Person-Centered Culturally Responsive Assessment

Overview

Goals:

1. *Assess mental health concerns from the perspective of youth and caregivers.*
2. *Understand influences of family culture and context on mental health concerns.*
3. *Foster an environment that allows clients and caregivers to feel safe, supported, understood, and empowered.*
4. *Integrate symptom-based concerns and cultural and contextual understanding to inform case conceptualization and treatment planning.*

Assessment starts from initial contact and continues throughout treatment. Initial contact consists of *concentrated assessment* to determine the appropriate course of treatment. Formal and informal ongoing assessment is used to monitor treatment progress, refine treatment course, and deepen engagement and rapport with the family.

Youth anxiety and obsessive-compulsive disorders are notoriously hard to detect for several reasons:

1. In many instances, whether anxiety is "disordered" (i.e., warrants treatment focus) or not is difficult to determine. Families can vary widely in the types of anxious behaviors that they view as normative and acceptable.
2. The stereotypes of the anxious child (e.g., one who is hiding behind their parent's leg or repeatedly washing their hands) represent only a small fraction of the ways anxiety can present in youth. Youth with anxiety can also present with behavioral dysregulation and have varying insight into their own emotional triggers, making it difficult to determine whether anxious feelings are a primary driver of youth behavioral disturbances or not.
3. Given the often taboo or stigmatizing topics of OCD obsessions, many clients with OCD can experience high levels of shame about their thoughts and may even be worried that they will be institutionalized or go to jail, if they disclose the content of their intrusive thoughts, leading them to conceal their symptoms.

Clients with OCD and anxiety, who have had prior mental health treatment, may also come into the treatment process with negative experiences; in many cases, this may be because their anxious symptoms were not accurately detected by prior providers. Clients of color are at particularly high risk for being misdiagnosed (e.g., being assigned externalizing or psychotic disorders, when they have OCD). Therefore, it is even more important to utilize a person-centered, culturally responsive assessment process, with youth of color, to create a safe environment, and consider cultural and contextual factors that influence expression and experiences of mental health diagnoses, like anxiety and OCD.

To optimize your assessment, we recommend conducting a **person-centered culturally responsive assessment** alongside standard structured assessment tools for anxiety and OCD.

- A person-centered culturally responsive assessment allows individuals to name their sources of identity, while avoiding stereotyping and the reduction of culture to one specific aspect of identity. The goal of this type of assessment is to understand the context in which mental

health difficulties exist, and to be able to make appropriate diagnoses and treatment plans that are responsive to the client's needs and life context.

- Asking brief questions about culture and context from the beginning, demonstrates that therapy is a safe place to have those conversations.
- Assessing the client and families' cultural norms, values, beliefs, and life context is critical for avoiding making assumptions or stereotyping. This gives the clinician context to their experience, helps improve treatment planning, and helps clients feel understood. Clinicians can use tools to guide this process like:
  - The Cultural Formulation Interview (Client Version and Informant Version)
  - The Culture Identity Wheel

Process Tips for Conducting Person-Centered Culturally Responsive Assessment:

- Remember the goal of this assessment process is to better understand your client and to begin to create a space of safety and openness.
- Conversations should avoid an interrogative approach and instead use a warm, casual manner, remembering that this may be the first (positive) interaction a client has had with a mental health professional.
- The assessment process should be flexible and follow the client's lead. The goal is not to "get all the answers". Clients will not always feel comfortable answering questions about their culture and life context**.** This may relate to cultural values of privacy, fear of bad consequences, shame, or mental rehearsal or rituals, among others. If a client or family is having difficulty with the assessment questions or begins to shut down: make sure to pause, slow down, leave room for silences, and avoid repeated questioning, unless the client asks for clarification (as the client may see it as disrespectful). It takes time to build trust, especially for clients who have had negative experiences with mental health care in the past. You can, and most likely will, come back to topics that were not discussed, in future sessions. Even if the client can engage fully in the assessment, the sample questions are not exhaustive, and instead are intended to create an environment in which conversations about identity, cultural values and life context are normal and valued.
- Some clinicians worry that asking clients about their cultural background or identity may be uncomfortable because the client may not wish to disclose; this assumes that a client will bring up those topics independently. While this may be true in some cases, it is critical to recognize the power differentials that exist in the therapeutic relationship. If the clinician does not ask (which makes it known that conversations related to identity and life context are acceptable), clients will likely not share. While we do not want to push a client to discuss something they are not ready to disclose, we do want to give them the opportunity to do so and demonstrate that the therapy room is a safe place to share.
- The assessment can be done with the caregiver and client together, or separately. Doing the assessment separately may allow both the caregiver and the client to feel more comfortable sharing and allow the caregiver to be more open about their perspective.

Person-Centered Culturally Responsive Assessment Guidelines

The following guidelines will loosely adhere to the domains of the Cultural Formulation Interview (CFI) (APA, 2013) in tandem with leading evidence-based assessment recommendations for multi-informant, multi-method interview procedures for youth mental health.

- The CFI is a brief cultural assessment that is freely available and part of the DSM-5. It has shown promise in improving engagement, rapport, and diagnostic accuracy. The interview is meant to be used flexibly, and as a starting place, to assess important cultural and contextual factors. Many of these topics should be reassessed with frequency. The assessment is not a closed conversation; it is best viewed as a starting point for conversations.

Note: We recognize that clinics have varying policies and requirements related to intake and assessment procedures. Intake assessments also often include assessments of medical, developmental, educational, and social histories. We have provided an example integrated biopsychosocial and culturally responsive assessment to use as a sample guide. These guidelines will need to be tailored to your clinic setting. We highly recommend incorporating person-centered culturally responsive assessment from the beginning, but these questions can (and should) be asked throughout treatment.

Initial Contact

Introductions

- Share brief information about yourself (e.g., what you enjoy about your work, previous experiences).
  - Intended impact: Help the client/caregiver feel more comfortable and humanize yourself as the clinician.
  - Sample Language: *"I really enjoy helping kids and families get along better and learn how brave they can be. My job is to learn about kids/teenagers and what they're good at and what kinds of things are more difficult for them and then come up with a plan to try to make the hard things easier."*

- Share your preferred pronouns and how you would like to be addressed and ask how caregiver(s) and client how they would like to be addressed (first name/Mr./Ms./Mrs./Mx/Dr).
  - Intended impact: Demonstrate that the space is inclusive of all gender identities. Ensure client and caregiver feel respected. Individuals have different values and beliefs about their interactions with providers. Some prefer to be more formal, others informal. *Note: discussing pronouns may not always be appropriate to do at the first contact and may be most appropriately done with the client alone. Use clinical observations (e.g., if the client seems uncomfortable or at odds with their caregiver) to determine whether to ask this upfront or once you are alone with the client.*
  - Sample Language: "*Before we get started today, I wanted to introduce myself. My name is X, and I use the pronouns she/her. You can call me by my first name, or last name, whichever you prefer. What names and pronouns do you both prefer?"*

- Validate your client/caregiver for taking this step to get support
  - Intended impact: Normalize the difficulty around seeking help and provide reassurance and hope that their efforts are worthwhile.

Intake Overview

- Describe to the family what to expect from the assessment process and ask if they have any questions. Provide the family explicit guidelines of what to expect next with each shift in the assessment.
  - Intended impact: Starting therapy for the first time (or restarting therapy) can be scary and uncomfortable. Transparent communication can help build trust, safety, and understanding of the treatment process.
  - Sample Language: *"Today, I am planning on asking you (or you and your child) some questions to get to know you a bit better, and some questions to better understand what brings you here so I can best support you all. This isn't a test – there's no right or wrong answers, I just want to learn what's true for you. If there is anything you don't want to answer, you don't have to. Does that sound okay?... Some parts will be more like a conversation, and some will be a little more boring, kind of like a checklist. This helps me best understand they types of challenges you are having. I will let you know when we transition from one section to another."*

- Remind your client that this is a safe space — explain confidentiality and HIPAA, including what you will and won't share with the caregiver.
  - Intended impact: Build trust and understanding of the treatment process. Assure them you always respect privacy to the fullest extent possible.

Cultural Understanding of the Problem

- Assess client/family's perception of current mental health difficulties (**in their own words**).
  - Intended impact: Understand the mental health difficulties in the family's own words to enrich your understanding of their concerns. Clients, especially those with less exposure to the mental health system, may not understand clinical terminology the same as a trained professional (even words like anxiety). By using their own words, you can improve the relevance of the language you use and help the client feel more understood. **Use the explanation they give you here throughout the rest of the interview.**
  - Sample Language: *"How would you describe what you/your child is dealing with in your own words? How would you describe it to your family or others in your community?"*

- Assess what bothers them most about their current challenges.
  - Intended impact: Understand what is important to the family (e.g., is mental health getting in the way of family connection/responsibilities at home, school functioning). This information can be used to inform goals and treatment planning.

Cultural Perceptions of Cause

- Assess client/family's perception of the cause of their difficulties.
  - Intended impact: Understand the family's perception of the cause of their mental health difficulties. This information can be used to tailor psychoeducation and potentially treatment targets and can help you navigate potential conflicts if members of the family have different perceptions of causes.
  - Sample Language: *"What do you think has caused these difficulties (the problem in their words)?"*
  - Sample Language: *"What do you or others in your family/community think is leading to these difficulties (the problem in their words)?"*
  - Special Considerations for Anxiety Treatment: How is the understanding of the problem and it's causes similar or different to how you as a clinician understands the causes and

maintaining factors of anxiety or OCD? Understanding their perspectives will help you tailor psychoeducation and help explain your conceptualization of their concerns in a way that is aligned with their perceptions.

Cultural Perceptions of Mental Health

- Assess how the client/family understands and discusses mental health in their family and community.
  - Intended impact: Understand normative practices regarding discussing mental health. This information could indicate potential challenges within the family/community related to mental health stigma, that can be incorporated into psychoeducation (e.g., normalizing the experience of stigma), and treatment planning (e.g., incorporating family into treatment sessions, teaching communication skills).
  - Sample Language: *"What are your/your family's beliefs about mental health? What is your family's comfort level with discussing topics related to mental health? How does your family discuss mental health?"*
  - Sample Language: *"Many clients and caregivers experience stigma or shame associated with discussing mental health difficulties. Is this something you have experienced in your family or in your community?"*
  - Special Considerations for Anxiety Treatment**:** The client/family's perceptions and comfort with topics of mental health can influence how you deliver psychoeducation and pace treatment, potentially spending more time with psychoeducation and tying treatment strategies to the goals and values of the family.

Family Norms and Parenting Values

- Assess parenting values.
  - Intended impact: Understanding caregivers' parenting values can help you align treatment in a way that is consistent with those values. Not knowing this information can lead to recommending treatment strategies that conflict with values, leading to low engagement. It is recommended to revisit this discussion frequently, especially when introducing a new treatment strategy.
  - Sample Language (for caregiver): *"What is most important to you, in your role as a caregiver (e.g., respect, independence, safety)?"*
  - Sample Language (for caregiver): *"How does your parenting style reflect your values of _____?"*
  - Special Considerations for Anxiety Treatment**:** Parenting values can influence how the caregiver responds to their child's anxiety, including accommodation behaviors. A caregiver with strong values of empathy and connectedness may try to offer support to anxious youth by removing anxiety-provoking situations, thereby increasing accommodation. Alternatively, families who strongly value independence may push their kids to face fears too quickly, leading to conflict. This information can help contextualize caregiver accommodation, allow you to validate why their approach made sense, AND allow you to support other values-consistent strategies to encouraging approach behavior.
    - Sample Language (for caregiver) during psychoeducation: *"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?"*

- Assess family norms including family/school/community expectations and communication.
  - Intended impact: Understand how family norms may relate to symptom experience to determine whether symptoms warrant treatment or are culturally normative, and help to ensure that you understand client/family's needs in regard to treatment.

- Sample Language (if family speaks another language): *"In what language do you communicate at home? With family members/friends?"*
- Sample Language: *"What are your/your parents' expectations of you/your child at schools, at home, in your community?"*
- Sample Language*: "Do you have any family routines or traditions that are important to you?"*
- Special Considerations for Anxiety Treatment**:** Understanding family norms can help to understand if a symptom experience is culturally normative or something that needs treatment (e.g., is something an excessive worry or normative family expectation) and how they can inform treatment planning (e.g., inclusion of interpreter for family involvement).

Cultural Context: Social Identity

- Invite clients and caregivers to describe intersecting identities that are important to them, instead of relying on stereotyped presumptions. Clinicians can use tools such as the ADDRESSING framework, or the Culture Identity Wheel to further explore various aspects of identity throughout the treatment process.
  - Intended impact: Understand social identity factors that relate to the way they experience the world and that may interact with their mental health. This knowledge can influence treatment planning (e.g., inclusion of racial socialization strategies, case management, religious practices). It can also help us understand if or how aspects of one's identity conflict and contribute to anxiety (e.g., religious views and gender identity), which may need to be addressed in treatment.
  - Sample Language: *"Sometimes people's backgrounds or identities influence their experiences in life and with their child's mental health, so it is important for us to begin to explore that. Important aspects of your background or identity may include your nationality, the languages you speak, race or ethnicity, gender identity or sexual orientation, faith or religion, ability status, family closeness, or even your profession or hobbies you enjoy. I would like to hear from you, what are some parts of you and your life that are important to you?"*
  - Sample Language (if religion/spirituality is important): **"***Would you like to share any religious values or practices that are important to you?*"
  - Sample Language: *"What does it mean to you to be Cuban/Muslim/a mother; what is important to you about that part of your identity?"*
  - Sample Language for younger clients (7-11): "*Do you feel you are like other children/youth your age? In what way?" "Do you sometimes feel different from other children/youth your age? In what way?" "What is something that is special about you or your family that you like or that you are proud of?"*
  - Special Considerations for Anxiety Treatment: Are there aspects of anxiety and distress reported that overlap with identities, yet also seem to be reflective of stress and anxiety that are outside of cultural norms? Understanding these interactions can help determine important treatment targets and augmentation strategies that may be needed to support identity development (see Augmentation Strategies).
    - Example: *A Jewish client is afraid of mixing milk with meat and checks the refrigerator seven times per hour to make sure nothing has been cross-contaminated*
    - Example: *A client who identifies as transgender expresses fear of speaking in class because they feel uncomfortable with the sound of their voice.*
    - Example: *A Black client reports anxiety around experiencing microaggressions or standing out because they are the only person of color in their classroom.*

Cultural Context: Stressors

- Assess client's life stressors. (e.g., community violence, chronic stressors related to poverty, family problems, experiences of racism/discrimination, immigration stressors). This is a place to assess potential social determinants of health (e.g., health care access, economic stressors, education resources, immigration status). You may wish to also include a formal social needs screener (see Additional Measures Section). *Note: This is not a replacement for a formal trauma screen. A formal trauma screen is recommended in addition to the culturally responsive assessment.*
    - Intended impact: Understand stressors and adverse social determinants of health that are affecting the client/caregiver. This knowledge can inform the addition of strategies outside of Ex-CBT to support your client's needs (e.g., case management to connect to needed resources and community groups).
    - Sample Language: *"Are there any stressors your family is dealing with or recently dealt with that might make things harder for you such as (family problems not being able to afford the food or housing you need, community violence, challenges with the school system)?"*

- Assess challenges (e.g., discrimination) associated with their identities? Are they experiencing anxiety related to their identities?
    - Sample Language (stressors related to salient identities): "*Are there any aspects of your background or identity that are causing (other) concerns or difficulties for you?"*

- Assess immigration-related issues with sensitivity, acknowledging family may not feel safe disclosing certain details.
    - Sample Language: *"I want to ask you about any issues you are having with immigration services. This information will not get back to ICE or any other authority. I just want to make sure that you have the resources that you need. Is there anything I can be helping you with?"*

Cultural Context: Supports

- Assess supports and strengths such as, religious beliefs/practices, community/family relationships and routines, social identity (e.g., being able to communicate in multiple languages, having a strong community, strength of elders), as well as interests or skills (e.g., sports, photography, art, music).
    - Intended Impact: Increase hopefulness by having client/family reflect on supports and strengths. Incorporate strengths and supports into treatment planning.
    - Sample Language: *"Are there any resources available in your community, you could turn to, if you needed emotional support or guidance?"*
    - Sample Language: "*Some families are connected to religious organizations or community groups who share similar beliefs and values. Is this something you have in your community?"* [If not] *"Do you feel like this is something you would like to have or utilize?"*
    - Sample Language (strengths related to salient identities/community): *"What are you most proud of about being [IDENTITY]"? "In what way does being [IDENTITY] give you strength?"*
    - Sample Language (interests/skills): *"What kind of activities do you like? What do you do that puts you in a good mood?"*
    - Sample Language (for caregivers): *"What makes your child great? What do you love most about your child?"*
    - Special Considerations for Anxiety Treatment: Note any potential strengths and treatment factors that are discussed that could be highlighted within treatment (e.g., areas of bravery or strength to highlight and incorporate into coping skills).

Previous Treatment Experiences

- Ask client/caregiver about ways they have sought support in the past and what was useful/not useful. *Probe for traditional and non-traditional mental health supports (e.g., support groups, folk healing, religious or spiritual counseling or support, other forms of alternative healing)*.
  - Intended impact: Understand family help-seeking strategies to identify additional supports that can augment psychotherapy.
  - Sample Language: *"Often, people may look for help from many different sources, including doctors, community members, helpers, or healers. In the past, what kinds of help have you sought? What was helpful or not helpful?"*

- For those who have received prior mental health services, assess their experiences.
  - Intended impact: Validate and normalize experiences. Gain information to problem solve potential barriers to current treatment and understand client preferences.
  - Sample Language: *"What were your past experiences in therapy like? Sometimes people have bad experiences because they have different expectations or come from different backgrounds. Has this ever happened for you? Do you have any current concerns or hesitations?"*
  - Sample Language (if applicable): *"What do you wish your previous clinician had done differently? What do you hope I do the same as your previous clinician?"*

- Assess previous and current barriers to engagement including logistical barriers (e.g., finances, childcare, transportation) and social/cultural barriers (e.g., stigma, discrimination, lack of language-appropriate services).
  - Intended impact: Validate and normalize experiences. Gain information to problem solve potential barriers to current treatment.
  - Sample Language: *"What, if anything, got in the way for you in therapy previously?"*
  - Sample Language for Logistical Barriers (e.g., finances, childcare, transportation): **"***For some families, things like finances, unpredictable work schedules, childcare, or transportation get in the way of them getting the care they need. Has that been a problem for you, or do you imagine that it might be?"*
  - Sample Language for Social/Cultural Barriers: **"***For some families, things like stigma about mental health/ experiences of discrimination in the healthcare system/ not feeling understood by their provider/ not having services available in their native language get in the way of them getting the care they need. Has that been a problem for you?"*

Current Treatment Expectations

- Assess client/family's expectations for therapy, including who they would like to be involved.
  - Intended impact: Make sure treatment planning aligns with client/family expectations or utilize psychoeducation to clearly note how treatment may be different than expected and why. There may be times where caregiver involvement is indicated, even when the client does not want them to be involved. Proactively identifying client expectations and preferences around family involvement can support your ability to work collaboratively with the client, to make a plan to optimize family involvement.
  - Sample Language: *"What do you hope to get out of treatment? What do you most need right now?"*
  - Sample Language: *"How do you see your family fitting into treatment? I usually have caregivers involved in part of the session to learn what we are working on and to better support you at home. I will always check in with you before sharing anything you tell me. What are your thoughts about your mom joining us at the end of our sessions?"*

- Sample Language: *"Some kids have other important people in their lives join some of their sessions. Is there anyone else important to you that you would like to have join you in your sessions?"*

- Assess potential challenges in therapist/client relationship. If client brought up previous challenges with a clinician, you can refer to that when discussing their current concerns.
  - Intended impact: Demonstrate that you are open to having conversations about disagreements or misunderstandings that may happen in treatment.
  - Sample Language: *"Sometimes clients have a hard time because they feel misunderstood or disrespected by their therapist, maybe because they come from different backgrounds, or have different expectations. Is this something you are concerned about now?"*
  - Sample Language (for caregivers)*: "You mentioned before that you had a bad experience with your previous clinician because they blamed you for your child's problems/they didn't understand you. Is there anything we can do to make sure that doesn't happen for you now?"*
  - Sample Language: *"I will try my best to listen and understand you and there will likely be times when I mess up or say something that doesn't sit well with you. I would like you to try telling me if that happens, so that I can do better, okay?"*

Challenges & Pitfalls

Potential Challenges:

- If you suspect the client may have stressors, but is not able to discuss them, brief measures may be useful to incorporate, in addition to the clinical interview (e.g., measures of racial stress, acculturation stress)
- Additionally, if you begin the assessment with the caregiver in the room and notice that the client or caregiver appears uncomfortable, you can re-ask those items when you are with the client or caregiver alone and remind them of confidentiality and its limits.

Potential Pitfalls:

- Many clinicians are concerned about "prying into" client's identity and background, and share sentiments like, "Won't clients share these topics if they want to, when they are ready?"
  - Clients may not always bring up aspects of their identity even if they want to talk about it. Given inherent power dynamics in the clinician–client relationship (see Relationship-Building Strategies), it is important that the clinician *initiate* these conversations to demonstrate their interest and the value of the client's perspectives and experiences.
  - Respecting a client's refusal to disclose specific information is also a way of demonstrating you value and respect their autonomy, so if the client does seem hesitant, don't push disclosure especially early on in treatment.

Note: See the sample integrated biopsychosocial assessment for an example of how to integrate person centered culturally responsive assessment within an intake.

Person-Centered Culturally Responsive Assessment

Ongoing and In-Depth Culturally Responsive Assessment

The guidance provided above is only a starting place. Just as it is critical to conduct ongoing assessment of youth avoidance behaviors, anxious distress, intrusive thoughts, obsessions, and compulsions, so too, it is important to continue assessing cultural and contextual factors.

The cultural formulation supplemental modules provide more in-depth questions for the culturally responsive assessment topics above, as well as more in-depth questions focused on immigrants and refugees (Client Version and Informant Version). In addition, we provide and Additional Measures section to assess cultural and contextual factors via validated measures.

Below we provide suggestions on two common topics that may be important to assess that are not represented in the core Person-Centered Culturally Responsive Assessment.

Immigration and Acculturation-related Stressors

- If the client or caregiver immigrated to the US, it is important to assess their acculturation and acculturation stressors, along with any needs and or stressors related to immigration if the client or their caregivers have recently immigrated to the US.
    - Assess client/caregiver acculturation, as it relates to their mental health/therapy (e.g., To what extent do their values and beliefs align with their country of origin/US, their values similar/different to/from family or friends). See Additional Measures section for measures of acculturation to guide further assessment.
        - Sample Language**:** *"Do you ever feel that your parents do not understand you or enforce customs/traditions that you do not agree with?"*
        - Sample Language**:** *"Have you experienced discrimination due to your beliefs/values or due to having immigrant parents/being an immigrant?"*
    - Assess experiences and needs related to immigration (see CFI supplement on immigrant and refugee experiences).

Beliefs about Medication

- Medication (e.g., selective serotonin reuptake inhibitors) can be an important part of recovery from anxiety or OCD. However, many families have negative beliefs about medication due to historical experiences or cultural beliefs.
    - If medication is recommended, assess previous experiences with medication.
    - Acknowledge negative attitudes toward medication, including those related to racial bias and disparities. Discuss these concerns openly and provide psychoeducation about the pros and cons of medication.
    - Validate their experiences and affirm their power to decide.
    - Consider encouraging families to familiarize themselves with the IOCDF/ADAA website and empower them to advocate to the prescribing physician about the types of medication that are recommended and to ask questions.
    - Sample Language**:** *"It makes sense that you would be concerned about putting your child on medication, since you have seen people in your community being overmedicated. I want to help you make the decision that feels best to you and your family. Can we talk about some of the potential harms and benefits?"*

Culturally Responsive Screening for OCD and Anxiety

Overview

This section provides guidance for conducting culturally responsive screening for anxiety and OCD symptoms that could benefit from Ex-CBT. The goal is to understand the full extent of a client's symptoms and the context in which the client's symptoms are occurring. This holistic approach guides the development of your culturally responsive treatment approach, by supporting accurate identification of impairing anxiety and OCD, while minimizing risk of over pathologizing behaviors normative to the client's context.

What to look for: Our primary objective with this screening is to learn if the client is experiencing impairing fear or anxiety, that is *out of proportion* given the child's environment, or if the child is exhibiting maladaptive avoidance behaviors or significant distress that gets in the way of their lives. Anxiety and OCD become problematic when maladaptive avoidance is occurring alongside functional impairment that persists across multiple settings.

Maladaptive avoidance refers to avoidance of feared stimuli – be that feared people, objects, places, internal sensations, or elicitation of familial accommodation behaviors – that are: (1) not objectively dangerous, and (2) causing substantial impairment and distress. Maladaptive avoidance often can be driven by a youth's **unrealistic fears**, or distorted thought patterns that contribute to distress, avoidance, or engagement in compulsive behaviors. Many youths, especially those from marginalized or minoritized backgrounds, experience realistic fears and chronic stressors that contribute to impairing anxiety symptoms or distress that lead to **adaptive avoidance**. Determining the extent to which a youth experiences realistic or helpful fears compared to **unrealistic fears**, is critical for shaping a treatment plan.

Adaptive avoidance is most often 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 or avoiding a certain person at school who verbally harassed them due to their gender identity). Adaptative avoidance is **not** to be targeted through exposure. **Culture influences what constitutes adaptive and maladaptive behavior. Be sure to incorporate the family's views when determining whether the client's avoidance is adaptive or maladaptive.**

Realistic or helpful fears may include anxiety related to environmental stressors, such as those associated with poverty (food and housing insecurity), neighborhood safety, chronic illness, immigration, family/peer conflict, and (intergenerational) trauma and identity-related stressors, such as experiences of discrimination (based on aspects of identity, such as race/ethnicity, SES, immigration status, ability status, gender/sexuality), and acculturation stress. We don't want to encourage a client and their family to adapt to harmful situations. These realistic fears and chronic stressors may exist alone or may co-occur with unrealistic or distorted thought patterns that contribute to a client's anxiety or OCD and may affect an individual's ability to respond to treatment.

Process Tips for Anxiety and OCD Assessment

- **Understand motivation of behaviors**
    - A key goal for your assessment is to understand the motivation or function that drives any avoidant, compulsive, or ritualistic behavior in which the youth engages. Careful

follow-up to understand any reported anxious behaviors will help you start to understand these motivations.
    - Sample Language: *"How is [anxious behavior] helping you?"*
    - Sample Language: *"What happens if you don't shower after each time you have left the house?"*
  - Listen for differences in motivation. Is it due to familial expectations or routines (which may indicate cultural and contextual factors at play), or is it due to the client's need to reduce uncomfortable or anxious feelings?
- **Relate to the information that the client/caregiver have already given you**
  - Once you have conducted the culturally responsive assessment you have a basic sense of the context in which their challenges are occurring. Reference the information the client/caregiver has given you when asking follow-up questions to further situate the symptom within their context. This demonstrates you were listening and using the information shared previously.
  - Sample Language: *"You mentioned that you are worried about your mother being deported. How do you think that affects your worries about going to the grocery store?"*
- **Communicate with transparency**
  - When conducting structured interviews or measures like the CYBOCS or SCARED, be sure to be transparent and explain to the client what you are doing and why; this can help with trust building, rapport building and hope. Feeling like you are being bombarded with questions can be overwhelming for clients, especially those who do not have experience with therapy.
  - Remember to orient the client to a shift in assessment structure.
    - Sample Language: *"We are now going to move on to more of the checklist-y part of the assessment. Remember, therapy will not be like this, we have to do the boring checklist questions, so that I better understand how to support you."*
- **Work to develop a common language**
  - A client may deny a certain experience due to not understanding clinical terminology (e.g., anxiety, worry, obsession, compulsion), or having different language that they use to describe it.
  - Use common language rather than clinical terminology and ask the client the words they use to describe their symptom experiences.
    - Sample Language: *"I want to make sure we are on the same page; the word obsession can mean different things to different people. What does it mean to you?"*
    - Sample Language: *"People explain their experiences in different ways. When we talked about how you describe what is going on with you earlier, you used the word feeling "stuck", are there other words you or your family use to describe what is happening when you feel like you need to wash your hands over and over?"*
    - Sample Language: *"Are you afraid of causing harm to others? By this, I don't mean that you are worried if someone hits you will hit them back, but that you are worried if you do a little thing wrong, it is going to hurt or cause harm to someone you care about?"*
  - Be careful about interpreting yeses and nos at face value, given the likelihood that clients may not fully understand the questions if you have not yet developed a common language.
- **Recognize and normalize variability of symptom expression**
  - Differences in the expression of anxiety exist between cultural background and identity. Societal and cultural norms influence the expression of anxiety, what emotions are acceptable, which are discouraged, and for whom. For example, males and some cultural groups may be more likely to express anxiety externally (e.g., aggression, yelling), due to

societal pressures or norms. Black and Latinx youth, for example, are often misdiagnosed with externalizing disorders, when their difficulties are best explained by anxiety. This may be due to both differential expressions of anxiety, as well as clinician biases.
    - Assess for physical expressions of anxiety and OCD, not just cognitive symptoms (e.g., worries, fears). Youth from many cultures express and experience anxiety physiologically and may not have the words to describe their thought process.
        - Sample Language: "*What does it feel like in your body when it is time to go to school and leave your mom? Do you notice any belly aches, headaches, or pains in other parts of your body?"*
- **Elicit hope**
    - Opportunities to normalize fears that youth experience and provide psychoeducation to address fears youth may have that they are "crazy" or "broken", often arise throughout the assessment – assuming you aren't in a research context, we encourage you to feel free to break from the interview process to provide gentle and brief psychoeducation to normalize youth concerns.
    - Acknowledge that coming into therapy can be a big step and challenging for many families, and that you will support them to get the care they need.
- **Use a scale (e.g., 1-10, emoji faces for younger kids) to assess for intensity of fear, amount of avoidance and intensity of obsessions/compulsions**.
    - For many youths without treatment experience or with limited awareness of their mental health symptoms, using a rating system (choosing numbers beyond the extremes) may be challenging.
    - To increase youths' understanding of a scale system, give day to day examples that are relevant to them. Incorporate their language and experiences. Anchor it in something they have shared.
        - Sample Language: *"On that scale from 1-10, how much does your/your child's fear of being away from you get in the way of your life as a family, your/her life and typical childhood activities?"*
    - It's OKAY if they don't get the rating system right away. They are beginning to recognize their own internal experiences, which takes time.
    - Allow youth to use the rating scale flexibly (e.g., providing a range, rather than an exact number).
    - Assess interference.

Measures

- Along with culturally responsive assessment, use measures tested in diverse populations to assess for maladaptive avoidance associated with elevated OCD and anxiety symptoms. In addition to aligning with gold-standard recommendations for diagnosing anxiety or OCD, using standard, structured assessment tools can also normalize the fact that many youths experience distressing, anxious emotions and demonstrates that the youth is not alone in their experience and that you will not judge or shame them for their thoughts and worries.
    - Anxiety or OCD Symptoms: Children's Yale-Brown Obsessive Compulsive Scale (CYBOCS), Screen for Child Anxiety and Related Disorders (SCARED)
    - Family Accommodation: Family Accommodation Scale

Culturally Responsive Screening for Anxiety and OCD

Guidelines

Screening for Anxiety Disorders
Below are common anxiety disorders, sample screening questions, and follow-up questions that relate back to the culturally responsive assessment. The goal is to identify targets that may benefit from exposure, not to get hung up on the diagnostic label.

Note: In many cultures, anxiety can present in different ways, including with externalizing behaviors. Aim to assess the antecedent to behaviors, *not* just the behaviors themselves.

- **Separation Anxiety**
  - Definition: Difficulty being away from their caregiver or home and experiences excessive distress that leads to impairment in daily functioning.
  - Common behavioral presentations: Difficulty separating when attending school, clinging to caregivers, throwing tantrums before school time or other instances of separation, nightmares or worries about something bad happening (e.g., attempting to call or text message their caregivers throughout the day), difficulties with being out of eyesight of caregiver or other attachment figure.
    - Child and caregiver trauma and caregiver anxiety can influence the child's experiences and expressions of separation anxiety.
  - Consider family norms.
    - In some cultures, such as among some Latinx families, co-sleeping and having a close relationship between children and caregivers is normative.
    - Sample Language: *"For some families and in some cultures, it is common or even expected for children to sleep together with other siblings or caregivers. What is typical for your family?"*
  - Causes and previous stressors/trauma.
    - Sample Language: *"Are there current or previous environmental concerns for caregivers' safety? Has the child experienced difficult separation with their caregiver in the past?"*
  - Assess interference.
    - This includes child's distress and interference in family functioning, related to child's difficulty being alone.
- **Generalized Anxiety Disorder**
  - Definition: Excessive worry about everyday situations (e.g., school, future, illness) that is difficult to stop and includes physical symptoms and impairment in daily functioning.
  - Common behavioral presentations: Perfectionistic behaviors (e.g., needed to redo work that isn't good enough, tearing up their own drawings), persistent worry perceived failures, frequent reassurance seeking (e.g., asking if they understood the directions appropriately), and somatic symptoms including stomachaches, headaches, or muscle aches.

Note: A word of caution about using a comparison of your client to other kids, given that it could be normative and encouraged in certain environments.

- Consider family norms and expectations.
  - Sample Language: *"What expectations do you have for your child's academic performance?"*
  - Sample Language: *"What happens at home if you take home a B instead of an A in class?"*

- Consider stressors that may explain or contribute to their worry.
  - Is the worry disproportionate to the family's context (e.g., worry about family health when a family member is sick, or family members have been recently harmed)?
  - Are fears influenced by ongoing stressors (e.g., discrimination, bullying, immigration stressors, community violence)?
  - Are worries realistic given family's context (e.g., worries about money for a family that is economically disadvantaged, worry about harm to family members, when they live in a high crime neighborhood or have experienced significant health concern)?
- Assess interference.
  - Is anxiety interfering and causing distress for youth and or their family members? How much time is it taking up (e.g., redoing homework, reassurance seeking)? How does perceived impairment differ between caregiver and youth? This may indicate disagreement in expectations between client and caregiver.

- **Social Anxiety**
  - Definition: Fear of social evaluation and avoidance of social interaction that leads to impairment in functioning.
  - Common behavioral presentations: Fears that they will be negatively judged by others in social situations and/or that they will experience intense embarrassment, extreme shyness (e.g., hiding behind caregiver for young children), isolation from peers, avoiding participation in social activities (e.g., at school, in their community), may exhibit high distress/avoidance in front of others or when at the center of attention.
  - Consider family norms and previous stressors that may contribute to social anxiety.
    - Is social avoidance or deference to adult figures aligned with cultural values?
      - Sample Language: *"How do other kids in your family or culture interact with adults?"*
    - Are fears influenced by negative experiences (e.g., discrimination, bullying) or lack of necessary skills (e.g., social skills)?
      - Sample Language: *"You mentioned that you sometimes experience discrimination because of your gender identity. Are there times where those experiences influence your anxiety around other kids?"*
  - Assess interference.
    - To what extent is anxiety interfering and causing distress for youth and/or their family members? Consider level of distress if the client is engaging in feared situation.
- **Selective Mutism**
  - Definition: Avoidance of speaking in certain social situations, despite the ability to do so.
  - Common behavioral presentations: Avoidance of social situations in which speaking is expected, looking down when asked a question, use of non-verbal communication (headshakes, pointing), using a peer of family member to speak for them. Caregivers from certain cultures may see selective mutism behaviors as rude or disrespectful, given their refusal to speak and sometimes make eye contact, even with family members.

Note: *Selective mutism is highly correlated with social anxiety, but some children with selective mutism do not appear to be anxious in social situations that do not involve speaking.*

Note: *Immigrants and bilingual children are more likely to exhibit behaviors consistent with Selective mutism. Varying acculturation level has been found to affect children's development of SM. Navigating multiple cultural contexts and learning new language may contribute to anxiety around speaking in social situations.*
- Consider language learning and acculturation context
- Assess interference.

        - Is anxiety interfering and causing distress for youth and or their family members? Consider the interference if others in the child's life were not speaking for them. How do family values/priorities influence the interference? If the family values respect and or strong family relationships, the SM behaviors in family settings may be even more impairing to the family and may be an early target in treatment.
- **Specific Phobias**
    - Definition: Irrational fear of something or a situation that possesses little to no actual danger.
    - Common behavioral presentations: Avoidance of specific objects or places, extreme reactions (e.g., screaming, crying, running) to feared stimuli.
    - Consider stressors that may explain or contribute to their worry.
        - Identity-related stressors
            - Sample Language: *"Are there aspects of your identity that influence your fear of going into stores? Some clients have told me that they worry they may be judged because of the way they look (e.g., color of their skin, their gender expression, their religious expression). Does that ever happen for you?"*
        - Previous trauma
            - Sample Language: *"You told me you are concerned about your mom being deported; you also told me that you are afraid to go to public places. Does your worry about your mom being deported influence your fear of public places, or is it separate?"*
    - Assess interference.
        - Is anxiety interfering and causing distress for youth and/or their family members?
- **Panic**
    - Definition: Feeling of fear that appears for no reason, causing a panic attack
    - Common behavioral presentation: Avoidance of locations where previous panic attacks have occurred, physiological symptoms including sweating, rapid heartbeat, difficulty breathing, fear of dying.
        - Sample Language**:** *"Have the feelings of fear that you described sometimes come up for no reason?"*
    - Consider family norms and beliefs about mental health.
        - Sample Language**:** *"How does your family respond when this happens to you?"*
        - Sample Language**:** *"You mentioned that your parents believe that these feelings in your body are caused by medical illness, how does that affect you?"*
    - Assess interference.
        - Is anxiety interfering and causing distress for youth and or their family members? Are there things they avoid or won't do because they are afraid, they might trigger a panic attack?

Screening for OCD

*Note**: OCD is notoriously hard to accurately diagnose. It often "hides" in family routines or aspects of the client's life that is important to them (e.g., scrupulosity with a religious client) and can present in a variety of ways. However, for all youth, no matter their background, OCD likes to attach itself to clients' values or aspects of their identity that are important to them and twist it. We can think of OCD as the "best friend you never wanted" because by driving compulsions, it is trying to support youth to remind themselves over and over that their core fears are not true; it just does so in a way that cause a lot of long-term distress! For example, a teenager with pedophilia obsessions about her niece, that lead to compulsive prayers asking for forgiveness and avoidance of being around young children, is likely best conceptualized as someone who loves and cares for her niece yet is terrified of being an immoral or terrible person. Compulsions*

provide repeated, short-term relief that her fears are not true; however, long-term, they lead to long-term distress.

Below are some of the common OCD symptoms, sample screening questions, and follow-up questions, that relate back to the culturally responsive assessment that expand on questions included in standard assessment measures.

OCD Compulsions: *Always provide a definition of what a compulsion is before asking potential compulsions that youth may experience.*

- Definition: The need to complete certain actions, physically or mentally, to reduce distress associated with a scary thought (e.g., obsession) or distress associated with not feeling *just right*.
- Common behavioral presentations: Checking to make nothing bad has/will happened, checking mistakes, hoarding and saving items, cleaning excessively, repetitive movement, the need to have things just right (right order, right physical arrangement)
    - Before labeling something as a compulsion, consider whether compulsions are appropriate given client's context and potential stressors in their environment.
- Checking nothing bad has happened
    - Consider environmental context and exposure to trauma.
        - Sample Language**:** *"You mentioned before that you lost your cousin to gun violence; how does that influence your checking to see if something bad happened to your brother?"*
- Checking locks
    - Consider environmental context and realistic fears.
        - Has the client experienced break-ins, are they common in their community? Are others in their community concerned about break-ins?
        - Sample Language: *"You told me earlier that you have a lot of break-ins in your neighborhood, how does that affect how often you check your door?"*
- Checking mistakes
    - Consider family norms and values.
        - Anxiety may be transmitted through families for protection.
        - Sample Language: *"How do adults respond when you make a mistake?"*
    - Assess if the ritual is part of a normative religious or family practice.
- Hoarding and saving
    - When assessing the motivation for hoarding behaviors, consider that trauma exposure, especially experiences of neglect, may lead to saving objects.
        - Sample Language: *"Has there been a time when saving food has been helpful to you?"*
- Cleaning/Washing
    - Consider family practices around cleaning. For some clients, cleaning rituals may be part of their family practices (e.g., Black families socialized around cleanliness due to racialized perceptions).
        - Is the cleaning/washing compulsion different from chores parents/siblings have assigned? The compulsion could mirror or look like something they are told to do.
            - Sample Language: *"Are others in your family/community doing similar rituals? Is that a common practice in your family?*
        - Are there clear deviations from family/cultural norms that are leading to distress and repetitive behavior?
            - Sample Language: *"Tell me about the cleaning practices in your family. Is this something you all have done before?"*
- OCD can be present, even if the client experiences real life stressors. Try to determine the function and the associated interference of any identified potential compulsions.

- Sample Language: *"How long does the anxiety (or the word they use to express anxiety) stay quiet before you have to go back again?"*

OCD Obsessions

- Definition: Persistent, unwanted, and intrusive thoughts, urges or images that cause distress.
- Common behavioral presentations: Having thoughts that "get stuck"; thoughts often drive a behavior ("compulsion") in response, to relieve or neutralize the distress.
  - OCD symptoms may be particularly stigmatizing if they are related to taboo topics (e.g., sexual or gender identity, harm to others, devil/religiosity), which may increase shame and guilt, and make it difficult to disclose during an initial evaluation.
    - Sample Language: Normalizing can help: *"OCD often makes kids/teenagers think about things that they don't want to. Sometimes those thoughts can be embarrassing. I know it can be hard and I want you to do your best to share what you can understand."*
- Contamination
  - Consider environmental context.
    - What are living arrangements like? Are they living in sanitary conditions?
    - Assess via client and family report being careful not to stigmatize.
- Religious obsessions
  - Consider family norms and values.
    - Sample Language: *"What were you taught about religious practices? Are these thoughts similar or different than what you hear form your family and /or religious community?"*
- Sexual or gender identity obsessions
  - Consider family norms and values.
    - Sample Language: *"What does your family say? I am not here to convince you what it is. I am here to explore with you."*
  - Consider client identities.
    - Clients' own sexual orientation or gender identity could interact with their worries.
    - Sample Language: "*Do you have attractions, fantasies, sexual interests, you feel like you do not want? What do your fears tell you will happen if you carry out those fantasies?*"
    - Sample Language: *"How does your family or those in your community react to your identity?"*

Differential Diagnoses and Common Comorbidities

Anxiety and OCD often present alongside other mental health conditions. Accurate detection of co-occurring presentations is critical to effectively sequencing treatment strategies to address the needs of each individual youth.

- **Trauma**: Marginalized and minoritized clients are more likely to have been exposed to traumatic events in their life. As such, it is even more important to assess for trauma and PTSD.
  - Assess experiences of trauma including racial trauma using validated measures (e.g., Child PTSD Symptom Scale, Child and Adolescent Trauma Screen (CATS); UNRESTS for Assessing Racial Trauma)
  - When a client presents with trauma symptoms and symptoms of anxiety or OCD, it can be difficult to tease them apart. Importantly, they **can coexist**. When symptoms coexist, engaging in shared decision making, and assessing which symptoms are causing the most interference, can help guide whether Ex-CBT vs. trauma-focused treatment should be the first line psychosocial treatment.

        - Ask about when symptoms began, which symptoms came first, and what is currently most impairing. If anxiety/OCD symptoms began only after the traumatic experience, it is likely that a trauma-focused treatment would be more appropriate.

- **Schizophrenia or psychosis**
    - Schizophrenia or psychosis can be confused with OCD obsessions. It is important to tease out whether there are audio hallucinations or obsessive thoughts.
    - Sample Language**:** *"You say you feel like someone is telling you that you stole something from the store, and it makes you feel like you need to confess. Do you hear that someone the way you hear my voice right now? Or do you think that you hear more inside of your head?"*

- **Autism Spectrum Disorder (ASD)**
    - Youth with ASD may engage in repetitive or ritualized behavior because they are pleasurable or stimulating, not because they feel like they must.
    - One way to differentiate between autism related repetitive behaviors and OCD, is to focus on the motivation (E.g., does the client fear something bad will happen if they do not engage in the ritual?).

- **Depression/Dysthymia**: Depression is a common co-occurring condition with OCD/Anxiety and needs to be assessed. Sometimes suicidal ideation can be an obsession without actual intent to harm oneself.
    - Ask about morbid/suicidal thoughts and non-Suicidal Self Injury (NSSI).
        - Use a suicide screening such as Columbia Suicide Severity Rating Scale (CSSRS).

Wrap-Up and Disposition

- Check in about the client and family's experiences and give a clear description of next steps in the treatment process.
  - Sample Language**:** "*This can be a new experience for many families. What was this experience like for you?"*
- Give a clear and accurate description of the treatment you offer either during the intake or during a scheduled disposition. Differentiate it from negative past experiences or preconceptions, if necessary. Discussing how treatment can help the youth's specific challenges, can help give feelings of hope and improve treatment engagement.
- Ask the client and their family if they have any questions and remind them that they can continue to ask questions throughout treatment.
- Give a summary of what you feel confident about, what you still need to learn and why you think therapy will be helpful for them.
- Provide them with information and or a skill they can take home with them right away.
- We find teaching strategies, such as a grounding practice (5-4-3-2-1 grounding-see augmented strategies), monitoring their anxiety/OCD experiences or naming their anxiety to externalize it, to be useful first practice.

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