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Sociocultural Constructs in the Conceptualization of Adjustment Disorder in an Undocumented Mexican Female

Selina Mangassarian, M.A. and Lekeisha Sumner, Ph.D.
Alliant International University

Latino immigrants of Mexican descent comprise the largest segment of the undocumented population in the United States and experience heightened risk for emotional distress. Despite this knowledge, psychological treatment for this group has received limited clinical attention regarding research and treatment options specific to this subpopulation. This case study describes the treatment of a young, undocumented, Mexican female diagnosed with adjustment disorder. Treatment was based on a cognitive-behavioral framework, which integrated cultural values within a socio-political context. Because treatment methods for adjustment disorder were found to be culturally inappropriate, outdated, or lacking empirical evidence, the clinician integrated various empirically supported methods. Treatment incorporated cultural values into cognitive-behavioral therapy methods. The sensitivity and awareness to culture by the clinician led to a successful treatment outcome.

Theoretical and Research Basis for Treatment

In 2011, Latino immigrants in the United States represented 80% of the approximately 11.2 million undocumented immigrants, and more than six million of these individuals were of Mexican descent (Gonzalez-Barrera, Lopez, Passel, & Taylor, 2013; Passel & Cohn, 2009). Latino immigrants, especially those who have resided in the United States for an extended period of time, are at heightened vulnerability for experiencing symptoms of emotional distress (Gonzales, Suarez-Orozco, & Dedios-Sanguineti, 2013). Furthermore, undocumented immigrants are more likely than documented immigrants to meet diagnostic criteria for anxiety and adjustment disorders (AD; Gonzalez-Ramos & Gonzalez, 2005). While several explanations for these findings have been offered, there is general consensus among researchers and clinicians that factors stemming from immigration-related and acculturative stressors (Gonzales et al., 2013).

Among undocumented Latino immigrants, unique factors that may complicate treatment and increase risk of AD and anxiety include the legal issues that surround undocumented status (Sullivan & Rehm, 2005). Smith (2001) reviewed mental health issues among individuals who recently immigrated to the United States mainland and found that many immigrants chose not to seek mental health or medical treatment. Smith (2001) concluded that this finding was due to fear of deportation, discrimination, lack of financial means, limited access to healthcare, as well as cultural factors including language barriers, stigma of seeking mental health treatment, and lack of education regarding what treatment entails.

Since mental health professionals vary in their case conceptualizations, subjective opinions, and creativity, the use of evidence-based practices (EBP) increase effectiveness of patient services and improve public health (Norcross, Beutler, & Levant, 2006). Interventions based on EBPs have shown scientific evidence of consistent client improvement (Drake et al., 2001). Evidence-based practices allow for a level of uniformity in providing care to a broad base of clients; therefore, promoting a systematic approach to treatment is beneficial for researchers and practitioners in order to measure efficacy among various populations (Bernal, Jiménez-Chafey, & Rodriguez, 2009). Unfortunately, there is currently a lack of evidence-based research to inform the necessary treatment for undocumented immigrants of Mexican descent.

Please address correspondence regarding this article to: selina.mangassarian@gmail.com

From the available literature, it appears that common coping strategies among some people in this population are: (a) the internalization of emotional distress, and (b) the avoidance and apprehension of seeking mental health treatment. O'Connor and Cartwright (2012) provided general recommendations that included symptom relief, restoration of functioning, and the prevention of developing more serious mental disorders. Cognitive-behavioral therapy (CBT) is one treatment modality that has demonstrated effectiveness in the treatment of AD (O'Connor & Cartwright, 2012). Although additional treatments can be supplemented, ultimately, the basic offering of EBPs should not be displaced for interventions of unknown or lesser effectiveness (Drake et al., 2001).

Cognitive behavioral therapy has been shown to be effective for immigrant Latino populations because it aligns well with many cultural values, including the expectation that treatment leads to immediate symptom relief, a focus on the present, a problem-centered approach, and direct and active interventions from someone who is considered an expert (Organista, 2006). Since CBT approaches quickly orient patients to the therapy process, this demystification of treatment allows for Latino immigrant populations to lessen their hesitancy toward treatment (Orlinsky & Howard, 1986). The collaborative and engaging approach of CBT, embodied in activities such as psychoeducation and homework assignments, may be better received by clients than other therapy orientations (Organista & Muñoz, 1996).

Given this emerging knowledge and the limited availability of empirically supported, culturally-tailored treatments, there is a pressing need for clinicians to consider the unique challenges faced by this population. The ethical use of culturally-tailored treatments have been debated because of the possibility that EBPs were developed with a particular linguistic and cultural context in mind. Thus, they may not be appropriate for ethnocultural groups that do not share the same language or cultural values (Bernal et al., 2009). Although CBT is most effective for Latino undocumented immigrants suffering from AD, not all components of CBT need to be followed. For example, the assertiveness of CBT is conceptualized to be based in a more individualistic society as opposed to a collectivist one (Hinton, Hofmann, Rivera, Otto, & Pollack, 2011; Organista, 2006; Organista & Muñoz, 1996).

The subject of the following case study, Eva, is from a collectivist culture, thus treatment. integrated cultural values within a cognitive-behavioral perspective. The treatment did not strictly adhere to a manualized treatment. Given the multi-level societal systems (e.g., political, education, occupational, and social) that contribute to the marginalization of undocumented immigrants in the United States, especially those of color, the role of socio-political factors was considered in conceptualization and treatment. Culturally-modified trauma-focused CBT for Latinos is a new treatment method that has been shown to improve engagement by those who were resistant to previous, non-culturally modified therapy options (Hinton et al., 2011). Thus, CBT was chosen for several reasons, including the client's desire for immediate symptom relief and preference for structured sessions. The purpose of this case study is to increase awareness of not only the lack of EBP methods available for AD, specifically to an undocumented immigrant population, but also to provide a framework for determining appropriate treatment options when systemized treatments are unavailable.

Case Study Introduction

"Eva," a 20-year-old undocumented single Mexican-American female living in Southern California, self-referred to individual therapy at a community mental health center for symptoms of anxiety. She presented as well-groomed and appropriately dressed, with a dark complexion, dark brown hair and eyes, and was noticeably overweight for her height. Eva had chosen to continue therapy after family therapy at the agency had unfavorable outcomes, as her parents felt that it was shameful to share their family troubles with an outsider. Since she was still living at home, where she experienced considerable family conflict, she wanted to process her anxiety. In Mexican cultures, seeking mental health treatment is viewed to be inappropriate due to values like *familisimo*, which views voicing family issues as a betrayal of loyalty to the family (Flores & Kaplan, 2009), and thus a disruption to the collective good (Martinez, Polo, & Carter, 2012). However, Eva was experiencing a clash between her cultural duties and her personal well-being, which was influenced by her American ideals. When this interplay of biculturalism, of or relating to two distinct cultures, occurs for

a Mexican-American immigrant youth, vulnerability to mental distress is heightened (Gonzales et al., 2013).

Eva was born in Mexico and moved to Southern California at age two with her mother and older sister to join her father. At the time of therapy, she lived with her parents and younger sister, with whom she began to experience considerable conflict. She also described financial strain. She had recently deferred from a local prestigious university in order to dedicate her time to work. She enjoyed her job and had developed strong supportive relationships with her co-workers. Her goal was to re-enroll in university once she saved enough money, as her undocumented status would not allow for financial assistance. Eva was diagnosed with adjustment disorder, chronic, with anxiety to reflect the severity of her psychological distress over the previous six months.

At the community mental health center, Eva was assigned to a student clinician, who is the author of this case study. The student clinician was a second-year Caucasian female graduate student supervised by a licensed mental health care professional. The clinic was located in a main city in Southern California where there was a varied client population of all ages, low to moderate socioeconomic income, low to high levels of education, and minimal undocumented immigrants. The following sections describe the case history, assessment of Eva's anxiety regarding the situation with her parents, course of treatment, a thought journal plus evidence, and assertiveness training.

Case History

Stressors

Eva presented with symptoms of anxiety, which she indicated that she had experienced for the past five years. Her adjustment issues began eight months prior to therapy when she encountered an unexpected stressor regarding her family system: she discovered that her father had an affair when she was two years of age that resulted in a half-brother for Eva. Her father asked that she keep this knowledge confidential. Eva respected his wishes for four months until she could no longer deal with the guilt of keeping this secret from the rest of her family. She had been severely affected by her family members' denial, verbal fights, and avoidance about the stressor. For example, with regard to her father, Eva felt that he was much kinder and attentive toward her when she was keeping his secret. She stated that their family only communicated when they were all watching TV together. Her mother, conversely, was more extroverted and outspoken about the family's conflicts. Eva stated that her mother had been acting "childish," "immature," and "pathetically." Because Eva believed that this news would lead to her parents' separation, she deferred from university and began to work full-time in order to support her mother and sister if needed. Eva's disbelief regarding her parents' decision to stay together despite their unhappiness represents a common bicultural clash between older and younger immigrant generations (Gonzales et al., 2013). She coped maladaptively by avoiding interactions with her parents, staying at work longer, and spending time with co-workers after work hours. Physical manifestations of her anxiety reportedly included bodily tension, especially in the upper back area, and frequent headaches.

Family Obligations

Eva is the second child of four children: three daughters and one son. Her family moved to Southern California from Mexico when she was two years of age to live with her father, who immigrated to the United States two years earlier for safety reasons stemming from a financial dispute in Mexico. When the family reunited in the U.S., there were no reported problems other than Eva's undocumented status, apparently because her immigration paperwork had not been completed and submitted. Her mother was a homemaker and her father had intermittent jobs in construction, which resulted in chronic financial strain for the family.

Eva's family held traditional Mexican beliefs, such as a concern for the image of the family in the community and gender-stereotyped machismo and marianismo roles of the father as a physical provider and the mother as a caretaker (Flores & Kaplan, 2009). She explained that if her mother were to work, it would be considered disrespectful. Because her mother was invested in this traditional gender role stereotype, Eva felt pressured to assume more financial responsibilities. Eva's impulsive decision to defer her attendance at the university was a reaction to what she perceived as her parents' imminent separation. However, her parents decided to stay together for the sake of their family image—albeit in a dysfunctional uncommunicative relationship. Moreover, they continued to depend on Eva's earnings for their expenses.

Cultural vs. Personal Goals

Eva disclosed her difficulty establishing and maintaining boundaries with her parents and felt torn between her cultural obligation to demonstrate deference to her parents and her personal, academic, and financial goals (Flores & Kaplan, 2009). At the time of treatment, Eva worked at a non-profit human and immigration rights organization with undocumented high school students who were applying for college. Eva had worked with immigration lawyers for many years to receive legal status in the U.S., without success. Thus, she planned to take classes at a city college while she saved money so that she could complete general education courses that would transfer to the university she previously attended. As an undocumented citizen without a social security number, Eva was ineligible to receive financial aid for school.

Cognitive-Behavioral Therapy

The psychosocial aspects of the case made CBT a good fit for treatment. Eva had been internalizing her emotional distress and avoiding communication with her parents. She and her family required direct interventions, which can be obtained using CBT (O'Connor & Cartwright, 2012; Organista, 2006). CBT is effective when one's distorted views can be altered by interpreting the background of a misinterpretation, recognizing the difference between the self and the ideal self, and recognizing that some fears are unrealistic (Beck, 1976). This internal dialogue of labeling experiences as positive or negative is what Beck (1976) referred to as "automatic thoughts," which are often impulsive and perceived as true (McKay et al., 2007). Beck aimed to challenge these spontaneous, learned, and idiosyncratic thoughts by confronting the limited thought patterns through cognitive therapy (McKay et al., 2007) and having the clients discover the meanings and functions behind the thoughts (Corey, 2009).

Initial Assessment and Conceptualization

Eva was cooperative during the initial assessment session. She presented as slightly overweight, generally healthy, dressed appropriately, and well-groomed. Her movement was unremarkable. Her speech took on a soft volume with moments of slowed speech when providing negatively emotionally charged information, yet pressured and sarcastic when speaking about upsetting and frustrating information. She displayed a broad range of affect that was congruent with thought content and her mood was generally anxious. She denied the presence of hallucinations and delusions, suicidal and/or homicidal ideation, and her sensorium appeared to be intact. She was oriented to person, place, time, and situation. Her intelligence and memory appeared to be average, and she demonstrated adequate judgment and insight. Throughout treatment, Eva was observed to be committed to psychotherapy and eager to alleviate her distress, as demonstrated by not missing any appointments, remaining punctual, open to the therapeutic process, and completing assignments.

Throughout the initial intake sessions, the therapist assessed for symptoms of generalized anxiety, depression, and alcohol use for differential diagnoses and to rule out disorders. Eva denied ever experiencing symptoms of anxiety of this severity before the current stressors (e.g., financial strains, deferring from university, family communication style). Based upon data revealed during the clinical interview, it was determined that symptoms reflective of adjustment disorder along with some symptoms of anxiety were causing the most interference and distress in Eva's life. She was relatively relaxed during the clinical interview and demonstrated a constricted affect; however, when discussing her family, a sharp change in demeanor would occur. For example, when discussing her father and her finances Eva became animated in her discussion—rolling her eyes, flaying her arms about, trembling with her hands, and shaking her right leg up and down uncontrollably. Due to the mental health center's policies, the therapist was unable to use self-assessment measures to assess for these diagnoses further.

Although the situation with her father's affair caused much anxiety, Eva's behaviors due to her anxiety had greatly interfered with her social and academic life. This anxiety likely interfered with her ability to create a logical plan regarding her university attendance and completion. As more people in her family discovered the situation, her worries grew and her tendency to want to control all outcomes within relationships increased, thus precipitating her issues with adjusting to the stressor further, resulting in AD with anxiety.

Course of Treatment and Assessment of Progress

Goals

The specific goals of treatment were (a) to provide cognitive-behavioral psychoeducation, (b) to learn to identify, challenge, and alter automatic thoughts, and (c) to engage in assertiveness training in order to set boundaries with Eva's parents in an attempt to decrease her financial burden. CBT is a theoretical orientation that has been adapted for patients with varying levels of education, socioeconomic status, ethnic and cultural identities, and developmental stages (Corey, 2009). These were key aspects taken into consideration while choosing the best approach for this case since the client was an undocumented Mexican immigrant youth from a lower socioeconomic background.

Structure of CBT Treatment

Treatment with Eva was once per week for 50-minute sessions for four months, totaling sixteen sessions with the clinician. Her symptoms were monitored throughout the course of treatment via clinical interview questions at the beginning of each session. The initial sessions were focused on establishing a healthy rapport and strong therapeutic alliance between Eva and the clinician. She and the clinician discussed relevant cultural differences between them; the clinician was Armenian-American, born in America, and a second year graduate student from upper-middle socioeconomic class, whereas Eva was Mexican-born, undocumented, unable to attend university, and from a lower socioeconomic class. Once they discussed the potential challenge of cultural dissimilarities between the two parties, the therapeutic alliance was easily established and was characterized by trust, comfort, and ease of conversation. Eva was rarely hesitant to share information and discussed her problems openly and effortlessly.

Although CBT methods served as the foundation for treatment, a formal treatment guide was not followed due to the lack of empirically supported methods for AD. In conjunction with O'Connor and Cartwright's (2012) previously described general guidelines for treatment, the clinician used portions of *Thoughts and Feelings: Taking Control of Your Moods and Your Life Workbook* by McKay and colleagues (2007). Resources utilized for sessions included providing psychoeducational CBT worksheets, blank thought journal worksheets, blank thought and evidence journal worksheets, and relevant and appropriate assertiveness training handouts.

The first phase of treatment was used to gather information regarding symptom frequency and severity, personal data, and diagnostic information in order to determine diagnosis and appropriate treatment. Additionally, the clinician and Eva clarified realistic expectations for change from treatment and the obstacles that may reroute some planned sessions due to the possibility of refocusing sessions based on her needs from that week. The second phase of treatment involved psychoeducation for the CBT orientation, the CBT thought triangle proposed by Beck (1976), and cultural implications of CBT. The clinician explained the general process of CBT as one that was structured, required homework assignments, and was based on the premise that an individual's behaviors and feelings lead to his or her thoughts. Eva displayed excitement to begin this plan because she preferred a structured treatment.

The third segment of treatment explored the nature and function of her automatic thoughts and schemas and how they informed her symptoms. This segment included homework assignments from McKay and colleagues' (2007) workbook, which promoted listening to the meanings behind automatic thoughts. For two weeks, Eva kept a thought journal of the presenting situations she encountered, which included (a) a one-word description of the feeling caused by the situation, (b) a distress rating from 0–100 (0 = no distress, 100 = most distress possible), and (c) the automatic thought she had just before and during the unpleasant feeling.

The fourth phase of treatment focused on how to label and challenge automatic thoughts by keeping a thought and evidence journal. This included the previous three thought journal columns (one-word feeling, distress rating, and automatic thought) and added three more columns that (a) labeled which limited thought pattern Eva experienced, (b) identified what techniques she could use to balance or alternate the thoughts, and (c) re-rated her feelings after working through them. Eva was provided with a handout of the main eight automatic thought patterns and their explanations as reference along with practice exercises of sample statements matched to the correct automatic thought.

After keeping these records for two weeks and processing them for repeated themes and patterns in sessions, it was determined that "catastrophizing," "shoulds," and "personalization" were the most frequent automatic thought patterns in which Eva would engage. As explained by McKay and colleagues (2007), catastrophizing is when an individual assumes that the worst will happen, shoulds are the arbitrary rules for behavior that one sets for themselves and others, and personalization is when an individual compares themselves to others or assumes that the reactions of others always relate to him or her.

Automatic thought pattern: Catastrophizing. When Eva thought in a catastrophizing manner, she would feel anxious, fearful, guilty, and self-loathsome. An example of her catastrophizing was when she felt she could never save enough money to go back to university because of her inability to set boundaries with her parents about finances, without disrespecting them. During treatment, the clinician and Eva deconstructed the meaning behind this automatic thought: Eva was uncertain of her ability to both support her family's finances and save money for herself to use to return to university. To challenge these thoughts, Eva would answer, "what are the odds?" of her automatic thought. Eva realized that she had been making her situation catastrophic in her mind when she knew if she approached her parents in an appropriate manner and voiced her concern, which she had not been able to do before, they would understand her struggle and decrease the amount of money they requested from her.

Automatic thought pattern: Personalization. An example of Eva's automatic personalization thought would typically occur when she tried to decrease the amount of money she gave to her family and perceived that they acted cold with her when she did not give enough. Thus her behavior was to continue to give them the exact amount of money they requested in order to avoid conflict. When the automatic thought was processed, it was determined that it was a function of her cultural belief that she was obligated to take care of her family before herself. Fitting with this belief, Eva had reported that her reason to achieve a higher education degree was not only to gain an education for herself but in order to secure a higher paying job and better provide for her family. When Eva explored this consideration and combined it with other cultural factors, such as her conflicting level of biculturalism with her parents, she realized that the purpose behind her desire to give her family less money now was so that she could provide more financial assistance to her family in the future.

Automatic thought pattern: Shoulds. When Eva judged her parents for their dysfunctional communication style, she would automatically reflect, "I shouldn't be thinking like this about my parents, I'm such a horrible daughter," indicating some overlap with shoulds and catastrophizing. The meaning behind this automatic thought was processed to understand that values are personal and so her judgment of her parents as "immature" and "irresponsible parents," is her right. She may feel guilty for such thoughts; however, the meanings behind them were not false accusations. Her avoidance of her parents exacerbated her guilt for judging them and led to other shoulds, such as "I should be able to handle their issues; my sisters are okay so why am I so affected by them?" Regarding comparing herself to her sisters (personalization), the clinician encouraged Eva to engage in positive psychological methods that would allow her to recognize that all individuals have their strong and weak points. She was not expected to think and behave like her sisters because she was not the same person as her sisters. Also, the clinician and Eva discussed the fact that she played a different role than her sisters since she was the first to know about their father's affair, as well as being the one to break this news to the family.

Assertiveness Program

Although Eva alleviated her adjustment issues using these CBT techniques, she still needed to improve her financial situation, which would involve reducing her financial assistance to her family from $600 to $250 per month. Thus, the fifth phase of treatment was a 10-week module-based assertiveness program developed by the Government of Western Australia's Centre for Clinical Interventions (2008). Although this program was created in Australia, it was the only easily available, empirically based resource for the clinician due to the clinic's limited CBT resources. This program was deemed appropriate by the clinician and her supervisor for an undocumented Mexican immigrant in the U.S., since its modules were broad, allowing for necessary cultural adaptations. The modules completed by

Eva consisted of psychoeducation on the meaning of assertiveness, how to recognize and engage in assertive behavior, how to reduce physical tension, and how to deal assertively with criticism and disappointment. In conjunction with these weekly modules, the clinician and Eva participated in role-playing situations to prepare Eva to approach her parents and respond to their reactions. The outcome of this was successful: Eva assertively approached her parents with her request to reduce the money she gave to them and used a chart to show them her budget and her plan for returning to university. Eva created this chart as a personal project outside of therapy, but she brought the chart into session after she unveiled it to her parents in order to process the experience.

During assertiveness sessions the clinician and Eva drew attention to the value differences between Eva and her parents, contextualized the difference, reframed the problem, and previewed the future possible bicultural challenges (Gonzales Suarez-Orozco & Dedios-Sanguineti, 2013). This way, Eva was able to present her argument to provide less money to her parents in a sensitive and thoughtful manner so they did not feel blamed for her struggles. Modifications made to the modules to fit cultural considerations included issues such as tone of voice, body language, and eye contact.

Outcome of Treatment

Eva reached the goals she had set for therapy and terminated at the same time that the clinician's training at the clinic was ending. By the end of treatment, Eva was able to identify her limited thought patterns and had challenged them by continuing to keep a thought and evidence journal. Due to the assertiveness training, she was able to limit her financial contributions to her family and was able to say "no" when they asked her for money that she could not allot from her budget. Thus, by saving this money, Eva was able to achieve her financial goals and return to university.

Since Eva's goals for therapy at the time of treatment were short-term and solution-focused, she did not always have the opportunity to process the weekly communication that occurred within her household. This was not detrimental to treatment because there was a mutual agreement that the session goals were oriented to solution-focused problem-solving more so than a processing style. Although she had a much lower amount of anxiety regarding the situations at home, there were some issues that she could not control, such as her parents' employment status. Therefore, it was recommended that Eva continue treatment as a transfer client to a new student clinician who would be joining the clinic in the coming year. She had acquired new tools to understand and process her emotions and thoughts, but the accountability presented by seeing a clinician, especially one trained in multiculturalism, would provide a good support system in order to continue to facilitate the development of Eva's coping strategies.

Case Conceptualization

Eva's case conceptualization was divided into two main domains, which influenced her presentation and treatment. The first domain involved Mexican cultural norms dictating parenting practices, regardless of children's age. In Mexican families there is an expectation to respect parents, to put the needs of the family above the needs of the individual, and to be obedient to family requests (Luis, Varela, & Moore, 2007). Although it has been reported that anxiety manifests itself as somatic complaints among Latinos more so than any other ethnic minority in the United States (Martinez et al., 2012), Eva's anxiety manifested as avoidance and internalized self-loathing. Eva's engagement in her selfless accommodating behaviors for her family conflicted with her thoughts regarding her own well-being; this reflected cognitive dissonance. That said, the clinician incorporated Eva's culturally-based inclination to protect her mother and sister from financial strain into treatment via validation and affirmation. This collectivist value was positively reinforced in session and was understood as a positive quality—reflective of Eva's thoughtful and dedicated character. Moreover, the clinician worked to help Eva utilize this strength in more adaptive ways that would not interfere with her personal goals.

The second domain considered while conceptualizing Eva's case involved her self-efficacy. Eva's diagnosis of adjustment disorder with anxiety was precipitated by Eva's difficulties with her father's affair and pressure to keep the secret. Her automatic thoughts of personalization, catastrophizing, and shoulds, as well as an emotional, behavioral, or physiological reaction served

as the basis for her diagnosis (Beck, 2011). Her symptoms were exacerbated by her limited coping strategies and self-schemas relating to self-efficacy. More specifically, she engaged in maladaptive coping (e.g., avoiding her parents) and believed that she had limited capacity to problem-solve and assert her needs to her family.

Three problematic situations triggered Eva's maladaptive and automatic thoughts. According to CBT, these automatic thoughts lead to symptoms of anxiety due to feelings of vulnerability (Beck, Emery, & Greenberg, 1985). Beck and colleagues (1985) defined vulnerability as the perceived internal or external danger a person feels, which cannot be controlled by his or her own efforts to feel safe. This vulnerability to learned, automatic thoughts leads to cognitive dysregulation, where the increased threat to security results in a decreased ability to cope and feel protected (Clark & Beck, 2010). Eva's symptoms were not solely due to cognitive processing but also due to a faulty information-processing system where situations presented were processed to have more meaning and perceived threat than necessary (Clark & Beck, 2010). When the news of the affair first broke out in her family, Eva would perceive any form of communication between her parents as an opportunity for them to inflict verbal and emotional pain on one another, thus affecting her as well. In reality, her parents' communication style at the beginning of this adjustment process was expected behavior for a couple working through relational issues. Eva attempted to alleviate her anxiety by making plans to "fix" her problems, such as mentally rehearsing what she would say to her parents about her financial stress. However, when those strategies failed, she would cycle back to relying on her effortless, involuntary, and automatic information-processing system.

Eva's compensatory behavioral strategies for these automatic thoughts included avoidant behaviors. Consistent with the literature, these behaviors served as safety measures that shielded Eva from unpleasant feelings and feared outcomes; however, they also exacerbated symptom severity (Helbig-Lang & Petermann, 2010). Eva used emotional avoidance strategies to escape undesirable emotions, which negatively reinforced feelings of anxiety and adjustment issues since they provided temporary relief (Barlow, Allen, & Choat, 2004; Helbig-Lang & Petermann, 2010). More specifically, Eva engaged in what Barlow and colleagues (2004) defined as preventative and restorative safety behaviors. Preventative safety behaviors are those that aim to prevent future distressing emotional events. This was exemplified in Eva's case by her act of deferring from university to prevent the financial strains that would have occurred if her mother were to leave her father. Restorative safety behaviors include those that attempt to control or alleviate emotional responses. This was evident in Eva's avoidance of her family home due to the conflict.

Undocumented immigrants of Mexican descent suffer a paradox because they require treatment for AD (Gonzales et al., 2013; Gonzalez-Ramos & Gonzalez, 2005; Sullivan & Rehm, 2005), but this specific population is unlikely to seek mental health treatment (Flores & Kaplan, 2009; Martinez et al., 2012; Smith, 2011). Moreover, evidence-based practices are necessary for effective and systematic treatment of AD; however, this is lacking for an undocumented Mexican immigrant population. Thus, this treatment took into consideration the cultural norms in Mexican parenting, collectivist cultural values, the self-concept and maladaptive coping of the client, and the preventative and restorative safety behaviors in which the client engaged. The clinician's sensitivity and awareness to culture led to a successful treatment outcome. Eva was able to identify limited thought patterns and challenge them, the assertiveness training was successful, and as a result, Eva achieved her financial goals and was able to return to university.

Treatment Implications of the Case

Mexican immigrants who have lived in the United States for longer than approximately thirteen years are at heightened risk for mental health disorders than those who have resided in the United States fewer years (Vega et al., 1998). Further, the circumstances by which individuals immigrate may render them socially vulnerable to experiencing distress. Eva's case was unique because she presented with a diagnosis for which treatment was lacking, especially among undocumented Mexican immigrant populations. The presenting case study illustrates the successful subjective integration of varying empirically supported CBT methods for AD with anxiety for an undocumented, immigrant, Mexican female.

Important considerations made for this successful outcome were (a) the awareness and sensitivity to the cultural clash, not only within the therapy room but also within Eva's family, and (b) the need to modify CBT methods to fit Eva's cultural background. The clinician was constantly aware of Eva's people-pleasing tendencies due to her cultural obligation influencing obedience to authority. To ensure that Eva would not simply try to please the clinician, as an authority figure, the clinician was cognizant of the directive language she used during sessions, especially since CBT sessions tend to be instructional. Additionally, when making modifications to empirically based programs, the clinician had to take all measures necessary to not completely alter the modules.

Recommendations to Clinicians and Students

It is important for clinicians to thoroughly research all available treatment options for diagnoses that lack suggested treatment methods. If research is lacking, it is the responsibility of the clinician to make an informed, rational, and competent treatment decision. A limitation of the treatment for this case was the use of an assertiveness training module based on research statistics among Australian adults. Given the limitations of resources to the clinician and the treatment setting, this program was deemed adequate for the goals at hand, especially since the modules left room for professionals to incorporate relevant factors, such as culture. For students, and even licensed clinicians, if a case is beyond the scope of practice, the safety and well-being of the patient should take precedence and consideration should be made for a referral to a more experienced therapist.

Although not extreme, the therapist did face some countertransference issues that required additional supervision. In order to maintain sociocultural sensitivity and a healthy therapeutic alliance with CBT techniques, therapists need to be cognizant of (a) their own reactions to clients, (b) their competence regarding sociocultural differences that can influence the therapeutic relationship, and (c) their competence concerning the specific norms and needs of the client's cultural background (Wright, Basco, & Thase, 2006). Because the therapist in this case was also from a collectivistic culture, she could understand Eva's rationale on many issues. However, the therapist had a hard time accepting that one's parents would put their child in a financially difficult situation where education would be a secondary goal. Since the therapist was raised in an environment where education was priority, it was necessary for her to come to terms with the differences in cultural expectations of children within a Mexican-American family.

The cultural factors presented in such a case as Eva's must be given the utmost attention so as not to jeopardize the therapeutic alliance. Issues of immigration, documentation, barriers to education, healthcare, and legal systems, biculturalism, conflicting family dynamics, and socioeconomic status have important implications for treatment. If the clinician had not considered the differences between herself and Eva, the clash between Eva's Mexican and American values, and the importance of respecting authority figures, Eva may have never felt fully understood by her clinician. Lastly, given that therapy may be terminated (in this case, due to the end of the clinician's training), the clinician should be aware of and address the patient's potential feelings of abandonment and create a plan for continued support outside of therapy. The recommendations to other clinicians and clinical students are to research all methods, consult with colleagues and experts, and make an informed decision on the best form of treatment when limited EBPs are available.

References

Barlow, D. H., Allen, L. B., & Choate, M. L. (2004). Toward a unified treatment for emotional disorders. *Behavior Therapy*, *35*(2), 205–230. doi:10.1016/S0005-7894(04)80036-4

Beck, A. T. (1976). *Cognitive therapy and the emotional disorder: Meaning and emotions*. Oxford, England: International Universities Press.

Beck, A. T., Emery, G., & Greenberg, R. L. (1985). *Anxiety disorders and phobias: A cognitive perspective*. New York, NY: Basic Books.

Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond*. (2nd ed.). New York, NY: Guilford.

Bernal, G., Jiménez-Chafey, M. I., & Domenech Rodríguez, M. M. (2009). Cultural adaptation of treatments: A resource for considering culture

in evidence-based practice. *Professional Psychology: Research and Practice*, *40*(4), 361.

Clark, D. A., & Beck, A. T. (2010). Cognitive theory and therapy of anxiety and depression: Convergence with neurobiological findings. *Trends in Cognitive Sciences*, *14*(9), 418–424. doi:10.1016/j.tics.2010.06.007

Corey, G. (2009). Cognitive Behavior Therapy. In G. Corey (Ed.), *Theory and practice of counseling & psychotherapy* (8th ed.; pp. 272–314). Belmont, CA: Brooks/Cole.

Drake, R. E., Goldman, H. H., Leff, H. S., Lehman, A. F., Dixon, L., Mueser, K. T., & Torrey, W. C. (2001). Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services*, *52*(2), 179–182.

Flores, L., & Kaplan, A. (2009). *Addressing the mental health problems of border and immigrant youth*. Retrieved from the National Child Traumatic Stress Network website: www.nctsn.org/nctsn_assets/pdfs/BorderlandersSpecialReport_Final_0.pdf

Gonzalez-Barrera, A., Lopez, M. H., Passel, J. S., & Taylor, P. (2013). *The path not taken: Two-thirds of legal Mexican immigrants are not U.S. citizens*. Retrieved from Pew Research Center website: http://www.pewhispanic.org/2013/02/04/the-path-not-taken/

Gonzalez-Ramos, G., & Gonzalez, M. J. (2005). Health disparities in the Hispanic population: An overview. *Journal of Immigrant & Refugee Services*, *3*(1–2), 1–19. doi:10.1300/J191v03n01_01

Gonzales, R. G., Suarez-Orozco, C., & Dedios-Sanguineti, C. (2013). No place to belong: Contextualizing concepts of mental health among undocumented immigrant youth in the United States. *American Behavioral Scientist*, *57*(8), 1174–1199. doi:10.1177/0002764213487349

Government of Western Australia, Department of Health, Centre for Clinical Interventions. (2008). *Assert yourself!* Retrieved from http://www.cci.health.wa.gov.au/resources/infopax.cfm?Info_ID=51

Helbig-Lang, S., & Petermann, F. (2010). Tolerate or eliminate? A systematic review on the effects of safety behavior across anxiety disorders. *Clinical psychology: Science and practice*, *17*(3), 218–233. doi:10.1111/j.1468-2850.2010.01213.x

Hinton, D. E., Hofmann, S. G., Rivera, E., Otto, M. W., & Pollack, M. H. (2011). Culturally adapted CBT (CA-CBT) for Latino women with treatment-resistant PTSD: A pilot study comparing CA-CBT to applied muscle relaxation. *Behaviour research and therapy*, *49*(4), 275–280.

Luis, T., Varela, R. E., & Moore, K. W. (2008). Parenting practices and childhood anxiety reporting in Mexican American, and European American families. *Journal of Anxiety Disorders*, *22*(6), 1011–1020. doi:10.1016/j.janxdis.2007.11.001

Martinez, W., Polo, A. J., & Carter, J. S. (2012). Family orientation, language, and anxiety among low-income Latino youth. *Journal of Anxiety Disorders*, *26*(4), 517–525.

McKay, M., Davis, M., & Fanning, P. (2007). *Thoughts and feelings: taking control of your moods and your life: A workbook of cognitive behavioral techniques*. Oakland, CA: New Harbinger.

Norcross, J. C., Beutler, L. E., & Levant, R. F. (2006). *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions*. Washington, DC: American Psychological Association.

O'Connor, B. P., & Cartwright, H. (2012). Adjustment disorder. In M. Hersen & P. Sturmey (Eds.), *Handbook of evidence-based practice in clinical psychology, adult disorders* (Vol. 2; pp. 493–506). Hoboken, NJ: John Wiley.

Organista, K. C. (2006). *Cognitive-behavioral therapy with Latinos and Latinas. Culturally responsive cognitive-behavioral therapy*. Washington, DC: American Psychological Association.

Organista, K. C., & Muñoz, R. F. (1996). Cognitive behavioral therapy with Latinos. *Cognitive and Behavioral Practice*, *3*(2), 255–270. doi:10.1016/S1077-7229(96)80017-4

Orlinsky, D. E., & Howard, K. I. (1986). The psychological interior of psychotherapy: Explorations with the Therapy Session Reports. In L.S. Greenberg & W.M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 477–501). New York, NY: Guilford.

Passel, J. S., & Cohn, D. (2009). *A portrait of unauthorized immigrants in the United States*. Washington, DC: Pew Hispanic Center.

Smith, L. S. (2001). Health of America's newcomers. *Journal of Community Health Nursing*, *18*(1), 53–68. doi:10.1207/S15327655JCHN1801_05

Sullivan, M. M., & Rehm, R. (2005). Mental health of undocumented Mexican immigrants: A review of the literature. *Advances in Nursing Sciences*, *28*(3), 240–251.

Vega, W. A., Kolody, B., Aguilar-Gaxiola, S., Alderete, E., Catalano, R., & Caraveo-Anduaga, S. (1998). Lifetime prevalence of DSM-III-R psychiatric disorders among urban and rural Mexican Americans in California. *Archives of General Psychiatry*, *55*(9), 771–778. doi:10.1001/archpsyc.55.9.771

Wright, J. H., Basco, M. R., & Thase, M. E. (2006). *Learning cognitive behavior therapy: An illustrated guide*. Arlington, VA: American Psychiatric Publishing.