny. One of the most important limitations hindering the success of many CATs is the assumption that the most clinically relevant cultural characteristics are easily inferred from a patient's race and ethnicity. Importantly, race and ethnicity often reflect values and meanings assigned to groups rather than peoples' individual meaning. Notably, several meta-analyses suggest that CATs are particularly effective when they involve a greater number of clearly defined cultural modifications that match patient characteristics (Hall et al., 2016; Smith & Trimble, 2016; Soto et al., 2018). As therapists identify the most relevant intersecting identities and cultural characteristics of their patients, they can plan treatments that more clearly fit the cultural characteristics of their patients (La Roche, 2013; Zane et al., 2005).

Although the literature has increasingly acknowledged the importance of incorporating cultural factors into case conceptualization, little guidance is offered on how best to gather cultural information and, in turn, how to incorporate it into case formulation and treatment planning (Lewis-Fernández et al., 2020; Zigarelli et al., 2016), particularly in the context of family-based CBT. Before demonstrating how the use of a supported cultural assessment tool can specifically inform case conceptualization and treatment processes, it is important to first define and review recent models of case conceptualization.

Science-Informed Case Conceptualization

It has been argued that case conceptualization (also known as case formulation) is the most important process for the competent treatment delivery of CBT in that it allows the therapist to ensure that treatment interventions and strategies are relevant to the patient's specific needs and contexts (Easden & Kazantzis, 2018). Cognitive-behavioral case formulation entails integrating data from diagnostic assessment, previous research, and patient perspective to generate hypotheses about the problems, mechanisms that cause and maintain patients' problems, origins of the mechanisms and precipitants or triggers of the current problem (Persons & Tompkins, 1997). By definition, case conceptualization provides a patient-centered framework for selecting interventions and tailoring those interventions so that they best meet the patient's needs. In family-based CBT, the therapist and family work together in developing shared goals based on the knowledge and perspective of the therapist, CBT theory, research, and patient perspectives and values. This prevents a "one size fits all" treatment approach that disregards important individual differences (Kazantzis et al., 2013).

There are plenty of examples throughout the literature of nonsystematic case formulations generated in the absence of guiding research. However, in recent years science-based guidelines for case conceptualization have been developed to help therapists systematically incorporate research into clinical decision-making in a way that ensures proper treatment tailoring to fit each patient's individual context (Barlow, 2004; Christon et al., 2015; Georgiadis et al., 2020). The ability to develop a case conceptualization informed by scientific findings is a critical therapeutic skill required in the evidence-based practice guidelines (APA, 2006), although one rarely emphasized in training programs. Importantly, despite increased focus on evidence-based guidelines for case conceptualization, this emerging literature has thus far offered little on systematic methods for the incorporation of patient cultural context (Hayes & Toarmino, 1995; Persons et al., 2007).

Most recently, Christon et al. (2015) have proposed a 5-stage model of what they term *science-informed case conceptualization*, which offers a strong model for integrating the latest evidence into case formulation and treatment planning. In the first stage of science-informed case conceptualization, the therapist integrates evidence-based assessment to identify presenting problems and casual/maintaining factors and historical factors (Stage 1). Then, the therapist reviews rating scales and relevant literature to classify diagnoses (Stage 2). Following diagnosis, hypotheses are developed regarding the relationship between problems, maintaining, and historical factors (Stage 3). Then the therapist, using relevant literature and data from the evidence-based assessment, selects the treatment plan (Stage 4). In the final stage, the therapist takes a scientific approach to developing individualized

assessment methods that can be used to test and revise hypotheses through the treatment process and to measure outcomes (Stage 5). The current science-based conceptualization model provides a strong foundation for effective treatment planning, yet currently lacks guidance for the assessment and inclusion of cultural factors into the conceptualization process.

Cultural Assessment

Although the field has witnessed a proliferation of diagnostic interviews and rating focused on identifying symptom clusters and maintaining factors, advances in the development and evaluation of cultural assessments have lagged. Despite the importance and complexity of going beyond demographic markers and assessing underlying cultural characteristics and values to inform case formulation, it has not been until relatively recently that person-centered tools for assessing clinically relevant cultural factors have emerged and undergone empirical scrutiny. Such cultural assessments examine cultural factors that may affect mental health or help-seeking and can directly inform culturally responsive treatment delivery (Hays, 2016; Zigarelli et al., 2016).

Across cultural assessments, the most well-studied and supported tool is the DSM-5 Cultural Formulation Interview (CFI; American Psychiatric Association, 2013; Lewis-Fernández et al., 2020), which was developed to assess potentially relevant patient and family cultural factors—including patients' (and their social networks') perspectives of their own cultural identity and how such perspectives might relate to mental health and help-seeking (Lewis-Fernandez et al., 2016). Specifically, the CFI is a brief 16-item semistructured interview that can be delivered in approximately 20 minutes on its own, or it can be incorporated into a diagnostic interview (see Table 1 for the main components of the CFI and DSM-5 for the full interview). The instrument assesses the patient's individual symptom experience, views of mental health, and perspectives and experiences of treatment across four key domains: (a) cultural definition of the problem, (b) cultural perceptions of cause, context, and support, (c) cultural factors affecting self-coping and past help-seeking, and (d) cultural factors affecting current help-seeking (APA, 2013). Expanding on the clinical information usually obtained in quality evidence-based assessment, the CFI elicits structured information about the cultural context of presenting problems as they relate to the patient's explanatory, coping, and help-seeking perceptions. Incorporating the CFI in pretreatment assessment can improve therapeutic alliance, patient satisfaction, and treatment engagement by helping the therapist (a) understand the broader context of presenting problems from the patient perspective, (b) appreciate and address structural/systemic barriers to care, and (c) learn about cultural strengths that can be drawn upon in treatment.

Evidence suggests that the CFI can improve medical communication, rapport, and diagnostic accuracy (Lewis-Fernández et al., 2020). In a recent RCT examining the benefits of the CFI in the context of family-based CBT, Sanchez et al. (2021) found that families

Table 1
Cultural Formulation Interview Main Components

Cultural Formulation Interview Main Components
Cultural Definition of the Problem
Definition of the problem as described by patient and explained to social network/community
Cultural Perceptions of Cause, Context, and Support
Causes as described by patient and social network/community
Stressors and supports (e.g., immigration, discrimination, lack of resources, community violence, problems with family, religion, and spirituality)
Role of cultural identity (e.g., important aspects of background or identity, challenges and strengths associated with cultural identity)
Cultural Factors Affecting Self-Coping and Past Help Seeking
Self-coping
Past help seeking (usefulness of past help seeking, e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other forms of traditional or alternative healing)
Barriers to help seeking (e.g., language, cost, discrimination, stigma)
Cultural Factors Affecting Current Help Seeking
Patient and social network therapy preferences
Clinician-patient relationship (possible concerns, e.g., structural/interpersonal racism, language barriers, communication)

randomized to receive the CFI prior to treatment reported feeling more understood by their therapist than did families simply receiving standard intake assessment, and went on to show improved treatment engagement and therapeutic response than did families solely receiving standard intake assessment. The positive CFI effects on treatment engagement and treatment response relative to standard assessment included improved treatment attendance and increased perception of being understood by the therapist, and were particularly pronounced among families receiving services in Spanish (Sanchez et al., 2021).

Moving Toward a Culturally Informed Model of Science-Based Case Conceptualization

Although most therapists agree that culture has a significant impact on the way we construe meanings, most underemphasize cultural variables in their work (La Roche, 2020). While recommendations for integrating multicultural considerations into the practice of CBT do exist (Hays, 2016), there is a lack of training and structured guidance for therapists, especially in regard to case conceptualization and treatment planning. Whereas previous models of case conceptualization do suggest incorporating cultural factors (Persons et al., 2007), they do not provide structured guidance for doing so. To address this gap, we now highlight how case conceptualization can be expanded to explicitly infuse cultural assessment and formulation throughout the entire conceptualization and treatment process.

Our *culturally informed model of science-based case conceptualization* builds directly on Christon et al. 5-stage model science-informed case conceptualization framework and incorporates the CFI (see Table 2). We organize our presentation around each of the five stages of science-informed case conceptualization and highlight strategies for improving the cultural responsiveness of care at each stage. Throughout, we illustrate key concepts and bring the content to life through presentation of material from the case of Mónica, a 17-year-old Latina female with a history of trauma.

The therapist in this case example also identified as Latina, yet from different heritage and social status. While the therapist was able to have some level of understanding of the patients' experiences and was able to communicate with her and her mother in their native language, she used cultural humility strategies to understand their experiences without assumptions of shared experiences. An important aspect of the cultural assessment is to acknowledge differences in cultural background and demonstrate willingness to understand patients' perspectives, experiences, and values. Moreover, APA's multicultural guidelines (APA, 2017) explicitly include the need to focus on both the therapist and the patient as cultural beings who hold multiple intersecting identities that affect experiences of privilege and power, and consider how they influence the conceptualization and treatment process.

Conceptualization Stage 1

The goals of the first stage of science-informed case conceptualization are to identify the presenting problem(s), list the presenting problems in terms of treatment priority, and to begin the process of collecting information on the factors that serve to cause or maintain those presenting problems (Christon et al., 2015). When considering which assessment tools to use to understand symptomatology, it is important to ensure that the tool is normed for youth from diverse backgrounds. Because many of the evidence-based assessment tools utilized were developed among middle- to upper-income Non-Hispanic White populations, they often fail to measure the same constructs in cultural minority populations (Reynolds & Suzuki, 2012).

We argue the necessity of including cultural assessment to supplement evidence-based diagnostic tools, to create a culturally informed case conceptualization and treatment plan and better meet the needs of our families. Conducting a cultural assessment as part of Stage 1 may not only improve the therapists' understanding of the family's presenting problems but can also demonstrate from the beginning of treatment that their perspectives are valued and that they play an equally important role in developing the treatment plan. Moreover, asking a patient about their cultural values, identification(s), and strengths demonstrates to patients that the therapist values their unique experiences and views. This can ameliorate the common power dynamics found in evidence-based practices that suggest the therapist is *the* expert, by acknowledging the therapists expertice while respecting the patient as the expert of their own experiences.

Although the CFI was developed to be delivered in full prior to diagnostic assessment, recent guidelines have acknowledged that flexibly delivering the CFI in parts or interwoven in a clinical interview may be just as beneficial (Lewis-Fernández et al., 2020). For the current case, the CFI was delivered in full during the intake sessions, however, information from the CFI is presented throughout the five case conceptualization stages, in the stage where it is most relevant.

Case Illustration

Mónica is a 17-year-old Latina adolescent living with her mother (Ms. Flores) and her sister-in-law in a metropolitan city in the southwest region of the United

Table 2
Culturally Informed Case Conceptualization

Original Science-Based Case Conceptualization	Culturally Informed Case Conceptualization

Stage 1
Identify and quantify presenting problems, causal/maintaining factors, and historical/contextual factors
• Administer broad and specific symptom rating scales, standardized clinical interviews, and idiographic tools to identify presenting problems
	Stage 1
	Identify and quantify presenting problems, causal/maintaining factors, and historical/contextual factors
	• Administer broad and specific symptom rating scales **(normed for specific patient population and background)**, standardized clinical interviews, and idiographic tools to identify presenting problems
	• Identify and quantify presenting problems
	  • **CFI 1: What is patient's/caregiver's description of their problem?**
	  • **CFI 2: How does patient/caregiver describe their problem to their family or community?**
	  • **CFI 3: What troubles the patient/caregiver most about their problem?**
	• Causal/maintaining factors
	  • **CFI 4: What does the patient/caregiver think is causing their problem?**
	• Historical/Contextual factors
	  • **CFI 8: What are the most important aspects of the patient's/caregiver's identity?**

Stage 2
Assign diagnoses
• Review results of rating scales and standardized clinical interviews
• Consider following the evidence-based medicine approach to diagnosis
	Stage 2
	Assign diagnoses
	• Review results of rating scales and standardized clinical interviews
	  • **Review cultural definition of the problem (CFI 1-3)**
	• Consider following the evidence-based medicine approach to diagnosis
	  • **Review the literature for potential cultural phenomenon that may better explain presenting problem**
	  • **Review DSM 5 cultural contexts of distress**

Stage 3
Develop initial case conceptualization
• Develop specific hypotheses about connections between variables
• Complete Figural Drawings
	Stage 3
	Develop initial case conceptualization
	• Develop specific hypotheses about connections between variables
	  • **Review cultural definitions of the problem (CFI 1-3)**
	  • **CFI 4: What does the patient/caregiver think is causing their problem?**
	  • **CFI 5: What do others in their family/community think is causing the problem?**
	  • **CFI 7: Are there stressors that make the patient's problem worse?**
	  • **CFI 9: Are there aspects of the patient's/caregiver's background that make a difference to their problem?**
	  • **CFI 10: Are there aspects of patient's/caregiver's background that are causing other difficulties for them?**

(*continued on next page*)

Table 2 (*continued*)

Original Science-Based Case Conceptualization	Culturally Informed Case Conceptualization
	• Complete figural drawings of relationships between variables • **Infuse cultural factors gathered from CFI**

Stage 4
Proceed with treatment plan and selection
• Consult treatment outcome studies and online searchable databases of treatments.
	Stage 4
	Proceed with treatment plan and selection
	• Consult treatment outcome studies and online searchable databases of treatments
	  • **Share treatment options with patient and collaboratively develop the treatment plan**
	• **Review CFI 1-10**
	• **CFI 6: Are there any kinds of supports that make the patient's problem better?**
	• **CFI 11: What has the patient/caregiver done to cope with the problem?**
	• **CFI 12: What types of help have been most and least useful to the patient/caregiver?**
	• **CFI 13: Has anything prevented the patient/caregiver from getting the help they needed?**
	• **CFI 14: What kinds of help does the patient/caregiver think would be most useful now?**
	• **CFI 15: Are there other kinds of help that others have suggested would be helpful for the patient?**
	• **CFI 16: Has the patient/caregiver had difficult experiences with current or previous providers?**
	• **Consider potential tailoring of EBT:**
	  • **Review evidence for treatment adaptations for patient population**
	  • **Review CFI of develop person-centered adaptations or augmentations to treatment**

Stage 5 Monitor and evaluate treatment outcomes and revise case conceptualization as necessary • Administer specific symptom rating scales • Conduct in session mood check-ups • Ask client to engage in self-monitoring • Engage in behavioral observations • Track outcomes according to patient defined top problems • Integrate data using clinical dashboards or graphing • At termination, re-administer broad symptom rating scales to confirm progress	**Stage 5** Monitor and evaluate treatment outcomes and revise case conceptualization as necessary • Administer specific symptom rating scales • Conduct in session mood check-ups • Ask client to engage in self-monitoring • Engage in behavioral observations • Track outcomes according to patient defined top problems • Integrate data using clinical dashboards or graphing • At termination, re-administer broad symptom rating scales to confirm progress • **Continue discussing issues that arise related to one's cultural context and identities, incorporating cultural strengths, and working on value consistent treatment goals** • **Repeatedly assess treatment experiences and satisfaction**

Note. Added cultural items are in bold. Based on Christon et al. (2015) science-based model.

States. She presented to the clinic due to a recent suicide attempt (overdosing on pain medication), traumatic stress symptoms related to a sexual assault one and a half years prior to the intake, and a history of anxiety. Mónica is the youngest of three children with two older brothers who do not live in the home. Ms. Flores was born and raised in Peru and her father (who lives in the same city but is separated from her mother) was born in Mexico. Both parents are Spanish-speaking only. Ms. Flores is a janitor at a local hospital.

Mónica and her mother arrived on time to their intake session, and both presented as well kept and alert. During their joint time with the therapist, Mónica and her mother made almost no eye contact with one another and sat several feet apart. Mónica appeared particularly reserved. She would respond to her mother and the therapist with one word or short sentence answers. Furthermore, although fluent in Spanish, she would respond in English to her mother's questions. She would do the same when speaking with the therapist.

The therapist integrated evidence-based assessment to identify presenting problems, casual/maintaining factors, and historical factors. To assess Mónica's presenting problems, the therapist conducted a semistructured diagnostic interview and then administered several evidence-based assessment tools, including the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001) to assess overall internalizing and externalizing problems, the Revised Children's Anxiety and Depression Scale (RCADS; Chorpita et al., 2000) to specifically assess mood and anxiety problems, and the UCLA PTSD Reaction Index (RI; Steinberg et al., 2004) to assess PTSD symptoms associated with the sexual assault.

Additionally, the therapist administered the CFI to better understand cultural factors affecting Mónica and her family. Mónica and Ms. Flores met together with the therapist briefly to validate their coming into therapy together, to discuss the plan for the first session, and to review confidentiality. Given Mónica's age and her reticence to speak with her mother in the room, separate clinical interviews were conducted with Mónica and with Ms. Flores. First, the CFI was used to assess Mónica's and her mother's cultural definitions of the problem.

When asked to describe the "problem" from their perspectives (CFI 1-3: presenting problem), Ms. Flores noted, "Mónica is almost an adult and she can't be responsible for herself, I have to be on top of her about everything, school, chores, smoking/drinking." Ms. Flores went further to explain that Mónica's issue is her "*falta de respeto*" and that Mónica does not respect her mother enough to help out at the house (CFI 1-2: presenting problem). *Respeto* is a cultural value endorsed by many people in the Latinx community, in which it is expected that children will obey and defer to their elders (Falicov, 2014). Ms. Flores noted being most concerned that Mónica is almost an adult and she cannot take care of herself, all she does is stay in her room (CFI 3: presenting problem).

In contrast, Mónica described her problem as being "mentally unhealthy and lonely." She noted that she has a lot of sad thoughts, and often does not feel like getting out of bed. When asked how she described her problem to others, she noted that she does not talk about how she feels with anyone else because she does not have anyone who understands her or who will listen, and that she will just get into trouble if she tries to talk to her mother (CFI 2: presenting problem). When asked about the worst part of feeling "mentally unhealthy and lonely," Mónica noted that she felt lonely without her mother to talk to and felt guilty for letting her family down by not doing well in school and by not always following the rules (CFI 3: presenting problem).

After asking about the "problem" in the first CFI question the therapist used the family's language throughout the rest of the interview. For example, the therapist was sure to refer throughout to issues of "*respeto*" and "obedience" and Mónica "feeling mentally unhealthy and lonely," rather than introducing any distracting jargon, such as "oppositionality" and "depression." This was imperative for demonstrating that the therapist was listening closely and understanding the family and what is important to them.

The role of cultural identity was assessed to provide more information regarding how their cultural identities affected or could be related to Mónica's main problems (CFI 8: contextual factor). Ms. Flores reported that her Peruvian heritage and her family were a central aspect of her identity. Mónica reported that the most important aspect of her identity was her family. This emphasis on family relationships is consistent with Latinos' reported high levels of *familismo* (Falicov, 2014; La Roche, 1999), which is defined as a cultural value that involves strong attachments to family members and a tendency to devalue outside relationships. The current presenting problems could be understood in the context of family values.

Throughout the clinical interview Mónica discussed the history of her presenting problems and reported a history of social worries since middle school (historical factor). She noted a history of feeling sad and down since the end of middle school, but shared that "it got much worse in the past year after the bad thing happened" (presenting problem, contextual factors). She noted the first time she engaged in self-harm

behaviors was after getting in trouble with her mom for smoking marijuana at school (presenting problem). She reported three instances of past self-harm and a recent suicide attempt. She was able to share that she would cut herself when she felt overwhelmed by her emotions, especially after arguments with her mother. Ms. Flores reported that when Mónica is upset that she tries to hold her emotions in (causal factors).

Mónica noted that she has always had difficulty sharing her emotions with her family because she feels like they won't understand her and will tell her to let it go, or focus on school. In addition, she worries that she will get into trouble because her mom is very strict (contextual factors). She explains that she smokes "weed" with friends or others because it helps her feel calmer and less worried (maintaining factor). She often thinks that she has let her family down and that they no longer trust her, particularly after the sexual assault she experienced during a party she had at her house (causal factor). During these moments, which can last over 2 hours and can be as frequent as every day, she feels extremely alone, depressed, and lacks interest in most activities. Furthermore, often she cannot sleep and has no appetite. Mónica added that when she felt sad, she would just sit alone in her room, or smoke weed to feel numb.

Mónica noted that her social worries started in middle school, that she felt nervous talking to people and would constantly worry about what others were thinking of her. Often, she feared that they were watching her and would think she was dumb. She noted it being hard to make friends and that she would do whatever her friends wanted so that they would like her. She reported continued social worries currently and added that it makes her feel uncomfortable to participate in class or ask for help from the teacher when she needs it. Furthermore, she reported that it is difficult to talk to anyone about her emotions because she worries they will judge her. She also shared that she sometimes does things that she does not want to because she does not want to say no to her friends.

Mónica is, however, aware of how her anxiety and depressive symptoms exacerbated after being sexually assaulted and consistently refers to it as "the bad thing that happened." Since this event, Mónica's relationship with her mother had worsened and her feelings of guilt around letting her family down had increased. Studies have consistently found that Latinx teenagers who come from families with high levels of *familismo* and traditional gender roles are at higher risk of suicide after their first sexual encounter. Losing one's virginity could be viewed as a *falta de respeto* to the whole family (Zayas et al., 2005). Mónica reported having frequent flashbacks and constantly replaying what happened to her. The flashbacks or memories and feelings of isolation prompted her first and only suicide attempt a month prior to the intake. She noted that she has not hurt herself since this attempt but did report more passive SI. When asked about her most important reason for living, she indicated her family. Nevertheless, thinking about her family also made her feel worthless and bad as she had profoundly shamed them.

In assessing for top problems Mónica and Ms. Flores continued having difficulty communicating with each other, making little eye contact, and remaining physically distant from one another, but with support from the therapist were able to agree on the following top problems:

1. Family problems (i.e., Mom: "she lacks respect and discipline"; Mónica: "mom doesn't trust me")
2. Dealing with emotions (Mom: "she holds in her emotions too much"; Mónica: "I don't feel mentally healthy, I get stuck feeling sad")
3. Problems with school (Mom: "She has to graduate school so she can be successful on her own"; Mónica: "I want to be able to pass my classes this semester and graduate but I am having a hard time keeping up")

Responses to items 1–3 and 8 of the CFI helped the therapist to think beyond the symptom presentation and embed the challenges within a cultural context that emphasized *familismo* and *respeto*.

Case Conceptualization Stage 2

While there has been growing support for the utility of incorporating cultural assessment as part of standard practice, cultural assessment, by itself, is not sufficient for improving the cultural responsiveness of care. The therapist must be able to meaningfully integrate gathered cultural knowledge into subsequent stages of case conceptualization and treatment planning (Sue & Zane, 1987). The second stage of science-informed case conceptualization is generating and assigning diagnoses (Christon et al., 2015). Here the therapist reviews the results of established rating scales, idiographic tools, and clinical interviews. Diagnoses are a critical part of case conceptualization, as they can begin to facilitate hypotheses and directly inform treatment selection. However, it is important to note that mental health diagnoses were largely developed within a Western individualistic framework, one that centers the Western White experience as being the basis of our understanding of mental health diagnoses.

Although science-informed case conceptualization generally incorporates causal, maintaining, and historical factors, specific factors relating to cultural context

are absent. Cultural context and information is critical for shedding light on the manifestation of mental health difficulties and contextualizing mental health symptoms and experiences to determine whether assigning a diagnosis is appropriate. Importantly, taking into consideration cultural context can help therapists distinguish behavior and thoughts that may be protective, or normative in certain contexts and requiring treatment in others (Liang et al., 2016). For example, elevated threat perceptions and fear of harm might not be indicative of an anxiety disorder if indeed one lives in a neighborhood with high rates of community violence. In some instances, what may be labeled or diagnosed as "oppositional" or "conduct disordered" behavior may actually represent positive survival mechanisms and adaptive resilience. Misinterpretation can lead to harmful misdiagnosis, such as Black and Latinx youth being overdiagnosed with externalizing disorders and psychotic disorders and underdiagnosed with depression and anxiety (Bailey et al., 2019; Liang et al., 2016). This misdiagnosis can lead to inappropriate and ineffective care (e.g., overpathologizing, lack of necessary care). Therapist racial bias and lack of awareness of cultural context and structural factors (housing/food insecurity, community violence, discrimination) play a crucial role in misdiagnoses of mental health disorders. Examining our own racial biases, the biases inherent in the diagnostic system, and conducting thorough cultural assessment (rather than making assumptions) can therefore lead to more accurate diagnoses.

Additionally, research has demonstrated that youth from different cultural backgrounds often communicate and experience symptoms differently (Liang et al., 2016). We recommend therapists familiarize themselves with cross-cultural variations in the presentation of mental illness as well as cultural concepts of distress found in the DSM-5 (APA, 2013). Different ethnic groups have been found to hold concepts of distress that differ from typical DSM diagnoses; for example, *Shenjing shuairuo* is a form of distress reported by some Chinese communities that is characterized by "physical and mental fatigue, headaches, difficulty concentrating, dizziness, sleep disturbance, and memory loss" (APA, 2013). Other cultural concepts of distress include *ataque de nervios* (e.g., feeling out of control, intense emotional upset, screaming and crying) in Latin American, Mediterranean, and Caribbean communities, and *Taijin kyofusho* (e.g., fear of interpersonal relationships, fear of displeasing other) in Japanese communities.

That said, while it is helpful to have some general knowledge related to different group-based norms across cultures, it is always critical to understand the problem from the patient and family's perspective, rather than assuming an individual ascribes to the same beliefs as the therapist or as others in their racial/ethnic group (Hall et al., 2016: La Roche, 2020). Therefore, employing cultural assessment such as the CFI with a cultural humility framework is imperative to develop accurate diagnoses.

Case Illustration

Mónica and her mother reported clinically elevated scores of anxiety and depression and clinically significant PTSD as measured on the CBCL, RCADS, and UCLA PTSD RI. Ms. Flores also reported Mónica's behavior as problematic and rated significant conduct problems. Several interacting cultural identities, for example, values of *respeto*, Mónica's gender, and their context (the fact that they lived in a neighborhood with high rates of violent crime), likely influenced Ms. Flores' reporting of conduct problems. Mónica also reported lying and engaging in risky behaviors that are often indicative of conduct problems. However, by understanding Mónica's tendency to avoid conflict and expressising strong emotions with her familiyand to engage in substance use to cope with feelings of anxiety and depression her therapist hypothesized that Mónica's anxiety was a better explanation for the conduct problems. Therefore, based on information gathered from Stage 1, Mónica's therapist carefully reviewed DSM-5 (APA, 2013) criteria, cross-cultural considerations, and rule-outs and assigned Mónica diagnoses of social anxiety disorder, major depressive disorder, and posttraumatic stress disorder.

Case Conceptualization Stage 3

The third stage of science-informed case conceptualization (Christon et al., 2015) entails making hypotheses regarding the relationship between causal and maintaining factors and the patient's main problems. For example, if a 5-year-old child meets diagnostic criteria for obsessive-compulsive disorder, the therapist may start to consider a cognitive-behavioral model of OCD—i.e., that the child's compulsions are functioning through negative reinforcement to help the child avoid distress and uncomfortable feelings, and that at this age it is likely that the child's parents may be playing instrumental roles assisting in the child's rituals and modifying their own routines to alleviate the child's distress through family accommodation patterns (Chou et al., 2017).

Importantly, hypotheses should be flexible and poised to shift as new information is gained throughout treatment. Christon et al. (2015) recommend framing the presenting problems identified in Stage 1 as

dependent variables, and mapping out how the identified historical, causal, and maintaining factors may be serving as independent variables that influence these dependent variables. Conceptualizing the pattern of factors in this manner affords the opportunity to use treatment to systematically test and refine hypothesized relationships in an iterative fashion. Christon et al. (2015) discuss the importance of the therapist sharing their hypotheses with the patient or family. Not only does this offer key opportunities for model refinement, but this process fosters mutual engagement and a respectful and collaborative working relationship with the patient and their family.

In our present focus on culturally informed case conceptualization, hypotheses about causal and maintaining factors should explicitly consider the family's cultural definition of the problem; families are encouraged to identify the presenting problems that, in their own words, influence the patient's mental health. CFI items 4 and 5 are about the patient's own conceptualization of their problem from their and their family's/-social network's point of view. Families often have different ways of understanding the cause of their child's mental health problem. One study assessing parental beliefs regarding the cause of mental health difficulties by race/ethnicity found that ethnic minority parents were less likely to endorse biopsychosocial beliefs as causes for mental health problems than Non-Hispanic White parents (Yeh et al., 2004). African American or Black parents were more likely to attribute causes to physical causes and prejudice than Latinx parents, while Latinx families were more likely to endorse family problems and trauma than were Asian Americans. Additionally, Asian Americans were more likely than Latinx and Black parents to say their child's mental health problems were due to American culture (Yeh et al, 2004). These beliefs about the cause of mental health problems can affect service engagement and utilization, especially if there is a mismatch between parental beliefs and the therapy being delivered (Yeh et al., 2005). By incorporating families' own perceptions of cause, the conceptualization and treatment planning can be more congruent and could lead to better engagement. In fact, adapting treatment to fit the family's explanation of illness was found to moderate effects of CATs. The congruence of family and therapist views of the mental health difficulty is predictive of better engagement and improved treatment outcomes (Benish et al., 2011).

When asking questions about the difficulties families experience related to their background (CFI Item 10), as well as other stressors than have made their problem more difficult (CFI 7 & 9), the CFI aids in prompting for therapeutic challenges such as discrimination, issues with immigration, acculturative stress, logistical barriers, and/or housing or food insecurity. With this information we are able to consider the structural issues that are often faced by cultural minority families and the ways in which systemic and structural racism has impacted their lives and experiences with mental health. Having this information may allow the therapist to understand maintaining or causal factors that are out of the family's control and develop treatment strategies that can address or directly target external stressors that likely influence their mental health (Graham-LoPresti et al., 2017).

Overall, understanding the family's perceptions and incorporating them into the case conceptualization is critical for developing rapport, supporting engagement, and the delivery of a person-centered treatment plan. The conceptualization for the current case example is represented in a figural drawing separating factors into historical/contextual, causal, maintaining, presenting problems and maintaining factors, starting with the presenting problems (see Figure 1). Mapping out the relationship between multiple clinical variables can help to visualize the overall conceptualization and determine possible places to intervene. This map is a starting place and will continue to change throughout treatment. As you will see in Mónica's case conceptualization map, family conflict is both a presenting problem and a maintaining factor interrelated with the other presenting problems. Making the case conceptualization figure helped us to see clearly the importance of focusing on CBT strategies that would ameliorate family conflict.

Case Illustration

Mónica and Ms. Flores were asked to share their own perspectives of why their problems were happening, or what caused them (CFI 4 & 5: causal factor). Ms. Flores noted that Mónica does not take responsibility for her actions, and instead lies or keeps things from her (causal factor). She also noted that Mónica's father also thinks she is irresponsible and that is why she is not doing well in school. Mónica noted that the struggles with her family, in regard to her mother and father distrusting her, has caused her to feel sad and guilty (causal factor). She also added that "the bad thing that happened" has made her feel more alone because she has no one to talk to (causal factor). She reported that her parents believe that her problems are caused by her being irresponsible (e.g.,"they tell me often ... they think I do not value our family and that I'm being disrespectful"). Mónica and Ms. Flores' perceptions of the cause of the problem are important to include in the case conceptualization and will be included in the full case conceptualization below (see Figure 1).

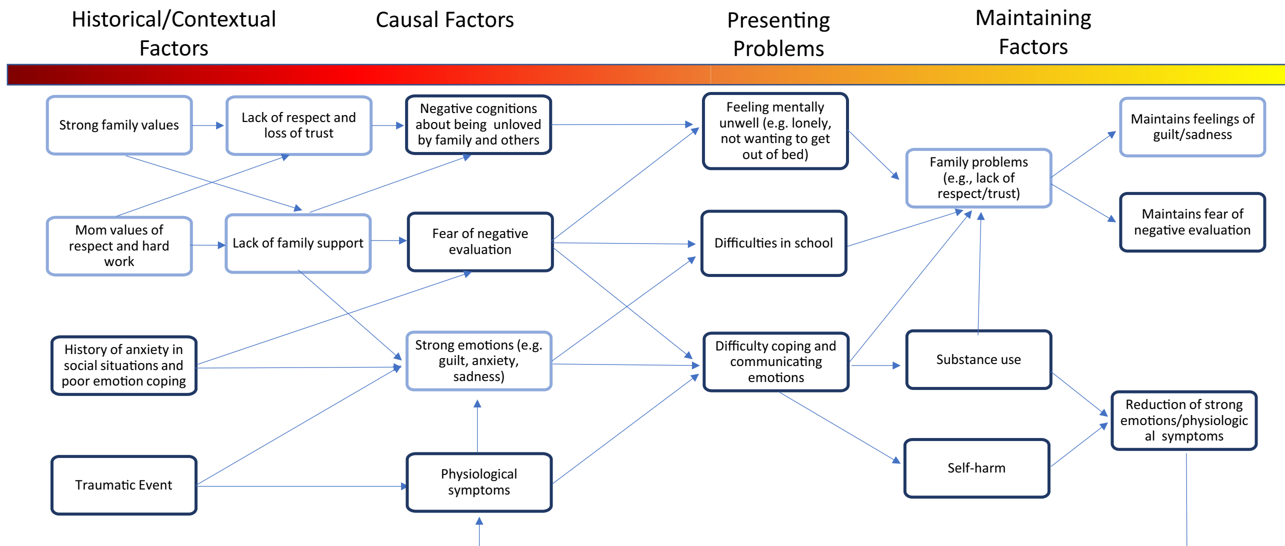

Figure 1. *Figural Drawing of Mónica's Case Conceptualization. Note.* Lighter boxes represent culturally specific factors gathered from the CFI, however all factors were assessed from the family's perspective. Based on Christon et al. (2015) science-based model figural drawing.

Mónica has a history of early behavioral inhibition and anxiety in social situations (historical factors). Both Mónica and her mother reported that she has difficulty coping with strong emotions and tends to keep things inside (historical/causal factor). Mónica is afraid of negative evaluation or judgment from her family (causal factor). Because she holds such strong family values, her parents' lack of support for her in times of distress leads her to have negative cognitions related to being alone and unloved (causal/maintaining factor). It is also after this conflict with her mother that she has engaged in cutting. Moreover, her mother's cultural beliefs related to the importance of family, responsibility and hard work, lead her to reprimand Mónica when she has been dishonest about smoking marijuana and about her difficulties in school. Her mother sees Mónica's lying as *falta de respeto*, or lack of respect, and has suggested that this is the cause of Mónica's problems (causal factor). It also leads her to be frustrated with Mónica when she does not help around the house and stays in her room. Ms. Flores noted that her problem (her frustration with Mónica not being responsible for herself) is made worse because she works a lot and feels like she has to support her family financially and does not have any help. She also reported that working late hours at the hospital adds to her stress (CFI 7, 9, 10: cultural perception of stressors). Her mother's lack of trust in her in regard to being truthful and upholding her responsibilities in the home led Mónica to have strong feelings of guilt and sadness (causal factor). Mónica, as we have previously discussed, describes her problem of being "mentally unhealthy" as being caused by her mother not trusting her and by feeling guilty for lying to her mother and losing her virginity. These conflicts led Mónica to continue feeling guilty and having negative beliefs about her family not loving her, and being worthless (maintaining factor). She noted that when her parents get angry at her for doing badly at school or for doing something wrong that it makes her feel more guilty (CFI 7, 9, 10: cultural perception of stressors; maintaining factor). Mónica's worries about what others will think of her (causal factor) lead her to avoid challenging social situations, like participating in class, attending class, and resisting peer pressure (presenting problem).

Additionally, the physical sensations, flashbacks, and guilt associated with the sexual assault create significant emotional and physiological distress (causal factor). Mónica feels like she is unable to talk with her family because they are angry at her for being irresponsible and putting herself in an unsafe situation. Her worries about her family being disappointed with her, and her inability to cope with strong emotions, cause her to use unsafe methods such as cutting and consuming alcohol to cope with her feelings of anxiety and depression as well as the guilt and loneliness she feels regarding her family (presenting problem). Mónica shared that "I would smoke just to get away from my feelings, to feel numb" (maintaining factor). Because family is also a central component of Mónica's identity, her relationship with her family is both a primary problem and maintaining factor. Mónica's negative cognitions about her family not trusting her, and about

the assault being her fault because she was irresponsible, led to extreme feelings of guilt for "letting down" her family (causal factor). Mónica's mother also unintentionally maintains Mónica's anxiety and fear of negative evaluation, by reprimanding her and expressing her disapproval rather than providing emotional support (maintaining factor). Finally, her NSSI reflected poor coping skills and was a means of escape from distress caused by her persistent physiological arousal and depression (presenting problem).

Without considering cultural factors and the family's perspective, we may have underscored her symptoms of anxiety and depression, which may have led us to pathologize her family for not supporting her sufficiently and not understanding them. Importantly, the case conceptualization was reviewed with the family and refined throughout the assessment and treatment process. In this conversation a broader understanding of Mónica's family understanding of family and respect was gleaned and incorporated into the case formulation. Additionally, multiple aspects of the family's context and cultural identity are interacting to influence their experiences of mental health and family functioning. Levels of acculturation and the differences and similarities between Mónica and Ms. Flores' perspectives were explored throughout the case-conceptualization treatment process.

Case Conceptualization Stage 4

The fourth stage of science-informed case conceptualization has the therapist working to create treatment goals and a collaborative treatment plan (Christon et al., 2015). Mutually prioritized presenting problems are now linked with clear and specific treatment goals in which the hypothesized dependent variables (i.e., presenting problems) are framed as tangibly improved—e.g., the child will have three fewer explosive meltdowns per week (for a child with behavior problems); the child will initiate conversations with peers at least one time each day (for a child with an anxiety disorder). A mutually agreed upon treatment plan then targets hypothesized causal and maintaining factors with the anticipation that these actions will, in turn, result in progress toward reaching the concrete treatment goals. The science-informed therapist weighs the research literature heavily when making treatment decisions.

Leading case conceptualization models rarely highlight the importance of considering how cultural factors can guide the precise framing of goals (Sue et al., 2009). In addition, cultural values around mental health and prior history with help-seeking can inform the framing of treatment goals and can influence the likelihood of success with a particular treatment plan (Hays, 2009). Studies have consistently found that when clinicians follow patients' treatment goals, treatment engagement, adherence, and outcomes increase (Smith & Trimble, 2016). Goals and treatment plans that are exclusively oriented around child behavior may be a poor fit if the family's values center around interdependence across relationships and hold more collectivist beliefs (i.e., emphasize the needs/desires of a group as a whole above the needs/desires of the individual). At the same time, goals and treatment plans that are exclusively oriented around parent behavior may be a poor fit if the family particularly values child independence and autonomy and holds more individualistic beliefs (La Roche, 2013).

As previously discussed, evidence-based treatments have been primarily developed and tested with White Non-Hispanic youth within a Western individualistic framework and do not typically provide guidance for the alignment of treatment strategies with family cultural context. Importantly, youth from cultural minority backgrounds may not benefit from the same treatment strategies as those from the majority culture. For example, for youth with PTSD who have been and continue to be exposed to community violence, what some may consider hypervigilance, or heightened physiological reactions, maybe actually be protective. Therefore exposures (which would traditionally be used to address hypervigilance) may actually be counterindicated (Gaylord-Harden et al., 2017). Additionally, it is important to consider how CBT strategies such as cognitive restructuring can be tailored to address racism and discrimination experienced by cultural minority youth. Graham-LoPresti et al. (2017) present a useful case example of conducting exposures to directly target experiences with discrimination for marginalized youth with social anxiety, including focusing cognitive restructuring on the internalization of discrimination, rather than on the validity of these experiences in the patient's life.

To improve the cultural responsivity of mental health services, it is important to consider not only risk factors but also the unique strengths and resiliency factors held by cultural minority communities. For example, for American Indian (AI) youth, interventions are more effective when they focus on recognizing and promoting AI cultural values, traditional practices, and cultural identity development (Walls et al., 2006). Moreover, ethnic-racial socialization is an important clinical strategy that has also been found to promote positive development and buffer negative mental health effects for multiple cultural minority groups, and especially for Black youth (Anderson et al., 2019; Neblett et al., 2010; Wang et al., 2020).

With regard to other treatment components such as safety planning and safety contracting, therapists must determine cultural and structural factors at play for families of different racial backgrounds. It is especially important to consider repercussions of recommending that families call 911 due to the danger this can pose to youth and their families. Just recently in West Philadelphia a young Black man, Walter Wallace Jr., was killed by police after his family called for help while he was experiencing a mental health crisis. Additionally, for immigrant families, calling 911 for mental health difficulties may be problematic due to deportation concerns. These potential issues must be discussed at the beginning of treatment so that a thoughtful, and more importantly, *safe* safety plan is developed. Many communities have alternative crisis services with personnel trained to support people with mental health difficulties that sould be employed as part of a safety plan. It is important for therapists to work with patients and families to develop a plan that fits their needs and context.

Further, cultural minority families often receive poorer quality of care (across all health care) relative to Non-Hispanic White patients. Minoritized families have historically been mistreated by medical institutions, which has, in many instances, cultivated institutional mistrust. Poor prior experiences in treatment may help inform current treatment plans and allow the therapist to address potential barriers before they become problematic. For example, a family's prior treatment may have failed due to the therapist failing to understand the family's needs or patient's feeling blamed or talked down to. Feeling misunderstood is a key predictor of dropping out of treatment prematurely for cultural minority families (Smith & Trimble, 2016; Sue & Zane, 1987). Cultural assessment overall, and especially its incorporation into treatment planning, can ensure families feel safe during the treatment process and understood by their therapist (Sanchez et al., 2021). Additionally, by starting a conversation with families about their experiences with structural racism (CFI 7, 9 or 10), or negative experiences with providers (CFI 16), one can begin to shift the inherent power dynamic and allow for families to know the therapist is willing to have difficult conversations and validate their experiences.

When developing a treatment plan and selecting a course of care, strategies and treatment programs with considerable research support should be prioritized (Southam-Gerow & Prinstein, 2014). We also recommended specifically including searches on cultural adaptations. For many cultural minority families, CATs that underscore the importance of family and *respeto* will be particularly important to consider. It is also possible that although a particular evidence-based treatment has not been culturally adapted, its standard format has been evaluated in a sample with comparable cultural characteristics to a given patient and has shown success. One should not assume that CATs are always preferred over standard treatment programs. The most important factor is that the best research evidence available is always considered. As noted, however, research supporting treatment outcomes in diverse and representative samples has lagged behind supporting evidence for various treatments in nonminority populations (Pina et al., 2019). The best evidence may offer very little for a given case. Importantly, any research information gathered should then be reviewed with the family to make a collaborative plan, with all parties understanding that outcomes in the research literature reflect group norms and may not reflect their own outcomes. All CFI items should be reviewed in order to create a culturally responsive case conceptualization; however, item 6 and items 11–16, which relate to coping and past and current help-seeking perceptions, may be particularly informative at the treatment planning stage.

Case Illustration

The therapist worked with Mónica and her mother to develop a set of prioritized treatment goals. Collaboratively the following goals were developed: “Get better at dealing with emotions and talking about them,” as evidenced by a reduction in self-harm and substance use, more frequent use of positive coping; “Help mom trusts me/Help Mónica become more responsible,” as evidence by increased rule following at home and more frequent communication about school tasks; and “Do better in school,” as evidenced by passing her classes, being able to ask for help.

Mónica and her mother's perceptions of past and current help seeking were discussed (CFI items 12-16). Ms. Flores shared that Mónica's father recommended to talk to her pastor but that she does not like to share her family's business so has not talked with anyone outside of the family. She reported that the last therapy Mónica attended at school did not help because Mónica did not open up to the therapist. Ms. Flores also shared that she had some difficulties with the inpatient hospital that recommended medication to Mónica. She shared that they did not listen to her or respect her concerns. Ms. Flores shared that what she wanted out of therapy now was for Mónica to have someone to talk to so that she does not have to keep her feelings inside. She also reported wanting help with teaching Mónica to be more responsible. Mónica

shared that for her current therapy she wanted help to be able to deal with her emotions so that she did not feel so overwhelmed by them and to be able to better communicate how she feels. Keeping in mind Mónica and Ms. Flores' past experiences and perceptions of therapy can help them feel heard and like active members of their treatment team, especially when they have had instances with other therapists when they felt like their ideas were not valued.

Ms. Flores reported that therapy has been difficult for them because she cannot take time off of work and she does not want Mónica missing any school (CFI 16). She requested medical documentation for her job in case she has to take time off to bring Mónica to therapy, as well as medical documentation for Mónica's school. These structural barriers were addressed prior to the start of treatment. The therapist communicated with the school and provided a note to excuse her from school. Additionally, the sessions were conducted on the only day Mónica's mother had off of work so that she was able to attend.

Additionally, from items 12-16 of the CFI, Mónica reported that she went to one other therapist at school but she did not feel comfortable talking to her because she told her mother things that Mónica did not want share. To address this previous concern, the therapist spoke to Mónica and her mother upfront about only sharing information with her mother if it concerned imminent danger, or if Mónica agreed to it, but otherwise, respecting Mónica's privacy.

The therapist was familiar with the extensive research support for trauma-focused CBT (i.e., TF-CBT; Jensen et al., 2014) for adolescents with traumatic stress problems and related depression (Huey & Polo, 2008), and noted that the literature had examples of TF-CBT yielding positive outcomes in Latinx samples (e.g., Allison & Ferreira, 2017; Huey & Polo, 2008; de Arellano et al., 2012). The therapist discussed the TF-CBT program with Mónica and her mother, including its focus on building coping skills, challenging the adolescent to engage in more pleasurable activities, and directly involving the whole family. The basic components of TF-CFT were reviewd— PRACTICE: Psychoeducation, Relaxation, Affect regulation, Cognitive processing skills, Trauma narrative, In-vivo mastery of trauma reminders, Conjoint child-parent sessions, and Enhancing safety. Mónica and her mother asked various questions about the model and agreed that this sounded like a good course of treatment.

Treatment followed the TF-CBT model, with the inclusion of additional coping skills, behavioral activation, and a strong focus on family communication and involvement. Due to a previous suicide attempt and current suicidal ideation, a safety plan was conducted with the family. Mónica and Ms. Flores agreed that if Mónica was feeling suicidal Ms. Flores would sit with her. Mónica would not have to say anything for a while and Ms. Flores would just be with her. Mónica also included spending time with her nephews as a positive distraction on her safety plan. The family also agreed to take Mónica to the hospital if she felt she could not be safe.

Treatment began with psychoeducation to help Mónica and her mother understand anxiety, depression, and the common effects of trauma in regard to emotional experiences, behaviors, and cognitions. Psychoeducation is an important opportunity to discuss symptoms in the patient's own words and connect the CBT model to their understanding of causes, symptom expression, and main problems/goals. It was helpful for Mónica's mother to begin to understand how her mental health difficulties were, in part, contributing to Mónica's "disrespectful behavior," and how symptoms influence family functioning and vice versa.

All parties agreed that improving Mónica's coping skills and her ability to tolerate her anxiety was an important first step in regard to her safety and to making improvements on her top problems. Additionally, it was also agreed that being able to understand and communicate her emotions could also influence her ability to demonstrate to her family that she can be responsible (e.g., school attendance) and could allow her to communicate with her family and share her needs with them. Mónica's mother was also supported in being able to identify her thoughts/feelings/behaviors and communicate them with Mónica. It was essential that Mónica's mother receive supported with expressing her needs and expectations to Mónica in a helpful way. When considering cognitive distortions, the therapist took into consideration that while some of Mónica's negative cognitions contained distortions ("no one loves me"), some of her negative cognitions were consistent with how she was being treated at home ("my mother is disappointed in me") and needed to be addressed with coping skills, psychoeducation for Ms. Flores, and family communication, rather than cognitive restructuring.

Due to her lack of current family support and validation, it was imperative that Ms. Flores learn how to validate and support her daughter while communicating her own needs. Because of the importance given to family, it was more important to understand symptoms and treatment strategies in relation to building trust and communication between herself and her mother rather than just focusing on the diagnostic symptoms she was experiencing. Exposures to anxiety provoking situations were conducted. Many of the exposures were

conducted in the context of family communication and or communication with teachers. For example, because gaining trust was an important value for both Mónica and her mother, an exposure practice for Mónica was asking her mother what she needed to do to gain back her trust and her mother was able to share with her steps for doing so (which included telling her mother the truth about her school participation and following the house rules). A final phase of treatment included trauma processing and exposure to address guilt associated with the sexual assault and to guide Mónica's mother in supporting her through the retelling of her trauma. This would allow Mónica to experience the support she felt she was missing from her mother in the past.

Cultural strengths were explicitly incorporated into the treatment strategies. In regard to cultural perceptions of support (CFI-6, 11), Mónica's mother reported that she did not have family support because her family was in Peru, but she noted feeling some support in her relationship with God and with her sons. Mónica's mother identified praying and taking walks as her form of coping. Mónica shared that spending time with her young nephews always made her smile. Both coping strategies and behavioral activation often included family members and helped to address concerns the patient's mother had regarding family responsibility. For example, behavioral activation activities almost always included a family member (e.g., taking a walk with her mother, helping to cook, babysitting her nephews) or were culturally based (learning to cook traditional meals, learning traditional Peruvian dances). Mindfulness activities were also introduced to reduce her rumination of negative thoughts. While some solo mindfulness activities were practiced, the majority of them focused on present-moment attention when observing others (e.g., her baby nephew, her pet dog, her favorite food). Positive identity development was also addressed as part of TF-CBT, in the trauma narrative. Mónica was able to consider important aspects of her cultural background and her personality, and how they made her who she is as an individual. By incorporating these cultural components, each practice was meaningful for Mónica and her mother, and homework compliance remained high.

Case Conceptualization Stage 5

The fifth phase of science-based case conceptualization includes ongoing treatment monitoring and evaluation. Routine outcome monitoring informs needed course correction and has been shown to improve effectiveness of services and decrease the risk of patient deterioration (Boswell et al., 2015). Routine monitoring helps to demonstrate whether or not hypotheses are supported, and if targeted causal or maintaining factors are not resulting in improvements and progress toward goals, the case conceptualization is revised.

When issues arise throughout the treatment process, it is important to remain culturally humble and open to understanding what may be contributing to challenges for the family. Therapists often discuss clinical issues with engagement or adherence with language such as "noncompliance" or "resistance" to certain strategies. This language places blame on the youth or family rather than allowing for the examination and addressing of structural barriers, cultural mismatch, and/or provider biases/mistakes. It is less likely that major issues with the treatment or particular strategies would arise in the middle of treatment, with conversations occurring from assessment and throughout treatment; however, if they do it is important that we as therapists continue to understand these challenges within the family's cultural context.

Case Illustration

Along with evidence-based assessment tools, such as the RCADS, CBCL, UCLA PTSD Scale, and Top Problems list, cultural information was continuously assessed and built upon the foundation provided by the cultural formulation interview. This allowed the therapist to further tailor treatment components to best fit the needs of Mónica and her family and ensure that they were benefiting as a result of treatment.

Mónica and Ms. Flores each completed the Top Problems measure prior to each session (idiographic assessment). Additionally, Mónica's daily anxiety level and flashbacks were tracked and mood check-ups were conducted at the beginning of each session, with the therapist keeping track of Mónica's self-reported ratings (idiographic). The therapist also asked Mónica at the beginning of each session to report on the urge, frequency, and context of any NSSI as well as substance use that occurred over the prior week (idiographic). Routine outcome monitoring also included the completion of all three rating scales every 3 months (nomothetic).

In regard to the affect regulation component of TF-CBT, it became clear that cognitive restructuring and relaxation strategies were not effective coping strategies for Mónica as she continued to try to avoid or "numb" her emotions through the use of substances (as reported through idiographic self-report). To address this challenge, mindfulness practices were added to the treatment plan. Mindfulness activities allowed Mónica to reduce rumination but also to be exposed to and become curious about her stronger emotions and how they showed up in her body. This emotion exposure aided Mónica in being able to com-

plete in-vivo exposures related to her social anxiety, at school and at home. Once the treatment was shifted to include mindfulness and meditation, Mónica's anxious and depressive thoughts began to decrease more rapidly.

With the use of behavioral activation strategies, relaxation and affect regulation skills, Mónica began to describe fewer instances of depressed mood and her relationship with her mother began to improve (as reported on idiographic self-monitoring measures). Throughout treatment Mónica became more comfortable sharing her emotions and thoughts with the therapist; however, it became clear that both Mónica and her mother's discomfort around talking about and expressing emotions was strong and potentially interfering with Mónica's ability to cope with her strong emotions.

For example, Mónica reported decreased depressed mood (as evidenced by idiographic and nomothetic assessment), yet she continued engaging in some unsafe coping behaviors for several months (e.g., substance use). She did not engage in self-harm behaviors (i.e., cutting) until about 10 sessions into treatment when she went to a party and a male peer attempted to touch her inappropriately. This experience led to flashbacks of the assault and also her feelings of loneliness and isolation when she had no one to talk to after the assault. Similar to after the original assault, her mother reprimanded her for being at a party. Mónica noted that she felt angry at her mother, lonely, and embarrassed for putting herself in a risky situation. In response to these emotions Mónica engaged in cutting. She was able to share that the cutting helped release her strong emotions that she felt she was not able to share with anyone. She reported, "All I wanted was for my mom to hug me and tell me it would be okay, but instead I got in trouble." She shared that this feeling reminded her of the months after the sexual assault when Mónica and her mother "felt like strangers, we wouldn't talk at all, it was an uncomfortable feeling, I just felt empty, and alone." While conjoint parent-child sessions usually occur later in TF-CBT, it was clear that Mónica needed to share her needs and emotions with her mother and she was ready to do so. Mónica wrote down her thoughts and feelings related to how she wanted to be supported and first shared them with the therapist (scaffolding exposure). The therapist gave her the option of sharing the letter with her mother in session and Mónica stated, "I am scared but I want to do it." She read the letter to her mother (reading from a paper was easier than having a conversation). Mónica was coached to look toward her mother while sharing her needs around physical and emotional support. This is the first time that she was able to tell her mother that she needed her, and that she wanted her physical and emotional support, and the first time Mónica and Ms. Flores had any kind of physical connection during session. Ms. Flores put her hand on Mónica's shoulder as Mónica teared up and shared her emotions and her needs.

Throughout therapy, Ms. Flores was able to share her difficulty with showing emotions because of how she was raised, with the need to show strength over weakness. However, through helping her daughter to express her emotions openly and appropriately, Ms. Flores was also able to learn to cope with and express her emotions to trusted family members.

Additionally, with further assessment it was determined that it was more challenging for Mónica to share her emotions in Spanish because Spanish was her emotional language—she felt the emotions more strongly when speaking in Spanish. The first challenging conversation she had with her mother in session (above example) occurred with her speaking in English and her mother in Spanish. Ms. Flores indicated that Mónica speaking Spanish to her would show her that she is respected and that Mónica was making an effort to connect with her and that she was valued. Therefore, exposure practices began in English and worked up to Spanish. It became apparent that it would be important for the trauma narrative to be shared in Spanish, to enhance the connection between Mónica and her mother.

Through the continued emphasis on the importance of family connection, Mónica and Ms. Flores were able to learn to communicate with each other to show their love and care for one another. Additionally, they were able to problem-solve issues around school and other responsibilities effectively. Mónica's mother usually showed her care by reprimanding Mónica and making sure she was responsible and did well in school. Throughout therapy she was able to learn skills to communicate her expectations and needs to Mónica as well as her love and affection. She was also able to learn how her behaviors/communication affected Mónica.

A reduction in symptoms on the CBCL, RCADS, and the UCLA PTSD scale to below clinical cutoffs indicated clinical improvement. A decrease in Top Problems (family problems, dealing with emotions, and problems with school) was evidenced by the following: Mónica and her mother being able to communicate about their needs and emotions, Mónica being able to communicate her emotions in session with the therapist and with her mother and other family members, a complete reduction in self-harm and a decrease in substance use, and Mónica being able to ask for help in school and passing all of her classes the second semester. Ms. Flores and Mónica's words were also incredi-

bly valuable in understanding their readiness for treatment completion. Mónica shared, “Sharing my feelings and emotions with my mom was kinda crazy because even me just sharing with her changed our trust because she was able to understand me better. It just takes speaking up about how you are feeling and what you want and need from that person. Now she has a different perspective of how she can help me as a Mom.” Ms. Flores commented, “después de todo el esfuerzo que le puso a esto, y superando estos retos, ahora yo creo que ella puede hacer cualquier cosa” (after all the effort she has put into this, overcoming these challenges, I now believe that she can do anything).

Conclusion

As mental health disparities persist there is a great need for continued movement toward patient-centered cultural responsiveness in mental health treatment. The current paper is a step towards the more equitable provision of mental health care for culturally minority families through the incorporation of cultural factors into case conceptualization and treatment planning. Importantly, by highlighting and demonstrating the value of the patient’s perspective, we are able to redistribute the imbalanced power inherent within the therapist-patient relationship that often overvalues the therapist’s expertice and undervalues the patient’s preferences, values, and experiences.

Initial findings of the use of a person-centered cultural assessment (i.e., CFI) have demonstrated tangible benefits of the addition of cultural assessment into standard assessment practices, including engagement, satisfaction, and treatment outcomes (Lewis-Fernández et al., 2020; Sanchez et al., 2021). However, more research is needed to determine the most effective models for implementing the CFI within standard clinical practice. Despite growing research on the implementation and utility of the CFI, there is a paucity of work evaluating how to systematically incorporate information from the CFI into treatment planning and delivery (Lewis-Fernández et al., 2020). Moreover, there have been no studies on the implementation of the CFI in standard care to evaluate when and how it should be implemented (e.g., how to incorporate CFI into standard clinical intakes; whether the CFI should be delivered by the therapist or intake coordinator; or whether or not the full CFI needs to be administered or if therapists should choose mose relevant components). Studies on the implementation of cultural assessment, including measuring stakeholder perspectives (i.e., therapists, patients), are imperative to better understand optimal procedures and implementation strategies to promote the use of cultural assessment, leading to culturally informed case conceptualization and treatment planning within standard clinical practice.

Additionally, in regard to utilizing the culturally informed case conceptualization in community-based clinics, clinic policies and therapist burden (e.g., high caseloads and administrative responsibilities) may present challenges to conducting thorough cultural assessment and engaging in conceptualization-driven treatment planning. While we argue that culturally informed case conceptualization is necessary for good quality care, we understand that these strategies must be feasible in order for them to be useful and sustainable in community-based settings. Therefore, future work should focus on understanding current clinical practices, therapist and clinic barriers and facilitators, and feasible methods for incorporating culturally informed case conceptualization and treatment planning to support the sustainable implementation of culturally responsive practices in community-based settings.

Moreover, to improve the cultural responsiveness of mental health services, we suggest researchers study specific strategies or adaptations specific to youth with various intersecting identities, rather than assuming that evidence-based treatments already contain the core treatment ingredients for culturally diverse youth. For example, it may be that, for youth who have been historically marginalized, such strategies as ethnic-racial socialization or identity/cultural development are equally, if not more, important than some evidence-based CBT strategies. These studies could aid in the development of a guideline containing specific culturally responsive treatment strategies.

While we have highlighted work with cultural minority families because of the historical lack of focus on youth with marginalized identities in clinical psychology research, culturally responsive care is imperative for families of all backgrounds, regardless of the privileged or marginalized statuses of the identities they hold. Importantly, evidence-based assessment should entail cultural assessment for all patients, not just for cultural minority communities (APA, 2006).

Challenges to implementing culturally informed case conceptualization begin with an underemphasis of training focused on topics related to diversity, intersectionality, and cultural humility in graduate school (Karazsia & Smith, 2016). The APA Multicultural Guidelines (APA, 2017, 2019) provide a framework from which to consider evolving parameters for the provision of multiculturally competent services with intersectionality as its primary framework. Intersectionality considers the ways in which identities related to multiple socially constructed categories (e.g., race, sex-

uality, gender, class, immigration status) create unique intersections of experiences that differentially relate to levels of oppression and privilege (APA, 2019; Crenshaw, 1991). While APA includes training standards focused on diversity and multicultural competence, there is a lack of guidance on how to measure these competencies, as well as a lack of value placed on these competencies compared to other APA standards. Buchanan and Wiklund (2020) highlight the neglect of topics related to diversity and provide recommendations for integrating social justice, intersectionality, and diversity frameworks into clinical psychology training (Buchanan & Wiklund, 2020). Improving the attention placed on multicultural training in graduate programs is essential for providing culturally responsive services, including the effective use of cultural assessment to inform case conceptualization and treatment planning.

The present expanded framework of science-based case conceptualization offers a guide for moving toward person-centered culturally informed case conceptualization that prioritizes both evidence-based assessment practices and cultural formulation. Last, and perhaps most important, using a culturally informed case conceptualization model can begin to address critical disparities in the treatment of culturally diverse patients. As practitioners and scholars reckon with centuries of inequity not only in the field of psychology, but more broadly, the framework we have discussed can hopefully play a small role in leading to a more equitable and just clinical practice.

References

Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA School-Age Forms & Profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

Alegría, M., Green, J.G., McLaughlin, K.A., & Loder, S. (2015). Disparities in child and adolescent mental health and mental health services in the US. Retrieved from https://wtgrantfoundation.org/library/uploads/2015/09/Disparities-in-Child-and-Adolescent-Mental-Health.pdf.

Alegría, M., Vallas, M., & Pumariega, A. J. (2010). Racial and ethnic disparities in pediatric mental health. *Child and Adolescent Psychiatric Clinics of North America, 19*(4), 759–774. https://doi.org/10.1016/j.chc.2010.07.00.

Allison, A. C., & Ferreira, R. J. (2017). Implementing cognitive behavioral intervention for trauma in schools (CBITS) with Latino youth. *Child and Adolescent Social Work Journal, 34*(2), 181–189.

American Psychological Association (2002). *Guidelines on multicultural education, training, research, practice, and organizational change for psychologists*. Washington, DC: Author.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

American Psychological Association, Presidential Task Force on Evidence-Based Practice (2006). Evidence-based practice in psychology. *American Psychologist, 61*, 271–285. https://doi.org/10.1037/0003-066X.61.4.271.

American Psychological Association (2017). Multicultural Guidelines: An Ecological Approach to context, identity, and intersectionality. Retrieved from: http://www.apa.org/about/policy/multicultural-guidelines.pdf.

American Psychological Association (2019). APA guidelines on race and ethnicity in psychology: Promoting responsiveness and equity. Retrieved from http://www.apa.org/about/policy/race-and-ethnicity-in-psychology.pdf.

Anderson, R. E., McKenny, M. C., & Stevenson, H. C. (2019). EMBRace: Developing a racial socialization intervention to reduce racial stress and enhance racial coping among Black parents and adolescents. *Family Process, 58*(1), 53–67.

Bailey, R. K., Mokonogho, J., & Kumar, A. (2019). Racial and ethnic differences in depression: Current perspectives. *Neuropsychiatric Disease and Treatment, 15*, 603–609. https://doi.org/10.2147/NDT.S128584.

Barlow, D. (2004). Psychological treatments. *American Psychologist, 59*, 869–879. https://doi.org/10.1037/0003-066X.59.9.869.

Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: A direct-comparison meta-analysis. *Journal of Counseling Psychology, 58*, 279.

Bernal, G., & Domenech Rodriguez, M. (2012). *Cultural adaptations: Tools for evidence-based practice with diverse populations*. Washington, DC: APA Press.

Boswell, J. F., Kraus, D. R., Miller, S. D., & Lambert, M. J. (2015). Implementing routine outcome monitoring in clinical practice: Benefits, challenges, and solutions. *Psychotherapy Research, 25*, 6–19.

Buchanan, N. T., & Wiklund, L. O. (2020). Why clinical science must change or die: Integrating intersectionality and social justice. *Women & Therapy, 43*(3–4), 309–329.

Chorpita, B. F., Yim, L. M., Moffitt, C. E., Umemoto, L. A., & Francis, S. E. (2000). Assessment of symptoms of DSM-IV anxiety and depression in children: A Revised Child Anxiety and Depression Scale. *Behaviour Research and Therapy, 38*, 835–855.

Chou, T., DeSerisy, M., Garcia, A. M., Freeman, J., & Comer, J. S. (2017). Obsessive-compulsive problems in very young children. In J. S. Abramowitz, D. McKay, & E. Storch (Eds.), *Wiley handbook of obsessive-compulsive disorders*. Wiley.

Christon, L. M., McLeod, B. D., & Jensen-Doss, A. (2015). Evidence-based assessment meets evidence-based treatment: An approach to science-informed case conceptualization. *Cognitive and Behavioral Practice, 22*, 36–48.

Comer, J. S., Hong, N., Poznanski, B., Silva, K., & Wilson, M. (2019). Evidence base update on the treatment of early childhood anxiety and related problems. *Journal of Clinical Child and Adolescent Psychology, 48*, 1–15.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*, 1241–1299.

de Arellano, M. A., Danielson, C. K., & Felton, J. W. (2012). Children of Latino descent: Culturally modified TF-CBT. In J. A. Cohen, A. P. Mannarino, & E. Deblinger (Eds.), Trauma-focused CBT for children and adolescents: Treatment applications (pp. 253–279). Guilford Press.

Easden, M. H., & Kazantzis, N. (2018). Case conceptualization research in cognitive behavior therapy: A state of the science review. *Journal of Clinical Psychology, 74*, 356–384.

Falicov, C. (2014). *Latino families in therapy*. Guilford Press.

Gaylord-Harden, N. K., So, S., Bai, G. J., & Tolan, P. H. (2017). Examining the effects of emotional and cognitive desensitization to community violence exposure in male adolescents of color. *American Journal of Orthopsychiatry, 87*, 463.

Georgiadis, C., Peris, T. S., & Comer, J. S. (2020). Implementing strategic flexibility in the delivery of youth mental health care: A tailoring framework for thoughtful clinical practice. *Evidence-Based Practice in Child and Adolescent Mental Health, 5*, 215–232.

Graham-LoPresti, J. R., Gautier, S. W., Sorenson, S., & Hayes-Skelton, S. A. (2017). Culturally sensitive adaptations to evidence-based cognitive behavioral treatment for social anxiety disorder: A case paper. *Cognitive and Behavioral Practice, 24*(4), 459–471.

Griner, D., & Smith, T. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory Research, Practice, Training, 43*, 531–548. https://doi.org/10.1037/0033-3204.43.4.531.

Hall, G. C. N., Ibaraki, A. Y., Huang, E. R., Marti, C. N., & Stice, E. (2016). A meta-analysis of cultural adaptations of psychological interventions. *Behavior Therapy, 47*, 993–1014.

Hays, P. A. (2009). Integrating evidence-based practice, cognitive–behavior therapy, and multicultural therapy: Ten steps for culturally competent practice. *Professional Psychology: Research and Practice, 40*(4), 354.

Hays, P. A. (2016). *Addressing cultural complexities in practice: A framework for clinicians and counselors* (3rd ed.). American Psychological Association.

Hayes, S. C., & Toarmino, D. (1995). If behavioral principles are generally applicable, why is it necessary to understand cultural diversity? *Journal of Counseling Psychology, 28*, 257.

Hogue, A., Henderson, C. E., Ozechowski, T. J., & Robbins, M. (2014). Evidence base on outpatient behavioral treatments for adolescent substance use: Updates and recommendations 2007–2013. *Journal of Clinical Child and Adolescent Psychology, 23*, 695–720. https://doi.org/10.1080/15374416.2014.915550.

Huey, S., & Polo, A. (2008). Evidence-based psychosocial treatments for ethnic minority youth. *Journal of Clinical Child and Adolescent Psychology, 37*, 263-3-1.

Jensen, T. K., Holt, T., Ormhaug, S. M., Egeland, K., Granly, L., Hoaas, L. C., Hukkelberg, S. S., Indregard, T., & Stormyern, S. D. (2014). A randomized effectiveness study comparing trauma-focused cognitive behavioral therapy with therapy as usual for youth. *Journal of Clinical Child & Adolescent Psychology, 43*, 356–369.

Jones, S. C. T., Anderson, R. E., & Metzger, I. W. (2020). “Standing in the gap”: The continued importance of culturally competent therapeutic interventions for Black youth. *Evidence-Based Practice in Child and Adolescent Mental Health, 5*(3), 327–339.

Kaminski, J. W., & Claussen, A. H. (2017). Evidence base update for psychosocial treatments for disruptive behaviors in children. *Journal of Clinical Child and Adolescent Psychology, 46*, 477–499. https://doi.org/10.1080/15374416.2017.1310044.

Kataoka, S., Zhang, L., & Wells, K. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry, 159*, 1548–1555. https://doi.org/10.1176/appi.ajp.159.9.1548.

Karazsia, B. T., & Smith, L. (2016). Preparing for graduate-level training in professional psychology: Comparisons across Clinical PhD, Counseling PhD, and Clinical PsyD Programs. *Teaching of Psychology, 43*(4), 305–313.

Kazantzis, N., Beck, J. S., Dattilio, F. M., Dobson, K. S., & Rapee, R. M. (2013). Collaborative empiricism as the central therapeutic relationship element in CBT: An expert panel discussion at the 7th International Congress of Cognitive Psychotherapy. *International Journal of Cognitive Therapy, 6*, 386–400.

Kirmayer, L. J. (2006). Beyond the ‘new cross-cultural psychiatry’: Cultural biology, discursive psychology and the ironies of globalization. *Transcultural Psychiatry, 43*, 126–144.

Kirmayer, L. J., & Jarvis, G. E. (2019). Culturally responsive services as a path to equity in mental healthcare. *Healthcare Papers, 18*(2), 11–23. https://doi.org/10.12927/hcpap.2019.25925.

La Roche, M. (2013). *Cultural psychotherapy: Theory, methods and practice*. Sage.

La Roche, M. (1999). The association of social relations and depression levels among Dominicans in the USA. *Hispanic Journal of Behavioral Sciences, 21*. https://doi.org/10.1177/0739986399214003. 420–420.

La Roche, M. (2020). *Towards a global and cultural psychology: Theoretical foundations and clinical implications*. Cognella.

Le Grange, D., Lock, J., Agras, W. S., Bryson, S. W., & Jo, B. (2015). Randomized clinical trial of family-based treatment and cognitive-behavioral therapy for adolescent bulimia nervosa. *Journal of the American Academy of Child & Adolescent Psychiatry, 54*, 886–894.

Lewis-Fernández, R., Aggarwal, N. K., & Kirmayer, L. J. (2020). The Cultural Formulation Interview: Progress to date and future directions. *Transcultural Psychiatry, 57*, 487–496.

Lewis-Fernandez, R., Aggarawal, N., Hinton, L., Hinton, D., & Kirmayer, L. (2016). *DSM-5 handbook on the cultural formulation interview*. American Psychiatric Publishing.

Liang, J., Matheson, B. E., & Douglas, J. M. (2016). Mental health diagnostic considerations in racial/ethnic minority youth. *Journal of Child and Family Studies, 25*(6), 1926–1940.

Marrast, L., Himmelstein, D. U., & Woolhandler, S. (2016). Racial and ethnic disparities in mental health care for children and young adults: A national study. *International Journal of Health Services, 46*, 810–824.

Maura, J., & de Mamani, A. W. (2017). Mental health disparities, treatment engagement, and attrition among racial/ethnic minorities with severe mental illness: A review. *Journal of Clinical Psychology in Medical Settings, 24*, 187–210.

Merikangas, K. R., He, J. P., Burstein, M., Swendsen, J., Avenevoli, S., Case, B., Georgiades, K., Heaton, L., Swanson, S., & Olfson, M. (2012). Service utilization for lifetime mental disorders in US adolescents: Results of the National Comorbidity Survey—Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry, 50*, 32–45. https://doi.org/10.1016/j.jaac.2010.10.006.

Neblett, E. W., Jr, Terzian, M., & Harriott, V. (2010). From racial discrimination to substance use: The buffering effects of racial socialization. *Child Development Perspectives, 4*(2), 131–137.

Persons, J. B., & Tompkins, M. A. (1997). Cognitive-behavioral case formulation. *Handbook of Psychotherapy case Formulation*, 314–339.

Persons, J. B., Tompkins, M. A., & Eells, T. D. (2007). Handbook of psychotherapy case formulation.

Pina, A. A., Polo, A. J., & Huey, S. J. (2019). Evidence-based psychosocial interventions for ethnic minority youth: The 10-year update. *Journal of Clinical Child and Adolescent Psychology, 48*, 179–202.

Rathod, S., Gega, L., Degnan, A., Pikard, J., Khan, T., Husain, N., Munshi, T., & Naeem, F. (2018). The current status of culturally adapted mental health interventions: A practice-focused review of meta-analyses. *Neuropsychiatric Disease and Treatment, 14*, 165.

Reynolds, C. R., & Suzuki, L. A. (2012). Bias in psychological assessment: An empirical review and recommendations. Handbook of Psychology, Second Edition, 10.

Sanchez, A. L, Jent, J., Aggarwal, N., Chavira, D., Coxe, S., Garcia, D., LaRoche, M. & Comer, J. S. (2021). Person-centered cultural assessment can improve child mental health service engagement and outcomes. Journal of Clinical Child and Adolescent Psychology. (Under review: revise and resubmit).

Smith, T., & Trimble, J. (2016). *Foundations of multicultural psychology: Research to inform effective practice*. American Psychological Association.

Soto, A., Smith, T. M., Griner, D., Domenech Rodriguez, M., & Bernal, G. (2018). Cultural adaptations and therapists of multicultural competence: Two meta-analytic reviews. *Journal of*

Clinical Psychology., 74, 1907–1923. https://doi.org/10.1002/jclp.22679.

Southam-Gerow, M. A., & Prinstein, M. J. (2014). Evidence base updates: The evolution of the evaluation of psychological treatments for children and adolescents. *Journal of Clinical Child and Adolescent Psychology, 43*, 1–6.

Steinberg, A. M., Brymer, M., Decker, K., & Pynoos, R. S. (2004). The University of California at Los Angeles Post-Traumatic Stress Disorder Reaction Index. *Current Psychiatry Reports, 6*, 96–100.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*, 477–486.

Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy. *American Psychologist, 42*, 37–45. https://doi.org/10.1037/0003-066X.42.1.37.

Sue, S., Zane, N., Nagayama Hall, G. C., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60*, 525–548. https://doi.org/10.1146/annurev.psych.60.110707.163651.

Walls, M. L., Johnson, K. D., Whitbeck, L. B., & Hoyt, D. R. (2006). Mental health and substance abuse services preferences among American Indian people of the northern Midwest. *Community Mental Health Journal, 42*(6), 521–535.

Wang, M. T., Henry, D. A., Smith, L. V., Huguley, J. P., & Guo, J. (2020). Parental ethnic-racial socialization practices and children of color's psychosocial and behavioral adjustment: A systematic review and meta-analysis. *American Psychologist, 75*(1), 1.

Yeh, M., Hough, R. L., McCabe, K., Lau, A., & Garland, A. (2004). Parental beliefs about the causes of child problems: Exploring racial/ethnic patterns. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*, 605–612.

Yeh, M., McCabe, K., Hough, R. L., Lau, A., Fakhry, F., & Garland, A. (2005). Why bother with beliefs? Examining relationships between race/ethnicity, parental beliefs about causes of child problems, and mental health service use. *Journal of Consulting and Clinical Psychology, 73*, 800.

Zane, N., Bernal, G., & Leong, F. (2016). *Evidence-based psychological practice with ethnic minorities: Culturally informed research and clinical strategies*. Washington, DC: American Psychological Press.

Zane, N., Sue, S., Chang, H., Huang, L., Huang, J., Lowe, S., Srinivasan, S., Chun, K., Kurasaki, K., & Lee, E. (2005). Beyond ethnic match: Effects of client-therapist cognitive match in problem perception, coping orientation, and therapy goals on treatment outcomes. *Journal of Community Psychology, 33*, 569–585. https://doi.org/10.1002/jcop.20067.

Zayas, L., Lester, R., Cabassa, L., & Fortuna, L. (2005). Why do so many Latinas teen attempt suicide? A conceptual model for research. *American Journal of Orthopsychiatry, 75*, 275–287. https://doi.org/10.1037/0002-9432.75.2.275.

Zigarelli, J. C., Jones, J. M., Palomino, C. I., & Kawamura, R. (2016). Culturally responsive cognitive behavioral therapy: Making the case for integrating cultural factors in evidence-based treatment. *Clinical Case Studies, 15*, 427–442.

We recognize the importance of acknowledging our levels of privilege (e.g., race, social/educational status) as we discuss clinical considerations for youth with marginalized identities. All suggestions should be interpreted within this context. We are three clinically trained psychologists. The first author identifies as a cisgender Latina and White female. She is a second-generation Cuban American (her father immigrated from Cuba and her mother is US-born with European ancestry) and a first-generation college graduate. She is currently a postdoctoral fellow. The second author identifies as a cisgender White male, a third-generation Jewish American, and a second-generation doctoral graduate. He is a full professor and director of a child mental health program. The third author is a Venezuelan-born, Latino male who identifies as a cisgender and directs a training program at a community mental health center in Boston. Our work with children from various racial and ethnic minority backgrounds, and our shared commitment to improving the quality and accessibility of clinical services for culturally diverse youth, have brought us together to write this manuscript.

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