Culturally Responsive Psychoeducation Guide

Goals:

1. *Co-create an understanding of the presenting problem and a treatment plan that takes into consideration how anxiety and OCD function within the client's cultural context.*
2. *Normalize experiences and instill hope that the tailored treatment plan can help them meet their goals.*

Psychoeducation begins during the initial assessment and continues throughout treatment. Formal psychoeducation is typically delivered after an initial case conceptualization and serves as the first step in treatment. Ex-CBT always begins with psychoeducation about how anxiety and OCD conditions develop and are maintained. It also includes explicit information about the rationale for exposure practice to build motivation within the youth and family to make changes and empower them to do things that feel hard or overwhelming. An important goal of psychoeducation is to develop a shared narrative of a client's mental health difficulty and how the treatment plan will address their concerns.

We provide specific guidance on how to incorporate what we learn from the cultural assessment into psychoeducation so that clients feel heard, respected, and that treatment is responsive to their unique cultural context.

The principles below can be applied to any youth struggling with anxiety or OCD and are particularly relevant for youth with marginalized and minoritized identities.

Guiding Principle #1: Discuss the role of avoidance both in protecting against harm and maintaining anxiety. Emphasize the importance of learning to break maladaptive cycles of avoidance through gradual, supported exposure practice. For OCD cases, explicitly discuss how compulsions relate to the cycle of avoidance. Include in this discussion the ways in which avoidance may be serving a protective role. The idea of exposure practice is naturally scary, and it is critical that youth and families understand the rationale for facing scary things on purpose.

- Intended Impact*:* Demonstrate that you understand that some avoidance may be adaptive and that you will never ask them to engage in exposure practice that could put a child in intentional harm's way. Communicate the rationale for exposure.
- Strategies:
  - Discuss with the client the ways that avoidance has and has not been protective or helpful.
    - *Sample Language: "Just like we talked about some anxiety alarms being helpful and others not so much, similarly, sometimes we avoid things because it keeps us safe. For example, avoiding spending time with people who call you names or are mean to you because of your gender identity can keep you safe, and at the same time, avoiding going to class to not have to be with those peers is getting in the way of your goals of doing well in school."*
  - Provide clear examples of how you see maladaptive cycles of avoidance occurring for the child to increase buy-in to the concept of Ex-CBT (e.g., checking the locks 25 times before bed) while also demonstrating your understanding of what you may *not* ask them to do (e.g., sleep with the door unlocked in an unsafe neighborhood).
  - For youth with OCD: Explicitly highlight how compulsions serve to continuously try to remind youth that the content of their obsessions isn't true (e.g., repeated checking that you have not run someone over with a car helps give mini bursts of relief that the obsessive thought did not occur). Youth with OCD may worry that disclosing the content of their obsessions will lead them to be labeled as crazy or potentially even result in hospitalization

or arrest; they also may worry that you as the therapist will judge them and think they cannot be helped.

- Share with youth that when someone has OCD, the only way they can feel sure that the content of their obsessions is untrue is through repeated compulsions. Explain that the goal of treatment is for them to learn that through gradual, repeated practice, they can begin to have faith the content is not true without doing compulsions.
- Normalize that OCD content can be really varied and that you have "heard it all before".
  - It can be helpful for some youth to frame OCD as the "best friend you never wanted." In other words, OCD takes what's important to you (e.g., being a good person) and "gets it twisted," such that the content of obsessions stands in stark contrast to one's own values. By engaging in compulsions, OCD wants you to repeatedly remind yourself that the content of your obsessions isn't true – in its own twisted way, it is trying to help! Ex-CBT can then be presented as a way to help youth learn *on their own* that they can have faith they are a good person, rather than relying on rituals and compulsions.
  - Sample Language*: "I know it can be hard to sometimes share what OCD is saying to you. I want you to know that I know what OCD does and I guarantee you I probably won't be surprised or shocked by what you share with me. The fact that you are having a hard time sharing this with me tells me that you are someone who really cares about being a good person."*

Guiding Principle #2: Culture influences clients' comfort in discussing or showing emotion. Some cultures think that conversations about difficult emotions are too adult for children. Others place an important emphasis on appearing calm or strong. Understanding each family's culture around discussing emotions (in addition to discussing how anxiety is a normal and natural emotion that functions to keep us safe from harm and motivate us to stay healthy and be successful) can help you meet families where they are and identify areas where there may be flexibility to make change.

- Intended Impact: *Develop a common understanding and language around anxiety and OCD*
- Strategies*:*
  - Ask the client/caregiver about their family approach to expressing emotions.
  - Validate and respect their views while explaining the importance of communicating emotions.
    - Sample Language: *"We are seeing now that when your child holds in their emotions and doesn't share or cope that she experiences a lot of pain. How do you feel about us coming up with more helpful ways to deal with her feelings of worry?"*
  - Ask about the words that families use to describe different emotions/experiences, including those from other languages. Use these words in combination with more traditional emotion words.
    - Sample Language: *"People can describe what I refer to as anxiety in many ways. What words do you and your family usually use to discuss anxiety or stress?"*

Guiding Principle #3: Minoritized clients can experience chronic invalidation of their minority stress experiences and are more likely to experience mistrust in their providers than youth of majority background. When Ex-CBT approaches are applied too rigidly, they run the risk of invalidating client experiences by over-focusing on thoughts as irrational and physiological, emotional, or behavioral responses as exclusively maladaptive. Validating the client's experiences as legitimate allows the family to feel heard.

- Intended Impact: *Validate the client's experiences and their physiological, emotional, and behavioral responses to demonstrate you understand their difficulties and are prepared to help.*

- Strategies:
  - Discuss how the client's physiological, emotional, and behavioral responses make sense, given their life context.
    - Sample Language*: "What you are going through is hard/real. It makes sense that you are feeling angry given the experiences you are having."*
  - Discuss how client's behaviors may have been protective or adaptive for them at one time and determine whether they are continuing to serve a fully adaptive function.
    - Sample Language: *"It seems like there are situations where avoidance has been helpful to you and has protected you from harmful situations. At the same time, it seems like the avoidance is no longer serving you."*

Guiding Principle #4. Standard psychoeducation regarding how anxiety functions as our body's alarm system ("fight, flight, freeze"), and how anxiety and OCD arise when that alarm system becomes oversensitive, should explicitly acknowledge how the body's alarm system responds to chronic identity-related and environmental stressors and incorporate the client/families understanding of anxiety. Some youth, especially those who have experienced chronic stressors, may have developed anxiety alarm systems that can look maladaptive or irrational to an outsider but best be understood as functioning in a protective capacity when considering the youth's context.

- Intended Impact*:* Understand the effects of chronic stressors to collaboratively determine which alarms are helpful and which are contributing the unnecessary distress. In addition, tailoring the explanation of the maintenance of anxiety to the family's beliefs can ensure shared understanding of the cause and maintenance of anxiety.
- Strategies*:*
  - Acknowledge that some anxiety alarms are "gray" and that you will want to work collaboratively to understand if a particular alarm is ultimately helping a youth or contributing to unhelpful anxiety.
    - If relevant, provide psychoeducation about how trauma (including intergenerational and historical or inherited trauma) can make our anxiety alarms more sensitive.
    - When relevant, describe that some anxiety alarms may have been helpful in the past to keep one safe or cope with past trauma, but may no longer be helpful.
  - For youth who have experienced identity-based discrimination or environmental stressors, explicitly discuss the role of experiences of discrimination and chronic stressors on making our anxiety alarms more sensitive and negatively impacting mental/physical health in general.
    - Constant stress can be toxic to the body and lead to physiological responses like body tension, health problems, and even changes in brain functioning due to the constant release of stress hormones.
    - Negative thoughts about oneself can arise if we repeatedly encounter negative or critical feedback from others and our environment.
  - Incorporate client/family's understanding of mental health.
    - For clients experiencing identity or environmental stressors, discuss how these stressors may be contributing to their stress and anxiety responses.
      - Sample Language*: "Our anxiety alarms can be triggered by many different things. Sometimes being in certain places or around certain people may trigger our anxiety alarm because of negative experiences we have had, like discrimination based on your identity. Has this been true for you?"*
    - For families with more biological or medical beliefs about the cause of their child's mental health, highlight how our brain triggers the release of hormones called cortisol that helps our bodies prepare for action (fight, flight, freeze) and how this influences our emotional experiences and behaviors.

- For clients/families who attribute their child's mental health difficulties to religious causes (e.g., lack of prayer), acknowledge the importance of religion in their lives, and ask if you can share additional explanations that may also contribute to the experiences they are having. In addition, discuss the role religion plays in the family and their coping, keeping in mind ways in which religious practice may be incorporated into the treatment plan (e.g., included as a coping thought, behavioral activation, encouraged as a family strength).
- For caregivers who report a lot of self-blame (e.g., "*my anxiety disorder caused this for my child*"), provide explicit information about a multifactorial etiology of anxiety disorders to reduce guilt and empower parents to take an active role in treatment.

***Guiding Principle #5:* Explain the potential impact of Ex-CBT to improve symptoms, describing how it is known to be helpful, has been tested in multiple studies, and can work as well as medication to address concerns. Discuss the potential of a combination approach of Ex-CBT and medication to treatment depending on youth response and family comfort. Explain strategies you may use to support youth motivation (e.g., reducing family accommodation, rewards). Throughout this discussion, elicit the client/caregiver perceptions of Ex-CBT and associated strategies to determine how their values align and increase engagement in treatment.**

- Intended Impact*:* Clients and families come to therapy with different perspectives of mental health. Some will struggle with the idea of anxiety/OCD or therapy itself. Seeking therapy may also run counter to some cultural norms. Improve engagement and ensure that the treatment plan aligns with the client's goals, values, and understandings of mental health. Eliciting feedback from the family throughout psychoeducation can help ensure shared understanding of treatment and goals.
- Strategies*:*
  - Take the time to make sure the client and family have clear expectations of treatment and treatment goals – even if it adds 1-2 sessions of psychoeducation.
  - For families whose anxiety is in part tied to realistic fears associated with identity-related or environmental stressors, discuss the importance of tolerating some anxiety, while also working on changing the environment to reduce experiences of harm.
  - Encourage the family to ask questions and make decisions with you about their treatment plan. Ensure the treatment plan aligns with client and family's values, goals, and expectations.
    - Elicit information about accommodation patterns and learn the caregivers' perspectives on how those patterns formed. Parenting values can influence how the caregiver responds to their child's anxiety, including accommodation behaviors. Knowing their values can allow you to validate their responses AND help them develop other behaviors that support their child in approaching anxious situations.
      - Sample Language: *"You mentioned that you care a lot about protecting your child. How, if at all, does that relate to how you respond when you notice that she is stuck/anxious? How might helping your child approach anxiety-provoking situations also fit with your desire to protect her?"*
    - Ask questions to ensure the treatment plan aligns with child/family's personal goals, values, or beliefs.
      - Sample Language: *"How does working to help your child approach situations that cause anxiety or stress align with your goals/values/beliefs?"*
      - Sample Language: *"How does the plan we have discussed fit with the goals you have as a family?"*
      - If parenting beliefs, values, or behaviors don't align with treatment strategies (i.e., exposure, rewards, consequences), acknowledge valid reasoning behind their

practices, give rationale for the strategy by connecting it to the family's goals and values, then engage in collaborative decision making to find culturally congruent strategies.

***Guiding Principle #6*: How you deliver psychoeducation is just as important as the content that you deliver for the family to take in the information presented.**

- Intended Impact: Rarely will individuals be willing to try things that are hard and scary if they do not understand the rationale for doing so. People often come to therapy in an emotional state, which can greatly impact one's ability to receive information successfully. A collaborative style (in contrast to a didactic, lecturing style) that frequently assesses family understanding and agreement with concepts presented can help you understand how much time to spend in the psychoeducation phase (and when and how to revisit it throughout treatment) and how to tailor the content to move families toward a willingness to try Ex-CBT.
- Strategies:
  - As you share information, ask clarifying questions to ensure joint understanding.
    - Sample Language: "*Does that fit your understanding of what is happening? Does this sound like what you are experiencing or am I missing something?"*
  - Use examples in the client's words presented during the assessment or collaboratively come up with examples to explain concepts (e.g., anxiety triggers, flight/fight/freeze responses, avoidance).
  - Be mindful not to overfocus on irrational fears, especially if the youth is also experiencing contextual stressors that are contributing to symptoms.
  - As you move toward the conclusion of your formal psychoeducation phase of treatment, help the child/family be able to tell a cohesive story of their anxious experiences.
    - What are the client's triggers of anxious feelings?
      - Sample Language: *"I also heard about how experiencing racism and microaggressions from your peers at school, as well as some worries about being embarrassed in front of others, contribute to your feelings of anxiety. Is that right?"*
    - What are the client's anxiety responses?
      - Sample Language: *"We talked about how anxiety/OCD can lead your body to have different reactions, for you that looks like some fight responses with your mom, flight with leaving social situations when they feel uncomfortable, or avoiding them altogether."*
    - How is their anxiety maintained and how will it be addressed in therapy?
      - Sample Language: *"Lastly, we talked about how the way anxiety sticks around or grows is by avoiding, and together we will decide what types of situations make sense to avoid and which we want to work on approaching together."*

References

1. Arora, P. G., Parr, K. M., Khoo, O., Lim, K., Coriano, V., & Baker, C. N. (2021). Cultural Adaptations to Youth Mental Health Interventions: A Systematic Review. *Journal of Child and Family Studies*, *30*(10), 2539–2562. https://doi.org/10.1007/s10826-021-02058-3
2. Carter, M. M., Mitchell, F. E., & Sbrocco, T. (2012). Treating ethnic minority adults with anxiety disorders: Current status and future recommendations. *Journal of Anxiety Disorders*, *26*(4), 488–501. https://doi.org/10.1016/j.janxdis.2012.02.002
3. *CBT+ Tips for Culturally Responsive Practice.pdf*. (n.d.). Retrieved November 7, 2022, from https://depts.washington.edu/uwhatc/PDF/TF-%20CBT/pages/1%20Therapist%20Resources/CBT+%20Tips%20for%20Culturally%20Responsive%20Practice.pdf
4. Chu, J., & Leino, A. (2017). Advancement in the maturing science of cultural adaptations of evidence-based interventions. *Journal of Consulting and Clinical Psychology*, *85*(1), 45–57. https://doi.org/10.1037/ccp0000145
5. Hall, G. C. N., Berkman, E. T., Zane, N. W., Leong, F. T. L., Hwang, W.-C., Nezu, A. M., Nezu, C. M., Hong, J. J., Chu, J. P., & Huang, E. R. (2021). Reducing mental health disparities by increasing the personal relevance of interventions. *American Psychologist*, *76*(1), 91–103. https://doi.org/10.1037/amp0000616
6. Hays, P. A. (n.d.). *Addressing Cultural Complexities in Practice: A Framework for Clinicians and Counselors.*
7. Hinton, D. E., & Patel, A. (2017). Cultural Adaptations of Cognitive Behavioral Therapy. *Psychiatric Clinics of North America*, *40*(4), 701–714. https://doi.org/10.1016/j.psc.2017.08.006
8. Park, A. L., Rith-Najarian, L. R., Saifan, D., Gellatly, R., Huey, S. J., & Chorpita, B. F. (2022). Strategies for Incorporating Culture into Psychosocial Interventions for Youth of Color. *Evidence-Based Practice in Child and Adolescent Mental Health*, 1–13. https://doi.org/10.1080/23794925.2022.2025629
9. Pinciotti, C. M., Smith, Z., Singh, S., Wetterneck, C. T., & Williams, M. T. (2022). Call to action: Recommendations for justice-based treatment of obsessive-compulsive disorder with sexual orientation and gender themes. *Behavior Therapy*, *53*(2), 153-169. https://doi.org/10.1016/j.beth.2021.11.001
10. Samuels, J., Schudrich, W., & Altschul, D. (n.d.). *Toolkit for modifying evidence-based practice to increase cultural competence*. Research Foundation for Mental Health. calmhsa.org/wp-content/uploads/2013/10/ToolkitEBP.pdf
11. Vieten, C., Scammell, S., Pilato, R., Ammondson, I., Pargament, K. I., & Lukoff, D. (2013). Spiritual and religious competencies for psychologists. *Psychology of Religion and Spirituality*, *5*(3), 129–144. https://doi.org/10.1037/a0032699
12. Williams, M. T., Rouleau, T. M., La Torre, J. T., & Sharif, N. (2020). Cultural competency in the treatment of obsessive-compulsive disorder: Practitioner guidelines. *The Cognitive Behaviour Therapist*, *13*, e48. https://doi.org/10.1017/S1754470X20000501
13. Wood, J. J., Chiu, A. W., Hwang, W.-C., Jacobs, J., & Ifekwunigwe, M. (2008). Adapting cognitive-behavioral therapy for Mexican American students with anxiety disorders: Recommendations for school psychologists. *School Psychology Quarterly*, *23*(4), 515–532. https://doi.org/10.1037/1045-3830.23.4.515

14. Zerrate Parra, M. C., Ortin-Peralta, A., Erban, R., Reyes-Portillo, J., Schonfeld Reichel, E., Desai, P., & Duarte, C. S. (2020). Providing Evidence-based and Culturally Competent Care to Racial/ethnic Minority Young Adults with Anxiety Disorders: The Experience of an Urban Medical Center Clinic. *Evidence-Based Practice in Child and Adolescent Mental Health*, *5*(2), 189–207. https://doi.org/10.1080/23794925.2020.1765436