Cognitive-Behavioral Therapy for Immigrant Youth: The Essentials

Robert D. Friedberg, Marisa Keller, Micaela A. Thordarson, and Paul J. Sullivan

Abstract

Cognitive-behavioral therapy (CBT) successfully treats a number of different emotional troubles youth experience. Though effectiveness studies with immigrant youth remain limited, the literature in existence reveals promising results for the treatment of immigrant youth with CBT. Modular CBT is a comprehensive treatment protocol specifically designed to flexibly address a variety of symptom clusters as well as attend to contextual psychosocial factors. In order to be potent, clinicians who practice must remain faithful to the cognitive-behavioral model and ground all interventions in the theoretical underpinnings. Case conceptualization represents the fundamental process that must be executed in order to understand the patient's particular presentation, identify crucial targets of treatment, and guide interventions along the way. This chapter thoroughly defines and illustrates content and process factors that comprise competent CBT for immigrant youth. Confabulated clinical examples are included throughout to depict in detail the ways that CBT is mildly modified to address cultural factors salient to practice with immigrant youth.

Keywords

Immigrant • Children • Adolescents • Youth • CBT • Modular CBT

All clinical examples contained in this chapter are de-identified and confabulated.

R.D. Friedberg (✉)
Center for the Study and Treatment of Anxious Youth, Palo Alto University, Los Altos, CA 94022, USA

Center for the Study and Treatment of Anxious Youth, Palo Alto University, 5150 El Camino Real Ste. C-22, Los Altos, CA 94022, USA
e-mail: rfriedberg@paloaltou.edu

M. Keller • M.A. Thordarson • P.J. Sullivan
Center for the Study and Treatment of Anxious Youth, Palo Alto University, Los Altos, CA 94022, USA

S. Patel, D. Reicherter (eds.), *Psychotherapy for Immigrant Youth*,
DOI 10.1007/978-3-319-24693-2_2

CBT with Immigrant Youth

Cognitive-behavioral therapy (CBT) is widely considered the most effective treatment for most childhood disorders. Until recently, however, the vast majority of empirical research was conducted with Caucasian youth of middle to upper socioeconomic status. The last two decades witnessed a dramatic increase in the research focusing on whether established psychosocial treatments are successful with immigrant and/or ethnic minority youth [1–4]. CBT is identified as a psychosocial intervention that works effectively for ethnic minority and immigrant youth with minimal modification to standard treatment [1, 3, 5]. The radical transformations that accompany immigration often elicit significant distress from youth as they learn to integrate into a new home [6, 7]. Research on CBT among immigrant youth is sparse, but also suggests CBT successfully treats distress these patients face [2, 3, 8].

This chapter briefly introduces the theoretical framework of CBT and the literature supporting its effectiveness with immigrant youth. Essential ingredients to deliver competent CBT are then outlined. Modular CBT, a cutting-edge format of CBT that emphasizes flexibility and underscores the need for individualization of treatment, is described. Modular CBT is composed of several modules that are utilized in a progressive manner, driven by the case conceptualization of the patient's distress. Within each module are a variety of theoretically sound interventions that address different aspects of the patient's pathology (e.g., cognitive restructuring targets maladaptive thoughts). This format allows clinicians to conduct therapy in a manner specifically tailored to individual immigrant youth and the unique challenges they face (e.g., loss of social support, discrimination, economic struggles, fears of deportation, and learning new cultural norms [6]). Throughout the chapter, readers are provided with confabulated case examples to illustrate various clinical techniques and the manner in which interventions are designed to attend to immigrant needs.

Cognitive Behavior Therapy Model

Theoretical Foundations CBT integrates social learning theory, operant and classical conditioning, information processing, and cognitive theories [9, 10]. This comprehensive theoretical framework aims to alter maladaptive behavior patterns through changes in youths' thoughts, emotions, and physiological responses [10]. Goals are targeted through experiential learning, allowing young patients to learn by doing [10].

Empirical Support Available studies indicate immigrant youth will likely benefit from CBT in the same ways as nonimmigrant American youth [11–14]. Demographic characteristics such as age, gender, ethnicity, and symptom severity do not impact CBT's effectiveness [1, 5, 15, 16]. The past 20 years produced studies that support the use of CBT to treat youth who present to treatment for anxiety (e.g., [15, 17]),

epression (e.g., [18]), posttraumatic stress disorder (e.g., [19]), disruptive behavior (e.g., [20, 21]), and challenges associated with autism spectrum disorder (e.g., [22–24]), substance use disorders (e.g., [25]), and eating disorders (e.g., [26]). CBT is an effective treatment model appropriate for youth for a wide range of presenting problems and cultural identities.

Appropriateness for Immigrant Youth CBT is an indicated intervention for immigrant youth. As discussed elsewhere in this book, studies introducing the use of CBT in schools with immigrant children reveal significant symptom reduction and enhanced functioning [2, 7, 27]. The empirical emphasis of CBT eliminates stigma often associated with therapy and encourages immigrant youth to identify the specific data that reflect distress—and growth [28, 29]. Emphasis on data collection allows cultural explanations of illness and idioms of distress to be expressed idiosyncratically, a facet providing much-needed flexibility when working with immigrant youth [11]. Collaboration and transparency imbue immigrant patients with much-needed empowerment [29].

Cognitive exercises can be used to identify attribution of discrimination and deconstruct perceived implications. Patel et al. [30] revealed such cognitive mechanisms influence severity of internalizing symptoms. A focus on concrete skills training gives immigrant youth and their families' specific strategies to help themselves, imbuing them with greater self efficacy [3, 28, 29]. Regardless of the country and culture of origin, research finds that CBT reduces symptoms of psychopathology and improves global functioning in immigrant youth and their families—whether they are experiencing anxiety, depression, posttraumatic stress, or other forms of psychopathology [2, 3, 27–29, 31]. Overwhelmingly, as researchers continue to investigate practice of CBT with ethnic minorities in general and immigrants in particular, results reflect the universal applicability and effectiveness of CBT for these youth.

Despite these very encouraging results, evaluating differences in treatment outcome provides only partial answers. For example, Cardemil [12] argues persuasively that no differences in outcome between culturally adapted and standard treatments are likely since the best culturally adapted programs maintain fidelity to the cognitive-behavioral models. Essentially, these comparative studies are evaluating very similar core elements. Consequently, examining differences in attrition rate and treatment involvement is more informative than symptom reduction alone. Indeed, Cardemil stated that cultural adaptations produce lower attrition rates and greater patient involvement in treatment among ethnic minority patients. Thus, if the particular cultural alteration (e.g., including extended family in sessions or predominantly targeting physiological symptoms rather than including cognitive) keeps more children in treatment and offers equivalent effectiveness, the change represents a good standard of care.

Based on the current literature, several recommendations emerge for working with immigrant youth. First, empirically supported treatments should be considered the first line of treatment for immigrant youth [1–3, 31, 32]. Simply, diverse groups of children profit from good CBT. Cultural adaptations should be considered and

implemented, based on functional analysis, case formulation, and treatment planning [5, 10, 12, 31]. Treatment with any population must toe the line between faithfully implementing an evidence-based protocol and flexibly tailoring the intervention to the unique needs of an individual patient [33].

Modular CBT is one particularly flexible evidence-based treatment that lends itself to cultural adaptation [32]. Modularity allows the clinician to integrate various individual traits and experiences, including cultural variables [32]. However, it is important to remember that cultural adaptations that alter critical elements of the intervention fail to remain faithful to the empirically supported protocol [12]. In fact, when core components of an intervention are diluted or altered in the process of cultural adaptation, the resulting changes can have a deleterious effect on treatment outcome [34]. In other words, cultural adaptation must preserve the core treatment ingredients while allowing for flexible integration of diverse perspectives and values.

Essentials

CBT is an empirically valid therapy that delivers well-established, positive treatment outcomes for a number of diagnostic categories. The essential ingredients necessary for training clinicians to deliver CBT are the subject of much discussion in the literature [35, 36]. Friedberg and McClure [10] identified flexible application of protocols, case conceptualization, an active therapeutic stance, and session structure as integral skills for the child CBT clinician's toolbox. The following sections review each of these indispensable proficiencies. This section delineates the step-by-step content of CBT from the process factors that distinguish true CBT from mechanical execution of a manual.

Flexibility Within Fidelity

A common misunderstanding of CBT is that it is a rigid treatment protocol with little room for individualization to patients' needs. CBT protocols operationalize a treatment; however, they are not unyielding mandates [33]. CBT encourages flexible application to fit with the presenting problems of each patient. Kendall and colleagues [37] warn clinicians that there is a difference between flexibility and nonadherence to treatment. Adherence is vital as failure to remain faithful to CBT principles renders treatment ineffective. The literature implies that personalized treatments lead to better therapeutic outcomes [38].

The Coping Cat program is an exemplar of a manual-based program for anxious youth that embraces flexible application while remaining loyal to the core procedures of CBT [39]. In Coping Cat, Kendall and Hedtke execute the FEAR plan by individualizing progressive muscle relaxation, coping self-talk, problem-solving skills, exposure, and reward modules to the patient by utilizing relevant child-centered examples and stimuli. Matching core cognitive-behavioral tasks to interests

and strengths of the child improves satisfaction with treatment and contributes to reductions in symptomology [37]. Rather than following a sequential manual, clinicians need to conceptualize and plan treatment around the contextual issues that influence their patients' presenting problems. Integration of various psychosocial challenges and deliberate attention to distinctive cultural norms are key aspects to practicing CBT with young immigrants.

Cultural adaptation occurs at all phases of treatment from the development, evaluation, and creation of interventions [12]. For example, clinicians working with Latino patients without knowledge of familismo—the importance of the physical and emotional closeness of the family—could damage treatment by not including multiple members of the family in their intervention [40]. In summary, cultural adaptations for immigrant youth simply entail that a clinician appropriately shape treatment to the individual—a fundamental requirement for all young patients.

Case Conceptualization

Effective case conceptualization is the mechanism by which a clinician flexibly designs treatment in a developmentally appropriate and culturally responsive manner. Case conceptualizations are fluid, dynamic, and change over time [10]. Through mutual collaboration between therapist and patient, an individualized, contextualized description of a patient's inner world and external environment is developed [10]. An effective case conceptualization is not a theoretical exercise; instead, it has practicality in promoting greater flexibility in customizing treatment that is culturally responsive and evidenced based—aspects of particular relevance in treatment with immigrant youth.

Data Needed for Case Conceptualization Clinicians develop case conceptualizations based on objective and subjective data gathered about the presenting problem. Data is gathered along a cluster of six symptom areas that include physiological factors, mood, behavioral symptoms, behavioral functioning, cognitions, and interpersonal relationships [41]. In addition, to individualize the descriptions, clinicians must gather data about patients' developmental history, cultural context, cognitive structures, and behavioral antecedents and consequences [42]. Perhaps most importantly, practitioners must consider these variables as conjointly influencing each other through a dynamic interplay.

Integral to conceptualization with immigrant youth is the careful consideration and integration of cultural context, self-identity, and levels of acculturation and assimilation [35, 43]. For instance, behavioral responses may be the consequence of cultural beliefs and norms or may be functional responses to sexism, racism, discrimination, and oppression. Knowledge of patients' experiences with power structures, privilege, oppression, marginalization, stereotyping, and prejudice are critical to painting a picture of their outer and inner worlds. Learning about patients' experiences with racially or ethnically charged teasing or bullying provides an important frame to understand the expression of particular symptoms [35, 43]. Therefore,

careful consideration of cultural context and identities allows clinicians to assess responses to environmental stimuli and treatment interventions [35, 43].

Design and Function of Case Conceptualization Case conceptualization follows an inductive approach. Inferences and hypotheses are drawn from observations and data. Friedberg and McClure [10] describe the cognitive therapist as relying on interview data, assessment instruments, objective self-report measures, objective checklists, verbal reports, and clinical impressions. Friedberg et al. [43] are also quick to note that case conceptualizations, because they are inferentially based, are not "marble statues of patients….hardened in stone" but instead are "hypotheses written in sand" (p. 26). Collaborative empiricism, guided discovery, and flexibility are necessary to revise hypotheses, formulate new ones, and discard those that have been disconfirmed.

Case conceptualization is a foundation of clinical practice (e.g., [35]) because it serves a number of important functions. In fact, case conceptualization is essential to sound treatment processes when working with patients from diverse cultural, racial, and ethnic backgrounds [10, 44, 45]. Advantages of case conceptualization include the promotion of patient engagement, normalizing presenting issues, validation of patients' experiences, simplification of more complex and numerous problems, identification of strengths, and the promotion of resiliency [41]. Finally, case conceptualization facilitates a transdiagnostic approach to treatment thereby allowing a clinician to individualize therapy by selecting tools from evidenced-based treatments that will facilitate change, alleviate distress, and provide for efficacious treatment.

Case Study

Carolina is a 16-year-old girl who immigrated from El Salvador at age six with her father. Since then, several aunts, uncles, and cousins have joined them, but her grandmother and a number of other cousins remain in El Salvador. Carolina speaks English fluently and appears highly acculturated; her father is able to communicate in English but prefers to speak Spanish. Carolina presents to treatment after being hit by a car while on her bicycle. Since the accident, Carolina is unable to ride her bike, sit in a car, or cross the street. Carolina reports feeling "very sad" that she is such a "burden" on her father and feels embarrassed that she is not getting her driver's permit like all her friends. Carolina also experiences panic attacks, which have increased in frequency since the accident. She notes trouble sleeping, feeling tired "every day," difficulty paying attention in class, and frequent headaches.

Aside from the two days she spent in the hospital after the car accident, Carolina has an unremarkable developmental and medical history. Her father reports no significant family history for medical or psychiatric problems. Carolina moved to the USA after her mother died from a brain aneurysm in El Salvador. Since that time, Carolina has been very fearful for her own, her

father's, and her grandmother's health. Carolina also worries about school, friends, and getting into college. Although Carolina was raised Catholic, she eschewed religion at the onset of adolescence because she "refused to believe God would plan to take [her] mother." Carolina's father continues to invite her to church, but her youth group friends stopped calling and she feels like the church community rejected her.

Carolina's recent car accident and the unexpected loss of her mother generated perceptions of herself as unable to exert control over her environment. In her mind, her father was forced to uproot them from their home and bring them to the USA as a result of her weakness. Even now, she is unable to contribute to the family by getting her driver's license and alleviating her father's care-giving responsibilities. Her cultural identity as a Latina immigrant youth exacerbated these perceptions as she believed she must be perfect in every way to justify her father's sacrifices in moving to the USA. The void created by Carolina's decision to stop attending church represented a significant loss of spiritual and emotional support for Carolina. She no longer believes life "has a plan" as she did before and the abrupt loss of her peers reinforced the intransience of social support.

Based on the relevant information, a parsimonious provisional formulation was constructed. Carolina's early learning history involved the sudden and unexpected death of her mother, followed closely by immigration to the USA. As a result, Carolina experienced her world as filled with invisible dangers, where tragedy strikes without warning and is accompanied by dire consequences. She was, therefore, predisposed to anxious feelings and perceptions. This vulnerability led to a tendency to focus on threat-related information both internally and externally. Carolina thus interpreted physiological sensations as catastrophic, leading to panic attacks. In her environment, peers, teachers, and strangers each evoked a level of fear. The car accident served as a confirmatory experience that Carolina is, indeed, in danger at all times. The formulation that Carolina and her clinician developed to understand her distress is succinctly summarized with the following: "I am unsafe, weak, incapable, and only cause problems for the people who care about me. I am trapped in an unpredictable, volatile world that is riddled with danger and people exist to harm me or leave me." Thus, treatment targets for Carolina included relaxation skills and cognitive restructuring for catastrophic thoughts related to her safety and distortions about social relationships. Therapy concluded with numerous experiments to assess a realistic threat level.

Therapeutic Stance Variables

Collaborative Empiricism Collaborative empiricism is an essential therapeutic stance in CBT. It is a data-driven process whereby the clinician and patient work together toward treatment goals. For example, the patient and therapist gather

information about the patient's thoughts and design experiments to systematically test these thoughts [10, 46]]. Rather than being prescriptive, the clinician assumes a curious approach in which "let's find out" is a key phrase [47, 48]. The goal of collaborative empiricism is not to directly dispute a patient's thoughts but rather to replace certainty with doubt [47]. Collaborative empiricism instills a greater sense of control over the treatment process. In fact, collaboration is the variable that explains the most variance in the therapeutic relationship and is positively associated with patient engagement in treatment tasks and understanding of treatment goals [49–51]. Although collaborative empiricism is a cornerstone of CBT with any population, it is particularly critical with youth because young people are frequently in a position of low power. Ultimately, this collaborative process allows for a gradual increase in autonomy. By the end of care, the patient is able to independently implement CBT techniques without the therapist, thereby maintaining treatment progress and fostering relapse prevention.

Transparency Transparency in CBT highlights the importance of clinicians working openly and honestly with young patients. There is necessarily a difference in power between a clinician and patient, and this difference is even more profound when working with youth [52]. A transparent clinician directly and explicitly addresses power and privilege with patients. Furthermore, transparency serves to decrease the mysteriousness of the therapeutic process [52]. In other words, the clinician does not act as an omnipotent expert, but rather is forthcoming about case conceptualization, assessment, and treatment planning using clear language. Transparency allows for genuine informed consent and facilitates the development of a candid therapeutic alliance [52].

Guided Discovery Guided discovery is another critical therapeutic stance variable in CBT for youth. Guided discovery is the process by which the clinician adopts a curious and nonjudgmental clinical position to assist patients in drawing their own conclusions [10, 46]. Guided discovery occurs through the use of the Socratic method, which relies upon the systematic use of questions, inductive reasoning, identification of patterns, fostering of cognitive dissonance, and changing perspectives [53]. Therapists carefully design questions that are goal directed and draw patients' attention to maladaptive patterns and overgeneralizations [53]. For example, rather than telling patients which facts will or will not support a specific belief, the therapist uses strategically chosen questions to allow patients to discover these truths themselves. As a result, patients are more willing to accept these conclusions than if the clinician provided them directly [10].

Session Structure

Session structure is a fundamental aspect of practicing competent CBT. Structured sessions allow treatment to address maladaptive behaviors in a methodical manner [9, 10]. A proper session of CBT includes these essential steps: (1) a mood check-in, (2) setting the agenda for the session, (3) processing the information from session,

(4) creating homework assignments with the patient, and (5) summarizing the session and eliciting feedback from the patient [9, 10]. As with all components of CBT, it is important to fit the patient's conceptualization and presenting problems [9].

Mood Check-In Sessions begin with a mood check-in. For clinicians working with younger children, drawing a face depicting their mood will suffice; whereas, for older children verbal reports and objective measures are given in order to make this process more enjoyable for youth [52]. Target-monitoring questionnaires completed by the child such as the SCARED [54], the CDI-2 [55], and the SNAP IV [56] supply the therapist with objective data based on scores. The mood check-in supplies the clinician with a baseline of patients' emotional state and assists young patients with the enhancement of emotional competence through verbalization of their feelings [10].

Agenda Setting Setting the agenda helps the therapist to prioritize issues to be discussed during the session. Agenda setting is a collaborative effort in CBT. The agenda consists of both the practitioner's planned objectives and topics solicited from the patient [57]. Clinicians must remain mindful of their case conceptualization rather than responding in a knee-jerk fashion to the patient's most recent distressing incident [35]. For youths who have many topics they want to address, it is critical for the clinician to model the importance of prioritizing goals [10]. Agenda setting is a vital element in guiding therapy.

Session Content and Process Processing consists of various therapeutic techniques including empathy, Socratic questioning, problem-solving, and behavioral experiments [10]. It is important for clinicians to apply these techniques and procedures in the context of patients' negative affective arousal [58, 59]. Friedberg and McClure [10] note that a CBT clinician must master the balance between structure, process, and content. Therapeutic structure consists of the tasks rooted in a CBT framework. Thought records, games, and homework are enduring aspects of treatment that are maintained over the course of therapy [58]. Structural components evoke the content. Thoughts, feelings, and behaviors generated by the session activities are examples of therapeutic content. Last, the therapeutic process reflects a child's psychological presence in therapy. The manner in which the child completes the tasks within therapy, responds to the clinician's questions, and solves problems can showcase this presence. Derived from the content of the session, the next essential step in CBT is to create a homework assignment with the patient.

Homework Homework is vital to maintaining the progression of therapy. Practicing new skills outside of the therapy session is crucial to achieving therapeutic change [57]. CBT requires real-world implementation that is relevant to what the patient experiences in everyday life [57]. A sound homework assignment has a rationale and is explicitly related to the patient's problems [9]. Homework assignments are determined via an active collaboration between the therapist and child [10]. Tracking homework completion supplies the therapist and patient with objective metrics to evaluate levels of progress [52]. If a homework assignment is deemed unhelpful by the patient, changes are made using the gathered empirical data. Rather than view-

ing homework incompletion as therapeutic noncompliance, a CBT therapist examines the potential barriers to completion of the task and collaboratively devises a more attainable exercise [57]. After the homework is agreed upon, the patient is given the opportunity to provide feedback on the session.

Session Summary and Feedback The session summary is a vital aspect of therapy. It is an opportunity to reinforce the most important aspects of that session [9]. Beck [9] recommends leaving 5–10 min at the end of each appointment to sufficiently review the session and collect feedback. With younger children, session summaries can take the form of a game in which the child teaches the parents what was accomplished in session [57]. During this process, the therapists inquire what the patient found to be helpful and what was less helpful during the session [10]. It is beneficial to vary the questions used to elicit feedback, as children tend to experience difficulties providing feedback to adults in positions of authority [10, 52]. The clinician's request for feedback from the patient prevents unspoken negative feelings from festering as the patient is encouraged to identify any dissatisfaction with the session [10]. Therapists need not fear the feedback they receive from their patients. Providing young patients the time to give feedback on their treatment strengthens the therapeutic alliance and assists the therapeutic process [9].

Modular CBT

Definition of Modular CBT

Modular treatments evolved out of the discovery that many evidence-based interventions shared more commonalities than differences [59]. By distilling the multitude of intervention programs down to critical elements, core strategies were arranged into "modules" [52, 60, 61] (see Table 1). Clinicians can select and arrange components into an individualized treatment plan. In other words, rather than following a session-by-session manual, modularity allows clinicians to flexibly adapt to an individual patient's needs by responding to crises that arise during treatment, changes in symptom presentation, and complex comorbidity [61]. Thus, modular CBT specifically integrates clinician judgment into the protocol [61]. This

Table 1 Components of modular CBT

Module	Treatment target
Psychoeducation	Increase understanding of therapy and psychopathology
Target monitoring	Enhance awareness of concrete manifestations of psychopathology Gather data to use in later modules
Basic behavioral task	Acquisition of skills to change overt behaviors
Cognitive restructuring	Reduce cognitive distortions and improve mental flexibility
Exposures	Experiential learning to apply skills gained in situations that evoke negative affect

flexibility also allows clinicians to integrate culture-specific adaptations into treatment while maintaining the elements that are critical mechanisms of change.

Cutting-edge research supports the efficacy of modular approaches with youth. Weisz and Chorpita [61] developed the Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct Problems (MATCH-ADTC), a comprehensive treatment protocol that allows clinicians to target up to four major symptoms clusters in one package. For example, psychoeducation, self-monitoring, and exposure are core procedures for anxiety, while active ignoring and contingency contracting may be implemented to address disruptive behavior. Instead of addressing the disorders distinctly, modular CBT presents clinicians with a road map of evidence-based elements that can be integrated to simultaneously target the observed deficits [61].

Termed *relevance mapping*, the "mix-and-match" approach combines the strengths of empirically supported treatments with culturally sensitive care [32, 62]. Relevance mapping software takes into account a youth's age, gender, ethnicity, and presenting problem to determine the most applicable interventions as determined by research [62]. By using this approach, more youth are able to be treated more effectively [62].

Importantly, emerging literature supports that modular treatment is associated with faster improvement than manualized CBT or usual care [63]. Lyon and colleagues [32] review the ways in which clinicians easily integrate cultural variations using modular CBT, highlighting the efficiency of this framework that delivers the necessary tools to treat a broad range of youth.

Psychoeducation

Psychoeducation involves orienting youth and their parents to the treatment process. This includes providing information about the child's presenting problem and discussing what to expect from the treatment approach [64]. Introducing families to the therapy process is particularly important with immigrant youth, whose families may not be familiar with psychotherapy. Explaining what to expect, addressing misconceptions, and providing information about the young patient's symptoms facilitates motivation and investment in treatment [58]. Skillful psychoeducation contributes to engagement in treatment. Cultural variables are easily integrated into this module.

For example, using a culturally and individually relevant metaphor to explain treatment fosters understanding and builds the therapeutic relationship. With an adolescent Mexican-American male who was a fan of sports, depression was once described as being like an injured soccer player, and treatment involves strategies to get the athlete back on the field. Culturally relevant analogies can also be used in describing the structure of cognitive-behavioral treatment.

With youth, it is particularly important that clinicians are creative in the implementation of psychoeducation. For example, multimedia including picture books, movies, songs, pamphlets, websites, and TV shows can be employed to communicate

critical information [52]. Practitioners should strive to provide information in a variety of different mediums to facilitate understanding and meet the needs of each unique family. For example, parents can be given printed material from websites (e.g., www.aboutourkids.com, www.effectivechildtherapy.com, www.aacap.org, www.nimh.org), and clinicians can read a picture book with young children (e.g., *What to Do When You Worry Too Much* [65]). Psychoeducational material should be presented in the preferred language of parent and child.

Target Monitoring

Target monitoring is the data collection phase of treatment and serves to both increase awareness and establish a baseline of symptoms. Patients and/or parents are asked to track thoughts, feelings, behaviors, and physiological sensations—essentially, patients gather information relevant to their presenting problem [64]. Thought records are one example of a method for monitoring automatic thoughts, situations that elicit particular beliefs, and patterns of cognitive distortions [64]. Target-monitoring techniques can and should be adapted to the patient's age, cultural background, interests, etc. For example, young children respond well to filling in faces with expressions or coloring in a thermometer to reflect the intensity of their emotions; adolescents may simply report intensity on a scale from 0 to 10. Cultural adaptations can easily be integrated into this module as well. For example, a young Chinese patient may experience her anxiety primarily as somatic symptoms such as stomachache, numbness, tingling, and racing heart. As a result, monitoring somatic symptoms and physiological arousal using culture-specific language (e.g., blockages of Xi) rather than asking her to rate her anxiety will make this module more relevant.

Clinicians can also utilize self-report measures such as the Children's Depression Inventory (CDI-2 [55]) and Screen for Child Anxiety Related Emotional Disorders (SCARED) [54]. The CDI-2 is available in English and Spanish, and the SCARED is available in Arabic, Chinese, English, French, German, Italian, Portuguese, and Spanish. These measures allow young patients and families to monitor symptoms over time using objective assessment.

Target monitoring also facilitates functional analysis of problem behaviors by identifying antecedents and consequences [38]. Furthermore, monitoring emotional intensity in response to feared situations enables patients and clinicians to collaboratively develop a hierarchy of feared stimuli for graduated exposure [61, 66]. In short, target monitoring provides essential data that guides later phases of treatment.

Basic Behavioral Tasks

Basic behavioral tasks relevant to a patient's presentation are identified by reviewing data collected from the target-monitoring module. Techniques are designed

from classical conditioning, operant conditioning, and social learning theory. Behavioral procedures aim to change overt actions. Through practice of these activities, patients acquire new tools to more effectively cope with distress and change action tendencies associated with heightened emotional arousal [67, 68]. Basic behavioral tasks are particularly relevant to many immigrant youth as somatic symptoms are often predominant with these patients [69, 70].

For example, the ideal behavioral tasks for a child who reports significant anxiety marked by autonomic hyperarousal and somatic complaints include relaxation techniques. Diaphragmatic breathing or progressive muscle relaxation teaches the patient to interrupt the pattern of physiological hyperarousal [58]. Activities for youth combating depression include pleasant activities scheduling or behavioral activation to mitigate the lethargy induced by depression. These interventions augment sources of positive reinforcement and improve mood [58]. Social skills training, habit reversal training, contingency contracts, and implementation of reward systems are other available procedures [52, 60, 71]. Basic behavioral tasks actively and explicitly teach the child that he/she is able to exert some control over distressful experiences. Skills gained in this module instill hope, motivate patients to progress in treatment, and pave the way for future interventions. Two clinical examples of the way behavioral tasks were designed to attend to important cultural factors with immigrant patients and their families are described.

Case Study 1

Dakila (6) and Bayani (7) immigrated to the USA with their parents from the Philippines for their father's work when they were 4 and 5. The family presented to treatment for help with sibling conflict and behavioral outbursts that onset the year following their immigration to the USA when the boys were 4 and 5. The parents were hesitant to implement behavior charts because they felt overwhelmed with the number of behaviors that they hoped to change. Additionally, both parents worked two jobs and were concerned that the system would be inconsistent between caregivers (mother, father, aunt). They were also unwilling to "reward bad behavior," feeling like the boys "should" get along because they were family. The clinician suggested that in place of devising individual contingency contracts, the boys would have a joint reward system. The mother used a jar and added marbles to the jar each time the boys played nicely together, cooperated on chores, followed instructions, and executed other desired behaviors. When the jar was full, the boys earned a pizza night, a trip to the movies, or a picnic in the park. The parents were willing to provide family-oriented incentives, and the joint system was more manageable for the parents' busy schedules. By tailoring the behavioral tasks to fit the family's cultural values and their specific needs, the family was more engaged, and the intervention was highly successful.

Case Study 2

Nico (13) emigrated from Sudan with his 19-year-old sister and 24-year-old aunt after being granted political asylum in the USA. He developed school refusal in the year following immigration. The school was much larger and more chaotic than the academic environment he experienced in Sudan; Nico also hated the loud bells that rang often throughout the day. He endorsed substantial physiological hyperarousal upon arriving on school grounds and hated the way his skin "crawled." Nico spoke often about his desire to be in a "peaceful" place and reported that the school was so aversive because it was the "opposite" of peace. When training Nico in breathing exercises, the clinician likened the activity to "breathing in peace, and breathing out chaos." Pairing Nico's desire for peace with the behavioral intervention gave him a concrete understanding of how the exercise helped him to achieve his goals.

Cognitive Restructuring

Cognitive restructuring interventions target patients' thought content and thought processes. Youth learn to reduce cognitive distortions and train their minds to think more flexibly [58, 60, 66]. Cognitive interventions include problem-solving, reattribution, decatastrophizing, test of evidence, and self-instruction [52, 72]. The use of metaphors related to concrete ideas or the youth's interests heightens the patient's experience of cognitive interventions [64, 73].

Case Study 3

Jesper, a 9-year-old male who emigrated from Denmark with his parents within the past year, presented to therapy for generalized anxiety: Jesper's favorite thing to do was to watch sports on TV with his father. He especially loved that they could pause and rewind the game to see if the referee made a good call. Jesper and his therapist talked about how sometimes when he took time to gather more evidence, like watching replays, Jesper changed his mind. He drew a remote control and in sessions the therapist encouraged Jesper to "pause" his thoughts, "rewind" to look for evidence that either supported or refuted his beliefs, and use "slow motion" to slow down his thinking. Jesper's parents were especially pleased with the remote control exercise as they related easily to the concepts and even gave him a broken TV remote to use at home. Thus, the salience of this metaphor facilitated the use of cognitive coping skills, propelling therapy forward.

Case Study 4

Asuka, a 14-year-old Japanese girl, immigrated to the USA with her parents, brother, and grandparents when she was 10. Asuka was diagnosed with OCD and displayed contamination fears related to "sharing air" with people; she could not talk to others unless she stood several feet away to ensure she breathed "fresh" air. This dramatically interfered with her ability to develop a social support system despite the fact she found a group of girls who shared her passions for anime and manga—animated adventures in video and graphic novel formats. When she reached the cognitive restructuring module, her therapist suggested that she make her own manga to chronicle her "battles" against the OCD. Asuka delighted in the exercise and created extraordinary pages illustrating her cognitive contests against the OCD villain living in her mind. Not only did this exercise make cognitive interventions literally come alive for Asuka, it also established a way for her to open communication with her friends.

Exposures

The final module is *exposures*, the zenith of CBT. While each previous segment substantially contributes to young patients' treatment, the exposures module presents patients with the opportunity to synthesize the gains they have made thus far. The ultimate experiential learning, young patients engage in exposures to emotionally evocative stimuli then apply coping skills learned throughout therapy. These interventions transform patients' action tendencies and eliminate maladaptive behavior patterns.

Founded on the social learning theory, concepts of performance attainment and mastery are the mechanisms through which distress is relieved [58, 74]. Effective exposures must take place in the context of emotional arousal so that patients truly learn how to utilize coping skills in the face of their ultimate stressors [73–75]. Clinicians collaboratively devise exercises where patients face challenging situations identified in the hierarchy from the target-monitoring module [73]. Exercises begin with situations that elicit a moderate level of discomfort; patients confront the experiences and employ adaptive strategies to either reduce distress or tolerate the uneasiness. If the exposure is executed properly, patients' fear of the stimulus is diminished. In this fashion, patients "climb their ladders" as they move through situations ranked as increasingly upsetting. Termination of care is indicated once patients leap these hurdles.

Case Study 5

Mitra, age 11, was an Iranian; she and her parents left Iran when she was 3 and moved in with an aunt, uncle, and four cousins in the USA. Her parents brought her to therapy for treatment of anger outbursts that occurred solely in the context of school. Upon intake, Mitra had been suspended twice for fighting. Her parents were so perplexed by her behavior; they were considering sending her back to live with family in Iran. Therapy revealed that Mitra was lashing out at peers physically in response to ethnically charged teasing. Mitra lacked complex language skills to be able to "fight back" with her words. Mitra created a hierarchy specific to the behaviors of her peers that "made her explode." The lower-rated behaviors included people staring at her, pointing, and whispering and then climbed to name-calling and physical contact (e.g., pushing her).

After learning skills to use when she "got hot," Mitra and her therapist went out into the waiting room wearing different props to attract people's stares. Mitra noted that she did not feel as angry when adults looked at her as she did when other youth did. Therefore, to make the exercise more relevant, Mitra and her therapist went to sit in a pediatrician's waiting room.

For the final step, Mitra and the therapist went into a crowded coffee shop close to the clinic to practice how to remain calm when others bumped into her. When they first began this step, Mitra's father came to the coffee shop with them. Mitra realized that she felt safe with her father near, stating "he will always take care of me." Thus, they pursued further practice with no parent nearby. Because the therapist attended closely to the level of emotional activation evoked by the interventions, Mitra was able to generalize her learning to the school environment and finished the academic year without another fight.

Case Study 6

Tammy (15) was born in the USA but lived in Vietnam with her mother from the ages of 7 to 11 to care for her dying grandfather. During that time, her father and older brother stayed in the USA. She presented to treatment for restricted eating behaviors. Tammy played varsity basketball; she was smaller than her teammates but fast and very skilled. She told her therapist that she feels "short and fat" and all her friends are "tall and thin." She also reported that she feels "out of place" with her friends and that her parents "just don't get it." Tammy stopped eating meals at school, refrains from eating in public, and recently fainted during basketball practice. When she reached the exposure module of treatment, she and her therapist made plans to conquer the steps on her ladder: sitting in an eating establishment with food on her plate, eating something "unhealthy" in front of others, ordering food at a restaurant, and eating with friends.

A significant amount of Tammy's distress emerged from the fact that she perceived implicit scrutiny from friends who were "so different." Tammy's therapist was a young female Caucasian; thus, the therapeutic relationship itself presented opportunities for exposure. Tammy and her therapist conducted all exposure steps in a café. For Tammy's final exposure, she invited her basketball team to her house for a pizza party. By actively engaging in experiential learning, patients learn firsthand that their coping tools work, and they are able to tolerate situations that previously seemed unbearable [58].

Conclusion

Disney proclaims, "A smile means friendship to everyone" in their song "It's a Small World" [76]. CBT is no different as the modifications needed to make CBT relevant to immigrant youth are no more than those a proficient CBT clinician would construct to match a patient of any age or background. Some question whether CBT thoroughly addresses the complex concerns of immigrant youth; these doubts reflect insufficient grasp of the execution of skillful CBT. The flexibility inherent in the modular cognitive-behavioral model mandates careful attention to all cultural identities [32, 77]. If faced with challenges such as difficulty with verbal techniques or a language barrier, clinicians may adapt interventions to use play or nonverbal techniques (e.g., art/drawing). To augment generalization of skills, therapists can utilize family members, community supports, and/or teachers as indicated by the needs of the immigrant patient. Each of these represents a faithful alteration to treatment as the original mechanisms of change are maintained; the mode of delivery is tailored to the specific youth's needs.

As discussed throughout the chapter, modifications needed for work with immigrant youth are simple adjustments in content and area of focus, not to the model or mechanisms of change [12, 31]. Psychosocial factors specific to immigrant youth are readily addressed [28, 32], for example, including influential people in treatment when appropriate (e.g., family, teachers, community leaders), ensuring homework is achievable given patient's circumstances, and adding interventions to the modules that directly address ways to manage perceived discrimination. Furthermore, while there is limited evidence in support of the effectiveness of CBT with a wide range of immigrant youth, there is a total absence of data to suggest CBT impacts young immigrants adversely.

CBT is a theoretically sound, empirically supported, and easily adaptable treatment. The innovative design of modular CBT further enhances the benefits young patients gain from a therapy that is intimately tailored to fit their specific presenting problems. In order to deliver this efficacious treatment to immigrant youth, however, clinicians must practice faithful CBT. This chapter outlines the essential elements of CBT, attending to both content and process factors. Additionally, the chapter illustrates each component of treatment in the context of a clinical experience with a young immigrant patient.

Clinicians treating immigrant youth must develop a robust case conceptualization to address the layered complexities often present in young immigrant patients. The use of CBT with immigrant youth in particular allows for clinicians to appropriately adapt exercises to idiosyncratic symptom presentation, interests, and psychosocial contexts. From that formulation, clinicians must fashion treatment to specifically target the maintaining factors of the patient's distress. When therapy is accurately guided by a precise conceptualization, clinicians fluidly move from module to module as they target discrete behavioral excesses and deficits evidenced by youth. Using these skills, clinicians will provide immigrant youth with the much-needed support they seek in this "small, small world."

References

1. Huey SJ, Tilley JL, Jones EO, Smith CA. The contribution of cultural competence to evidence-based care for ethnically diverse populations. Annu Rev Clin Psychol. 2014;10:305–38. doi:10.1146/annurev-clinpsy-032813-153729.
2. Kataoka SH, Stein BD, Jaycox LH, Wong M, Escudero P, Tu W, et al. A school-based mental health program for traumatized Latino immigrant children. J Am Acad Child Adolesc Psychiatry. 2003;42(3):311–8.
3. Nicolas G, Arntz DL, Hirsch B, Schmiedigen A. Cultural adaptation of a group treatment for Haitian American adolescents. Prof Psychol Res Pr. 2009;40(4):378–84.
4. Stein BD, Jaycox LH, Kataoka SH, Wong M, Tu W, Elliott MN, et al. A mental health intervention for school children exposed to violence: a randomized controlled trial. JAMA. 2003;290(5):603–11. doi:10.1001/jama.290.5.603.
5. Huey Jr SJ, Polo AJ. Evidence-based psychosocial treatments for ethnic minority youth. J Clin Child Adolesc Psychol. 2008;37(1):262–301.
6. Pumariega AJ, Rothe E. Leaving no children or families outside: the challenges of immigration. Am J Orthopsychiatry. 2010;80(4):505–15.
7. Rettger JP, Kletter H, Carrion V. Trauma and acculturative stress. In: Patel S, Reicherter D, editors. Psychotherapy for immigrant youth. New York: Springer; 2015.
8. Ngo V, Langley A, Kataoka SH, Nadeem E, Escudero P, Stein BD. Providing evidence-based practice to ethnically diverse youths: Examples from the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program. J Am Acad Child Adolesc Psychiatry. 2008;47(8):858–62.
9. Beck JS. Cognitive behavior therapy: basics and beyond. 2nd ed. Guilford: New York, NY; 2011.
10. Friedberg RD, McClure JM. Clinical practice of cognitive therapy with children and adolescents: the nuts and bolts. 2nd ed. Guilford: New York, NY; 2015.
11. Benish SG, Quintana S, Wampold BE. Culturally adapted psychotherapy and the legitimacy of myth: a direct comparison meta-analysis. J Couns Psychol. 2011;58:279–89.
12. Cardemil EV. Cultural adaptations to empirically supported treatments: a research agenda. Sci Rev Ment Health Pract. 2010;7(2):8–21.
13. La Roche M, Christopher M. Changing paradigms from empirically supported treatments to evidenced based practice: a cultural perspective. Prof Psychol Res Pr. 2009;40:396–402.
14. Kazdin AE. Evidence-based treatment and practice: new opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. Am Psychol. 2008;63:146–59.
15. Kendall PC, Hudson JL, Gosch E, Flannery-Schroeder E, Suveg C. Cognitive-behavioral therapy for anxiety disordered youth: a randomized clinical trial evaluating child and family modalities. J Consult Clin Psychol. 2008;76(2):282–97. doi:10.1037/0022-006X.76.2.282.
16. Walkup JT, Albano AM, Piacentini J, Birmaher B, Compton SN, Sherrill JT, et al. Cognitive behavioral therapy, sertraline or a combination in childhood anxiety. N Engl J Med. 2008;359(26):2753–66.

17. Franklin ME, Sapyta J, Freeman JB, Khanna M, Compton SN, Almirall D, et al. Cognitive behavior therapy augmentation of pharmacotherapy in pediatric obsessive-compulsive disorder. J Am Med Assoc. 2011;306(11):1224–32.
18. March JS, Vitiello B. Clinical messages from the Treatment of Adolescents with Depression Study (TADS). Am J Psychiatr. 2009;166:1118–23.
19. Cohen JA, Deblinger E, Mannarino AP, Steer R. A multi-site, randomized controlled trial for children with abuse related PTSD symptoms. J Am Acad Child Adolesc Psychiatry. 2004;43(4):393–402.
20. Lochman JE, Powell NP, Boxmeyer CL, Jimenez-Camargo L. Cognitive-behavioral therapy for externalizing disorders in children and adolescents. Child Adolesc Psychiatr Clin N Am. 2011;20(2):305–18.
21. Eyberg SM, Nelson MM, Boggs SR. Evidence-based psychosocial treatments for children and adolescents with disruptive behavior. J Clin Child Adolesc Psychol. 2008;37(1):215–37. doi:10.1080/15374410701820117.
22. Wood JJ, Drahota A, Sze K, Har K, Chiu A, Langer DA. Cognitive behavioral therapy for anxiety in children with autism spectrum disorders: a randomized, controlled trial. J Child Psychol Psychiatry. 2009;50(3):224–34. doi:10.1111/j.1469-7610.2008.01948.x.
23. Sofronoff K, Attwood T, Hinton S. A randomised controlled trial of a CBT intervention for anxiety in children with Asperger syndrome. J Child Psychol Psychiatry. 2005;46(11):1152–60. doi:10.1111/j.1469-7610.2005.00411.x.
24. White SW, Ollendick T, Albano AM, Oswald D, Johnson C, Southam-Gerow MA, et al. Randomized controlled trial: Multimodal Anxiety and Social Skill Intervention for adolescents with autism spectrum disorder. J Autism Dev Disord. 2013;43(2):382–94. doi:10.1007/s10803-012-1577-x.
25. Waldron HB, Turner CW. Evidence-based psychosocial treatments for adolescent substance abuse. J Clin Child Adolesc Psychol. 2008;37(1):238–61. doi:10.1080/15374410701820133.
26. Keel PK, Haedt A. Evidence-based psychosocial treatments for eating problems and eating disorders. J Clin Child Adolesc Psychol. 2008;37(1):39–61. doi:10.1080/15374410701817832.
27. Beehler S, Birman D, Campbell R. The effectiveness of cultural adjustment and trauma services (CATS): generating practice-based evidence on a comprehensive, school-based mental health intervention for immigrant youth. Am J Community Psychol. 2012;50(1–2):155–68.
28. Dattilio FM, Bahadur M. Cognitive behavioral therapy with an East Indian family. Contemp Fam Ther. 2005;27(3):367–82.
29. Sandil R. Cognitive behavioral therapy for adolescent depression: Implications for Asian immigrants to the United States of America. J Child Adolesc Ment Health. 2006;18(1):27–32.
30. Patel SG, Tabb KM, Strambler MJ, Eltareb F. Newcomer immigrant adolescents and ambiguous discrimination the role of cognitive appraisal. J Adolesc Res. 2015;30(1):7–30.
31. Hays PA. Integrating evidence-based practice, cognitive-behavior therapy, and multicultural therapy: ten steps for culturally competent practice. Prof Psychol Res Pr. 2009;40(4):354–60.
32. Lyon AR, Lau AS, McCauley E, Vander Stoep A, Chorpita BF. A case for modular design: implications for implementing evidence-based interventions with culturally diverse youth. Prof Psychol Res Pr. 2014;45(1):57.
33. Kendall PC, Beidas RS. Smoothing the trail for dissemination of evidence-based practices for youth: flexibility within fidelity. Prof Psychol Res Pr. 2007;38(1):13–20. doi:10.1037/0735-7028.38.1.13.
34. Kataoka S, Novins DK, DeCarlo Santiago C. The practice of evidence-based treatments in ethnic minority youth. Child Adolesc Psychiatr Clin N Am. 2010;19(4):775–89.
35. Friedberg RD, Gorman AA, Beidel DC. Training psychologists for cognitive-behavioral therapy in the raw world: A rubric for supervisors. Behav Modif. 2009;33(1):104–23. doi:10.1177/0145445508322609.
36. Beidas RS, Koerner K, Wiengardt KR, Kendall PC. Training research: practical recommendations for maximum impact. Admin Pol Ment Health. 2011;38(4):223–37.

37. Kendall PC, Gosch E, Furr JM, Sood E. Flexibility within fidelity. J Am Acad Child Adolesc Psychiatry. 2008;47(9):987–93. doi:10.1097/CHI.0b013e31817eed2f.
38. Chorpita BF, Taylor AA, Francis SE, Moffitt C, Austin AA. Efficacy of modular cognitive behavior therapy for childhood anxiety disorders. Behav Ther. 2004;35(2):263–87. doi:10.1016/S0005-7894(04)80039-X.
39. Kendall PC, Hedtke K. Cognitive-behavioral therapy for anxious children: therapist manual. 3rd ed. Ardmore, PA: Workbook Publishing; 2006.
40. Bernal G, Cumba-Aviles E, Saez-Santiago E. Cultural and relational processes in depressed Latino adolescents. In: Beach SRH, Wamboldt MZ, Kaslow NJ, Heyman RE, Reiss D, editors. Relational processes and DSM-V: neuroscience, assessment, prevention and treatment. Washington, DC: American Psychiatric Association; 2006. p. 221–4.
41. Kuyken W, Padesky CA, Dudley R. Collaborative case conceptualization: working effectively with clients in cognitive-behavioral therapy. Guilford: New York, NY; 2008.
42. Pearl AM, Mahr F, Friedberg RD. Supervising child psychiatry fellows in cognitive behavioral therapy: crucibles and choices. J Cogn Psychother. 2013;27(1):61–71.
43. Friedberg RD, Gorman AA, Wilt LH, Biuckians A, Murray M. Cognitive behavioral therapy for the busy child psychiatrist and other mental health professionals: rubrics and rudiments. New York, NY: Routledge; 2011.
44. Macneil CA, Hasty MK, Conus P, Berk M. Is diagnosis enough to guide interventions in mental health? Using case formulation in clinical practice. BMC Med. 2012;10(1):111–3.
45. Persons JB. Cognitive therapy in practice: a case formulation approach. New York: Norton; 1989. p. 109–18.
46. Overholser JC. Collaborative empiricism, guided discovery, and the Socratic method: core processes for effective cognitive therapy. Clin Psychol Sci Pract. 2011;18(1):62–6.
47. Padesky CA, Greenberger D. Clinician's guide to mind over mood. Guilford: New York, NY; 1995.
48. Southam-Gerow MA. Emotion regulation in children and adolescents: a practitioner's guide. Guilford: New York, NY; 2013.
49. Creed TA, Kendall PC. Therapist alliance-building behavior within a cognitive-behavioral treatment for anxiety in youth. J Consult Clin Psychol. 2005;73(3):498–505. doi:10.1037/0022-006X.73.3.498.
50. Kingery JN, Roblek TL, Suveg C, Grover RL, Sherrill JT, Bergman RL. They're not just "little adults": developmental considerations for implementing cognitive-behavioral therapy with anxious youth. J Cogn Psychother. 2006;20(3):263–73. doi:10.1891/088983906780644037.
51. Podell JL, Kendall PC, Gosch EA, Compton SN, March JS, Albano A-M, et al. Therapist factors and outcomes in CBT for anxiety in youth. Prof Psychol Res Pr. 2013;44(2):89–98. doi:10.1037/a0031700.
52. Friedberg RD, Brelsford GM. Core principles in cognitive therapy with youth. Child Adolesc Psychiatr Clin N Am. 2011;20(2):369–78. doi:10.1016/j.chc.2011.01.009.
53. Overholser JC. Psychotherapy according to the Socratic method: integrating ancient philosophy with contemporary cognitive therapy. J Cogn Psychother. 2010;24(4):354–63. doi:10.1891/0889-8391.24.4.354.
54. Birmaher B, Khetarpal S, Brent D, Cully M, Balach L, Kaufman J, et al. The screen for child anxiety related emotional disorders (SCARED): scale construction and psychometric characteristics. J Am Acad Child Adolesc Psychiatry. 1997;36(4):545–53.
55. Kovacs M. The children's depression inventory: manual. Multi-Health Systems: North Tonawanda, NY; 1992.
56. Swanson JM. SNAP-IV scale. Irvine, CA: University of California Child Development Center; 1995.
57. Bearman SK, Weisz JR. Cognitive behavioral therapy for children and adolescents: an introduction. In: Szigethy E, Weisz JR, Findling RI, editors. CBT for children and adolescents. Washington, DC: American Psychiatric Publishing; 2012. p. 1–28.
58. Friedberg RD, McClure JM, Garcia JH. Cognitive therapy techniques for children and adolescents: tools for enhancing practice. Guilford: New York, NY; 2009.

59. Wilamowska Z, Thompson-Hollands J, Fairholme C, et al. Conceptual background, development and preliminary data from the unified protocol for transdiagnostic treatment of emotional disorders. Depress Anxiety. 2010;27(10):882–90.
60. Chorpita BF. Modular cognitive-behavioral therapy for childhood anxiety disorders. (J. Persons, Ed.). Guilford: New York, NY; 2007.
61. Weisz JR, Chorpita BF. "Mod Squad" for youth psychotherapy. In: Kendall PC, editor. Child and adolescent therapy. New York, NY: Guilford; 2012. p. 379–96.
62. Chorpita BF, Bernstein A, Daleiden EL. Empirically guided coordination of multiple evidence-based treatments: an illustration of relevance mapping in children's mental health services. J Consult Clin Psychol. 2011;79(4):470–80.
63. Weisz JR, Chorpita BF, Palinkas LA, Schoenwald SK, Miranda J, Bearman SK, et al. Testing standard and modular designs for psychotherapy treating depression, anxiety, and conduct problems in youth: a randomized effectiveness trial. Arch Gen Psychiatry. 2012;69(3):274–82. doi:10.1001/archgenpsychiatry.2011.147.
64. Friedberg RD, Gorman AA. Integrating psychotherapeutic processes with cognitive behavioral procedures. J Contemp Psychother. 2007;37(3):185–93. doi:10.1007/s10879-007-9053-1.
65. Huebner D. What to do when you worry too much: a kid's guide to overcoming anxiety. Washington, DC: Magination Press; 2005.
66. Kendall PC. Child and adolescent therapy. Guilford: New York, NY; 2006.
67. Ehrenreich JT, Goldstein CM, Wright LR, Barlow DH. Development of a unified protocol for the treatment of emotional disorders in youth. Child Fam Behav Ther. 2009;31(1):20–37. doi:10.1080/07317100802701228.
68. Chorpita BF. Modular cognitive-behavioral therapy for childhood anxiety disorders. Guilford: New York, NY; 2007.
69. Anderson ER, Mayes LC. Race/ethnicity and internalizing disorders in youth: a review. Clin Psychol Rev. 2010;30(3):338–48.
70. Kirmayer LJ, Narasiah L, Munoz M, Rashid M, Ryder AG, Guzder J, et al. Common mental health problems in immigrants and refugees: general approach in primary care. Can Med Assoc J. 2011;183(12):E959–67.
71. Kendall PC, Morris RJ. Child therapy: issues and recommendations. J Consult Clin Psychol. 1991;59(6):777–84. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/1774363.
72. Sburlati ES, Schniering CA, Lyneham HJ, Rapee RM. A model of therapist competencies for the empirically supported cognitive behavioral treatment of child and adolescent anxiety and depressive disorders. Clin Child Fam Psychol Rev. 2011;14(1):89–109. doi:10.1007/s10567-011-0083-6.
73. Peterman JS, Read KL, Wei C, Kendall PC. The art of exposure: putting science into practice. Cogn Behav Pract. 2014. doi:10.1016/j.cbpra.2014.02.003.
74. Barlow DH, Allen LB, Choate ML. Toward a unified treatment for emotional disorders. Behav Ther. 2004;35(2):205–30. doi:10.1016/S0005-7894(04)80036-4.
75. Kendall PC, Robin JA, Hedtke KA, Suveg C, Flannery-Shroeder E, Gosch E. Considering CBT with anxious youth? Think exposures Cogn Behav Pract. 2005;12:136–50.
76. Sherman RB, Sherman RM. It's a small world (after all). Anaheim, CA: Walt Disney Corporation; 1963.
77. Chorpita BF, Daleiden EL, Weisz JR. Identifying and selecting the common elements of evidence based interventions: a distillation and matching model. Ment Health Serv Res. 2005;7(1):5–20.

http://www.springer.com/978-3-319-24691-8

Psychotherapy for Immigrant Youth
Patel, S.; Reicherter, D. (Eds.)
2016, XVI, 203 p. 1 illus. in color., Softcover
ISBN: 978-3-319-24691-8