Case Conceptualization and Treatment Planning Guide

Overview

Goals:

1. *Integrate cultural and contextual understanding of the client's mental health difficulties and symptom experience to inform case conceptualization and treatment planning for anxiety and OCD.*
2. *Select culturally and contextually relevant treatment strategies to address anxiety and OCD.*

This section provides guidance for conceptualization of your client's mental health difficulties within their cultural context and the development of culturally responsive treatment plan. It is meant to be referenced throughout the treatment process as your case conceptualization evolves.

A primary question for any youth with anxiety and OCD is whether Ex-CBT is appropriate, considering the client's presenting problem(s) and cultural and environmental context.

The **aim of Ex-CBT** is to empower youth to face feared situations and learn to tolerate difficult emotions that lead to **maladaptive avoidance,** defined as distress that is driven by anxiety, fear, or intrusive thoughts. Ex-CBT is the **gold-standard, frontline psychosocial treatment approach for anxiety/OCD**. Ex-CBT may need to be augmented with additional treatment strategies to specifically address cultural and environmental context. However, in some cases, when facing feared situations is not appropriate, Ex-CBT may be contraindicated.

Many youth, especially those from marginalized or minoritized backgrounds, experience **realistic fears** and chronic stressors that contribute to anxious distress. Such stressors can lead both to **adaptive ("helpful") or maladaptive ("unhelpful") avoidance**. Determining the extent to which a youth experiences **helpful avoidance** and **unhelpful avoidance** is critical for shaping your treatment plan – Ex-CBT targets **unhelpful avoidance,** and augmented strategies can be used to address other stressors. Importantly, we acknowledge that fears and avoidance are not binary and instead exist on a continuum.

> **Realistic or helpful fears and worries** may include anxiety or distress related to environmental or identity-related stressors. These fears signal real risk associated with different situations.
>
> **Adaptive avoidance** is associated with realistic or helpful fears. Adaptive avoidance refers to youth avoiding situations that place them at high risk for physical or psychological harm (e.g., not wanting to go to the neighborhood park because of fear of gang activities, avoiding a certain person at school who verbally harassed them due to their gender identity, avoiding a life-threatening allergen). Adaptative avoidance is not targeted through Ex-CBT. Changing youths' thoughts or exposing them to distress associated with realistic, challenging situations without trying to change or improve the environment can give the message that the youth or their family is to blame – or even worse, put the youth or family in harm's way.

We must be careful not to attribute symptoms of anxiety-related distress to internal client experiences (e.g., distorted thought patterns) when they may be caused, at least in part, by environmental conditions associated with adverse social determinants of health (e.g., economic instability, housing/food insecurity, neighborhood and built environment, social and community

context, such as family conflict, [intergenerational] trauma, or identity-related stressors, including identity-based discrimination, immigration, or acculturation stressors).

Summary

We want youth to learn to listen to their anxiety alarms when they are adaptive and helping them stay safe, remain healthy, or be successful.

Ex-CBT is the recommended treatment strategy when youth are struggling with **maladaptive avoidance.**

We **do not recommend** using Ex-CBT for realistic or helpful fears that drive **adaptive avoidance**.

However, youth who have realistic fears *may* also benefit from Ex-CBT strategies in addition to augmented supportive and advocacy strategies (See Augmentation Strategies Section) **IF** realistic fears are causing maladaptive avoidance or compulsive behaviors to reduce distress or if they are co-occurring with other unhelpful fears that are causing distress or unhelpful avoidance.

Clinical Guidance for Determining When to Use Ex-CBT

One of the most common challenges clinicians face (especially when working with marginalized youth) is determining when to target fears that may be realistic or helpful, and to what extent avoidance behaviors are adaptive.

There is no clear, universal rule of what fears and associated avoidance behaviors are and are not helpful; determining this can be challenging. Fear and avoidance are best understood as on a continuum, and **understanding a client's cultural and environmental context is essential for determining the extent to which a youth's avoidance is adaptive or maladaptive**. For example, physiological arousal and scanning your environment for danger can be adaptive or helpful in one setting (e.g., in a community with high levels of violence, walking an unfamiliar city street after dark) and less helpful in another (e.g., on a supervised school playground).

We recommend that clinicians work closely with clients and their caregivers to determine what avoidance behaviors are appropriate to target with Ex-CBT, guided by the child's distress, level of impairment, family preferences and values, and clinical judgment. This is often challenging – a feared outcome (e.g. getting sick, becoming injured) may very well be possible; however, associated avoidance may be majorly interfering and still warrant treatment focus.

> **Culture can influence whether avoidance is considered adaptive or appropriate.** For example, in many cultures a child sharing a bed with their caregiver may be normative and unnecessary to target, while in other families it may be disruptive.
>
> **Intergenerational anxiety also can influence whether avoidance is viewed as adaptive.** For example, a parent who also struggles with anxiety may be more likely to view their child's avoidance as non-problematic due to their own symptoms.

We also recommended that clinicians engage in ongoing self-reflection to increase awareness of their own perceptions of what is adaptive or maladaptive avoidance. You may ask yourself, "How do my own experiences inform my perspective of whether this avoidance is unhelpful?", and "What realistic fears have I dealt with or *not* had to deal with that affect how I interpret my client's fears?" Self-reflection can help avoid making assumptions and ensure treatment goals are set in collaboration with the client and their family and guided by what is most important to them.

An Avoidance Continuum document is provided with examples of how fears can lead to both adaptive and maladaptive avoidance across a continuum.

Case Examples Illustrating How to Determine When to Use Ex-CBT

Case #1: *An 8-year-old male who recently immigrated from Mexico is experiencing anxiety around leaving his mother and going out in public, including frequent reassurance seeking from his mother about whether she will be safe. Upon further assessment, it becomes clear that he is afraid of his mother being deported.*

1. **Key Question:** To what extent are client's fears normative or adaptive based on their cultural or environmental context?
    - **Ask the client: "***You told me you are worried about your mom being deported;*

that sounds scary. Is that something that has happened to someone you know?"

- **Ask the caregiver:** "*I want to better understand your son's worries and support your family. Nothing you tell me will be shared outside this room. You mentioned that your son is worried about leaving the house because he is afraid you will be deported. Is that something that you are concerned about? Has this ever been a concern for your family or others close to you that your child may have witnessed?"*
  - **Decision point:**
    - *Fears do not seem normative or adaptive:* The client's mother shares that she has a work visa and is not concerned about deportation. The child and the mother share that watching the news has contributed to the child's worries. This may indicate that the fears are (at least in part) due to unhelpful and unrealistic fears.
      - **Ex-CBT may be indicated if this worry is contributing to maladaptive avoidance or distress.**

    - *Fears may be normative or adaptive***:** The client's mother shares that she is concerned about deportation due to her immigration status and increased political rhetoric about immigrants. This suggests that the fears are likely consistent with their life circumstances.
      - **Ex-CBT may or may not be indicated, depending on the level of avoidance and distress.**

2. **Key Question:** Do my client's fears lead to *maladaptive* avoidance that is getting in the way of their goals, values, or functioning?
   - **Ask the client: "***Is your fear about your mom's potential deportation preventing you from doing the things you would like to do?"*
   - **Ask the caregiver: "***Do you think your child is unable to do things that are important to them or to you because of their fear?"*
     - **Decision point:**
       - **Maladaptive Avoidance Endorsed:** Child is avoiding school (something important to both caregiver and child); this avoidance seems to be impairing the child's day-to-day functioning.
         - **Ex-CBT is likely indicated.**
       - **No Maladaptive Avoidance Endorsed:** Child is only avoiding locations with a high police presence, and this does not limit anything within their day-to-day functioning.
         - **Ex-CBT may not be indicated depending on the level of avoidance and distress. The client may still benefit from professional mental health supports to facilitate healthy functioning in the face of ongoing stressors.**

Case #2: *A 13-year-old Black female presents with social and generalized anxiety worries, including fears of being harmed on public transportation or in her home, which leads to repeated lock checking and constant review of the news to see if there have been recent crimes in her area. It is unclear to what extent fear and avoidance should be attributed to environmental dangers or to unrealistic worry, intrusive thoughts, or compulsive behavior.*

1. **Key Question:** To what extent are client's fears normative or adaptive based on their cultural or environmental context?

- **Sample questions to ask the client:** "*You mentioned feeling unsafe taking the bus to school and repeatedly checking that the door is locked after you get home. Can you tell me a little bit more about that? What are you worried might happen? Have you or someone you know experienced that before? How do other kids in your neighborhood get to school? Do your parents expect you to take the bus or to check the locks to your house? Do others in your family do that too?"*

- **Sample questions to ask the caregiver:** "*I want to better understand your daughter's worries from your perspective. Your daughter mentioned that she is worried about taking the bus to school. She also mentioned she feels unsafe and that someone may break into her home, which leads her to check the locks. Is this also a concern for you? Have you or others close to you had bad or unsafe experiences on the bus or had someone break into your home? How do other kids your child's age get to school? Do you expect your child to check the locks multiple times? Do you or others in your family check the locks or are you concerned about break-ins?"*

    - **Decision point:**
        - *Fears do not seem normative or adaptive: Client* has not witnessed or heard of anyone in their family or neighborhood being harmed on the bus, but she has heard on the news that people have been assaulted on the bus near her home. Child and caregiver note that most kids her age take the bus alone or in groups to school. Caregiver says that once the door has been locked, no one else in the family feels the need to check the lock again.
            - **Ex-CBT may be indicated if this worry is contributing to maladaptive avoidance or distress.**
        - *Fears may be normative or adaptive***:** Client is worried that she may be physically or sexually harmed. Client knows kids in their neighborhood who have been harassed on the bus, and at her local bus stop. Child and caregiver note that most kids in the neighborhood do not take the bus alone and usually go with an adult from the community or with another child. They report checking locks to ensure safety is an important part of the family's routine and that of others in their neighborhood.
            - **Ex-CBT may or may not be indicated, depending on the level of avoidance and distress.**

2. **Key Question:** Do my client's fears lead to *maladaptive* avoidance that is getting in the way of their goals, values, or functioning?
    - **Ask the client: "***Is your worry about taking the bus getting in the way of things for you? How many times are you checking the locks? Is it distracting you from other things you would like to be doing?"*
    - **Ask the caregiver: "***Do you think your child is not able to do things that are important to you all because of her worry about taking the bus? Do you think your child's worry about safety and checking the locks gets in the way for her?"*
        - **Decision point:**
            - **Maladaptive Avoidance Endorsed:** Child is avoiding the bus and mother must ride the bus with her daily, risking mother being late to work; the avoidance seems to be impairing the child's day-to-day. Child checks the locks approximately 15 times a night and has trouble engaging in

homework and leisurely activities.
  - **Ex-CBT may be indicated.**
- **No Maladaptive Avoidance or Distress Endorsed:** Child reports she would have no trouble taking the bus alone, she just likes getting to spend time with her mother. Child checks the locks one or two times a night before going to bed, but it does not distract her from other activities.
  - **Ex-CBT may not be indicated.**

For both example cases, if the child endorses significant avoidance, even if their fear is realistic, some Ex-CBT practice is likely warranted. If the child is not experiencing significant maladaptive avoidance, exposure is likely not indicated and other supportive strategies should be used. If realistic fears are present, augmented strategies (e.g., supportive and advocacy strategies: See Augmentation Strategies Section) are likely warranted, regardless of whether Ex-CBT is also indicated.

*These case examples are based on client's seen in a community clinic serving primarily low-income youth and families. It is important to note that aspects of culture and context should always be considered whether the client holds multiple or no marginalized identities.

Ex-CBT Treatment Planning Guide

Let's say that based on assessment and screening, you determine that a youth has anxiety and OCD symptoms worth targeting through Ex-CBT. For some youth, Ex-CBT may be sufficient for them to reach their treatment goals. However, for others, Ex-CBT will be only one tool of many to help them manage their distress more effectively.

This **five-step guide** will help you map out a treatment plan to address the client's symptoms that considers the client's treatment goals, cultural context, and any chronic environmental and identity-related stressors alongside other common co-occurring mental health difficulties. This guide builds on the Person-Centered Cultural Assessment section to support you in identifying an initial, cohesive set of treatment strategies to address the client's needs.

Note: This section is intended to help you develop a high-level treatment plan. Subsequent sections of this toolkit on specific treatment strategies will go into more detail on how each strategy can be optimally delivered in a culturally responsive way, as well as provide examples of how to apply them.

Step 1: Continuously situate presenting problem within client's cultural and environmental context to inform responsive treatment planning.

Selecting treatment strategies that align with a family's values and cultural context fosters treatment relevance and engagement. Principles of these considerations are woven throughout the remainder of this section.

Cultural and Contextual Factors	**Guidelines for situating presenting problem within the client's cultural and environmental context, treatment tailoring and intervention selection**
Cultural Understanding of the Problem and Its Cause	• Use the client's own explanation of their symptoms/causes to prioritize treatment targets and guide your presentation of psychoeducation
Cultural Perceptions of Mental Health	• Incorporate client/family perceptions of mental health into psychoeducation (see Psychoeducation Section)
Family Norms and Values	• Align treatment strategies with client and family's values and goals
Cultural Context: Social Identities (e.g., race, sexuality, gender, class, immigration status, religion or spirituality, languages, disability)	• Identify how aspects of identity relate to treatment priorities and symptom experience to inform psychoeducation and treatment strategy selection.
Cultural Context: Supports	• Identify cultural and family supports that can be leveraged throughout treatment
Cultural Context: Stressors	○ Identify environmental stressors or social determinants of health that may be influencing the client's mental health including the

	causes and experiences of their current mental health difficulty
Previous Treatment Experiences	• Identify how previous experiences with mental health treatment/providers influence current perceptions of care • Acknowledge, validate, and discuss these concerns initially and throughout treatment as relevant • Clarify how current treatment will be different and collaborate to identify ways to improve their experience (e.g., transparent communication about expectations and therapy processes)
Current Treatment Expectations	• Use transparent communication to discuss how treatment may differ from expectations and incorporation of preferences

We provide specific examples of ways to tailor content to be relevant to the client's cultural context within each treatment strategy section in the toolkit.

Step 2: Shape the treatment support team
Using information from the assessment and your reflections in Step 1, work with the family to determine who in the child's life should be involved in treatment (whether they attend all or only some sessions). Some examples of possible support team members include, but are not limited to, parents, grandparents, other family members, teachers, religious leaders, natural healers, interpreters, nannies, coaches, or close family friends.

Below are guiding questions to help determine the treatment support team:

- Who is the child's family support network?
- Where are symptoms most impairing (e.g., school, community, home)?
- What cultural and family supports can be leveraged (sports teams, religious groups)?
- Are language supports needed for client or family members?

Step 3: Identify a cohesive set of treatment strategies to address youth needs
Psychoeducation and exposure techniques are **always** included in treatment for youth with anxiety disorders and OCD, as both have maladaptive avoidance as a key diagnostic feature. However, there are often additional strategies that should be utilized to best meet the client's needs. The below table is intended to highlight various ways youth may present clinically and provide targeted, theoretically informed, suggestions for indicated treatment strategies to augment psychoeducation and exposure techniques.

The below table consists of an overview. Specific guidelines for delivering each strategy are presented later in the toolkit (see Psychoeducation, Exposure, Cognitive Skills, or Augmentation Strategies section).

Remember: Initially indicated strategies may shift over treatment as you build relationships with your client and learn more about their needs.

Aspect of Clinical Presentation	Indicated Strategies and Mechanisms
Basic Needs and Safety Concerns	
Basic needs are not being met (e.g., housing, food, support, transportation, school supports)	• **Case management** → connect to resources (e.g., transportation passes, school support) • **Problem solving** → determine possible options for changing/improving environmental context *Basic needs should be addressed at the outset of treatment for the client to have the opportunity to benefit from treatment*
Client is experiencing thoughts of self-harm or self-harm behaviors	• **Safety planning** → Create plans to stay safe when heightened emotions and thoughts of self-harm arise • **Connect to strengths (personal/cultural/community)** → increase sense of belonging and social support *Suicide risk should be stabilized at the outset of treatment for client to have the opportunity to benefit from treatment*
Environmental and Identity-Related Stressors	
Client experiences environmental stressors (e.g., community violence, economic stressors, family discord)	• **Psychoeducation** → educate on the cycle of avoidance and how environmental stressors influence anxiety sensitivity and fight/flight/freeze response to anxiety • **Caregiver/youth communication skills** → address family discord with family communication skills • **Connect to strengths (personal/cultural/community)** → increase sense of belonging and social support • **Planning for physical safety** → Create plans for how to stay safe if a dangerous situation were to arise • **Mindfulness and grounding** → reduce worries by focusing on present moment • **Relaxation** → reduce physiological responses of stress • **Problem solving** → determine options for dealing with stressful situations • **Validation** → acknowledge client's experiences and emotions are valid • **Worry sorting** → help client identify what their worries are and which ones are out of their control/ they can potentially let go of
Client experienced trauma (and is currently in a stable environment)	• **Trauma processing (narrative)** → help the client tolerate difficult memories and emotions • **Cognitive skills** → help client notice unhelpful or self-blaming thoughts and replace them with more helpful ones • **Mindfulness and grounding** → prevent dissociation or re-experiencing by helping client connect to present moment • **Connect to strengths (personal/cultural/community)** → increase sense of belonging

Client experiences identity-related stressors (e.g., racism, discrimination, acculturation)	• **Psychoeducation** → educate on the cycle of avoidance and how identity-related stressors influence anxiety sensitivity and fight/flight/freeze response to anxiety • **Client advocacy and empowerment** → engage in advocacy to change systems • **Connect to strengths (personal/cultural/community)** → increase sense of belonging and social support • **Emphasize caregiver-youth communication skills** → Help families experiencing acculturation stress to communicate and understand each other's perspectives • **Racial/ethnic socialization** → support youth in connecting to racial/ethnic background • **Supporting emotional safety**→ assist clients in finding safe spaces to express their identity and get support from others • **Validation**→ acknowledge client's experiences and emotions are valid
Client experiences identity-related stressors due to religious obsessions	• **Consult with clergy** → gather expert information about how to contextualize symptoms within religious norms • **Differentiate religious practices from obsessions** → discuss the difference between religious values and practices and OCD-driven religious compulsions • **Connect to strengths (personal/cultural/community)** → increase sense of belonging and social support
Clinical Symptom Expressions	
Client experiences distress or avoidance related to unrealistic fears of unlikely occurrences (e.g., catastrophic thoughts)	• **Psychoeducation** → educate on the cycle of avoidance and connection of thoughts feelings and behaviors • **Exposure to feared outcome** → teach that likelihood of feared outcome is significantly less than expected • **Cognitive skills** → restructure irrational fear by replacing irrational thoughts with more appropriate thoughts and externalizing anxiety/OCD, and developing helpful coping thoughts • **Mindfulness and grounding** → reduce control of worry thoughts through non-judgmental present moment awareness • **Parent coaching** → increase parent self-efficacy to support their child in approach behavior and appropriate coping
Client experiences anxious distress leading to rumination	• **Mindfulness/grounding** → reduce rumination and improve present moment awareness
Client experiences physical symptoms or "fight" response to anxiety (e.g., nausea, headaches, muscle tension, aggression)	• **Relaxation** → use progressive muscle relaxation to reduce muscle tension and diaphragmatic breathing to help client calm themselves • **Mindfulness and grounding** → improve non-judgmental awareness of symptoms and shift attention to external world

Client experiences panic attacks	• **Interoceptive exposures** → help youth learn to tolerate physical sensations
Client perceives their excessive worrying or mental rituals as helpful	• **Mindfulness and grounding** → improve non-judgmental awareness of symptoms and shift attention to external world • **Prescribed worry time** → Conduct behavioral experiments to see if reducing worry changes risks or feared outcomes
Common Comorbidities	
Client experiences low mood and lack of interest	• **Behavioral activation** → improve mood by increasing activity level and improving engagement in positive and valued actions
Client engages in externalizing behaviors (e.g., frequent tantrums, aggression)	• **Parent coaching** → teach parents positive attending and discipline skills to improve behavior and parental self-efficacy • **Psychoeducation** → educate caregiver on causes and maintenance of externalizing behaviors, educate child on emotion identification • **Relaxation**→ use progressive muscle relaxation to reduce muscle tension and diaphragmatic breathing to help client calm themselves • **Cognitive skills** → identify unhelpful thoughts and encourage development of more helpful coping thoughts

Step 4: Determine what, if any, advocacy steps are needed.
It is important to recognize that there will be many factors out of a family's control. We know that structural and systemic issues lead to many of the stressors experienced by our clients. We cannot take on all the burden of systemic failures– doing so will inevitably lead to us feeling hopeless and burnt out. Instead, we recommend focusing on where you can support the client by advocating for them (see Clinician Advocacy Strategies in Augmentation Strategies section). Below are some examples of how we can advocate to ensure the family's needs are being met:

- Communicate with school to ensure IEP is being followed appropriately or assist family with developing IEP/504 plan, attend school or meetings with client if needed
- Communicate with other providers (e.g., psychiatry, medical providers)
- Connect family to advocacy groups in their area

Step 5: Identify and generate strategies for engagement

Barriers	**Potential Strategies for Addressing Barriers**
<u>Barriers to Engagement:</u> Adverse social determinants of health Previous negative experiences with providers or mental health system Limited motivation for treatment	• Case Management • Transportation passes • Offer flexible scheduling (hybrid telehealth) • Extended concentrated rapport and trust building • **Values exercise** → understand values to encourage values consistent behaviors and to align treatment strategies

	See Engagement and Empowerment Section in Relationship Strategies
Potential Clinician Biases Clinician biases, identities, or experiences that may affect their work with the client	• Seek consultation • Discuss potential biases in supervision *See Self-Reflection subsection in the Relationship Building Strategies section.*

Putting it All Together: Ex-CBT Treatment Planning Checklist

The below checklist can help ensure you have the information you need to develop an initial treatment plan with the family.

- **Step 1**: Situate client's presenting problem within cultural and environmental context
  - Do I understand the most important aspects of the problem in the family's own words?
  - Have I identified client's cultural, familial, and individual strengths to be incorporated into treatment?
  - Do I understand the relevant cultural or environmental stressors that may be influencing client's problem?

- **Step 2**: Shape the treatment support team
  - Have I identified key family and community members who should be involved in the client's care?

- **Step 3**: Identify a cohesive set of strategies to address youth needs
  - Do I have a clear understanding of areas of maladaptive avoidance for this client to move forward with Ex-CBT?
  - Have I identified specific Ex-CBT and Augmented Strategies to target client's presenting problems?

- **Step 4**: Determine what, if any, advocacy steps are needed
  - Have I asked myself how I can help my client work against structural barriers?

- **Step 5**: Identify and generate strategies for engagement
  - Do I understand what factors may make it difficult for the client/family to engage in treatment?
  - Have I problem-solved solutions with the family to foster engagement?
  - Have I identified barriers that may influence my ability as a clinician to serve this client (e.g., knowledge gaps, personal beliefs or experiences)?

Brief Case Conceptualization and Treatment Planning Chart

Frame Treatment According to Client Values and Treatment Goals:		
Client/Family Strengths (e.g., cultural, familial, individual):		
Client/Family Stressors (e.g., cultural, environmental):		
Clinical Team:		
Aspect of Clinical Presentation	**Ex-CBT or Augmentation Strategy**	**Target**
1.		
2.		
3.		
Advocacy Needs:	**Advocacy Strategies**	**Target**
Engagement Needs:	**Engagement Strategies**	**Target**

Example Case Conceptualization and Treatment Planning Chart for Case #1: *An 8-year-old male who recently immigrated from Mexico is experiencing anxiety around leaving his mother and going out in public, including frequent reassurance seeking from his mother about whether she will be safe. Upon further assessment, it becomes clear that he is afraid of his mother being deported. We also learn that the client's caregiver is undocumented, and that this child's concerns and fears are preventing him from leaving the house, even to go to school. He experiences frequent stomachaches, difficulty sleeping, and has become socially isolated. His mother feels she is not at imminent risk of deportation and wants her son to be able to successfully attend school without distress. She expresses frustration with how often he checks in with her.*

Frame Treatment According to Client Values and Treatment Goals: Mom and client both want client to "feel less stressed" and be able to engage in school and other activities. Client's mother is particularly concerned about her son's avoidance of school and wants her son to trust her and leave the worrying to her. Supporting her son to be brave and get a good education is important to her.		
Client/Family Strengths (e.g., cultural, familial, individual): Client has a close relationship with his aunt, enjoys art, and reading with his mom. Client's mom has support from her sister who has been in the US for a few years, has joined a church group that has services in Spanish, and enjoys being in nature.		
Client/Family Stressors (e.g., cultural, environmental): Difficulties navigating the immigration process, stress related to immigration policies, some difficulty with finding social community.		
Clinical Team: Mother, Therapist, Caseworker, School Counselor		
Aspect of Clinical Presentation	**Ex-CBT or Augmentation Strategy**	**Target**
1) Maladaptive avoidance	Exposure	Learn to cope with anxiety provoking situations without relying on unhelpful avoidance behaviors to reach goal of client attending school
2) Experiencing isolation related to maladaptive and adaptive avoidance	Connect to strengths-based activities (e.g., supporting family events, engagement in community, or other preferred activities)	Increase sense of belonging and social support
3) Chronic worries about his mother's safety	Mindfulness strategies Worry sorting	Reduce physiological arousal and focus on chronic worries by engaging in present moment awareness (e.g., grounding techniques); support client in "letting go" of worries outside his control
4) Physiological distress (stomach aches, headaches) associated with chronic worry and difficulty sleeping	Relaxation strategies	Reduce physiological arousal to cope with chronic environmental stressors (e.g., breathing and muscle relaxation skills before bed)
5) Identity and environmental stressors	Client advocacy and empowerment	Help family connect to advocacy groups for immigrant families to support systemic change

6) Identity and environmental stressors	Planning for emotional and physical safety	Find spaces (e.g., community center) that feel safe to client and his mother
Advocacy Needs:	**Advocacy Strategies**	**Target**
Challenges with the immigration process	Connect to a caseworker	Connect the family with legal support for the immigration process
Engagement Needs:	**Engagement Strategies**	**Target**
Transportation challenges	Offer flexible scheduling (hybrid, telehealth)	Reduce or eliminate transportation barriers
Mistrust of the medical system	Extended concentrated rapport and trust building	Build trust and rapport to engage in treatment

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