Cognitive-Behavioural Therapy for People of Latin American Origin

A Manual for Enhancing the Effectiveness of CBT for People of Latin American Origin in Canada
Acknowledgments

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There could not be a more opportune time to complete this project. In Ontario, the Spanish-speaking Latin American and English and French-speaking Caribbean populations are growing faster than the overall population. Their mental health needs are also growing rapidly through no fault of their own. The stressors they face are enormous. Recent studies reveal that newcomers arriving since the 1990s are facing greater socio-economic hurdles than previous groups of migrants in spite of higher education and skill levels.

Seeking and securing services and support remains a challenge for many people because of a host of barriers such as limited access, stigma, language and unemployment. Ethnoracial and cultural groups face additional challenges including racism and culturally-rooted stigma. The mental health resources that have specifically been designed to meet these populations’ needs also remain scant. Thus, many individuals who could benefit from care that is culturally adapted to serve their specific needs never receive these services.

This manual represents one small yet significant effort in the right direction. It features such practices as proactive outreach, cultural safety and timely and relevant cultural modifications to cognitive-behavioural therapy (CBT). The approach calls on health professionals familiar with CBT to go the extra mile for these target populations. We recognize that while all individuals from such groups will not require culturally-adapted interventions, many will be better served with such a resource. A final note, be sure to enjoy your inward journey with the manual. As with traditional CBT, we aim to build your knowledge, skills and self-awareness.
Dear health professionals,

Citizenship and Immigration Canada is pleased to present to the health professionals community working with immigrants a series of resources developed by the Centre for Addiction and Mental Health (CAMH):

1. The facilitator’s manual *Cognitive-Behavioural Therapy for People of Latin American Origin*

2. The facilitator’s manual *Cognitive-Behavioural Therapy for English-Speaking People of Caribbean Origin*

3. The facilitator’s manual *Cognitive-Behavioural Therapy for French- and/or Creole-Speaking People of Caribbean Origin*

4. The training DVD *Exploring a Service Model for Canadians of African Descent*, which includes a historical segment providing context for the problems facing members of the African-Caribbean community and the impact on their identity and mental health; statistics and experiences that demonstrate the ongoing impact of prejudice; some benefits of cognitive-behavioural therapy; and interviews with specialists in the field


The mental health of newcomers to Canada is a key priority for CIC. CIC Ontario Region has contributed to the funding of these tools through its settlement programs.

Health professionals will find key resources in these manuals and in the DVD for their day-to-day practice with a diverse clientele. These tools will enable them to identify best practices in cognitive-behavioural therapy (CBT), culturally adapted to newcomers’ needs as recommended by mental health experts.

We hope that you will find these resources useful in your professional activity, and that they help to facilitate newcomers’ integration into Canadian society.

Sincerely,

Darlyn Mentor
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Foreword

Cognitive-behavioural therapy (CBT) is a highly effective therapy for the treatment of common mental health problems such as anxiety and depression. While CBT works for patients from most cultural backgrounds, research has shown that adapting CBT to meet the needs of specific groups increases its effectiveness. CA-CBT (Culturally Adapted Cognitive-Behavioural Therapy) has been designed to increase the accessibility of CBT interventions in populations that are typically underserved by the mental health system.

About This Manual

This CA-CBT manual focuses on Spanish-speaking Latin American immigrants in Canada. It is the product of an intensive development process that started with a detailed literature review, focus groups with members of the Latin American community living in the Greater Toronto Area (GTA), and interviews with psychiatrists who provide services to this population. From this research and community feedback, an initial manual was produced and then pilot tested in the community. The lessons learned from the pilot testing, from follow-up consultations with Latin American patients who participated in the pilot testing, and from experienced bilingual psychotherapists who practise this form of psychotherapy in this community were then used to produce this final manual.

The manual aims to improve the capability of therapists to deliver CBT to Latin American immigrants in Canada. It has been written for therapists with adequate training in counselling, nursing, psychiatry, psychology, social work and other helping professions. To be most useful, therapists should also have basic therapy skills in interviewing and building a working alliance, have a sound knowledge of the fundamentals of CBT, cultural awareness, and an understanding of the cross-cultural dynamic. That being said, it is strongly recommended that therapists first seek specific CBT training and education on the fundamentals of cognitive-behavioural therapy before attempting to implement the recommendations in this manual. For more information on standard CBT theory, process and interventions, and training opportunities, please refer to the following texts and websites:

- www.padesky.com
- www.catrec.org
- www.per-ce.net/professional.php
This manual is intended as a resource to help therapists understand and work with the complexities and subtleties that can arise in the delivery of CBT to Latin American immigrants in Canada. While there is no simple formula for providing effective culturally competent therapy, this manual offers general background information about the largest Latin American population in Canada, which happens to be in Toronto, and recommendations for therapeutic stances, interventions and tools that may assist therapists in facilitating successful treatment outcomes with patients from this population.

The chapters in this manual outline how CBT can be delivered in a manner that is more relevant to and consistent with the cultural values and life context of Latin American immigrants in Canada.

Chapter I, “The CA-CBT Framework and Treatment Approach,” presents the basic principles of CBT and discusses how these principles have been shaped in the process of developing CA-CBT. This chapter also reviews how organizations, therapists and patients should prepare to implement the recommendations and techniques outlined in this resource.

Chapter II, “Working with Latin American Patients,” describes the Latin American population living in Canada and presents the process of CA-CBT with Latin American patients from beginning to end, from first contact to after termination.

Chapter III, “CA-CBT Interventions,” details how conventional CBT approaches can be adapted for Latin Americans. The specific interventions are discussed by category: these include self-monitoring, cognitive restructuring, behavioural experiments, problem-solving skills, relaxation techniques, social skills training, self-care, and finding meaning and purpose.

At the end of this manual, Appendix 1 provides a supplementary reading list and Appendix 2 includes intervention tools that can be used as patient handouts.
Chapter I: The CA-CBT Framework and Treatment Approach

Cognitive-behavioural therapies have certain elements in common:

- They are based on the notion that unhelpful or negative thoughts contribute to problematic behaviours and negative emotional and physical responses that impair people’s ability to cope with everyday life.
- They are designed to help patients identify goals that are important for them. Then problems (e.g., sadness, anxiety, sleeplessness) are targeted for change and are monitored before, during and after the treatment process.
- Treatment usually involves multiple interventions directed at identifying and changing cognitions and behaviours that are contributing to the patient’s problems.
- Although the process may involve discussing events that have happened in the past, the focus is on events that are happening in the present.
- The problems to be addressed, the goals of intervention and the tasks involved in completing the therapy process are defined collaboratively between the patient and the therapist, and possibly with the assistance of significant others in the patient’s life.

There are some additional emphases in CA-CBT. Emotional and physical states are considered together, using the word “feelings,” since many cultural minority groups see the two as intertwined (e.g., Sobo, 1996). It is also important to be aware of the influence of environment on feelings, thoughts and behaviours. The environment includes events in the past and present that affect the way people think, contribute to positive and negative emotional and physiological states, and influence the way people behave. The environment also refers to the social milieu in which people interact with others each day and their experiences when dealing with institutions such as workplaces, schools, hospitals and government agencies. These interactions and experiences all affect feelings, thoughts and behaviours.
Although many cognitive-behavioural manuals have been developed for the treatment of specific mental illnesses such as social anxiety, depression, posttraumatic stress disorder and psychosis, this CA-CBT manual differs from these in that treatment is not primarily guided by diagnoses. Instead, work is directed to finding ways to “unlearn” thoughts and behavioural patterns that are causing problems and replace them with thoughts and behaviours that will promote health and well-being.

CA-CBT is based on a 12-session individual treatment protocol that follows the progression of treatment common to most cognitive-behavioural therapies:

1. engaging/orienting the patient to the process of treatment and assessment
2. performing an assessment and defining the problem
3. defining a treatment plan
4. implementing treatment
5. terminating treatment.

At its core, CA-CBT emphasizes that the therapist needs to make clinical judgments about appropriate matches between the patient’s presenting problems and cognitive, behavioural or social interventions. In doing so, the therapist must ask himself or herself three questions:

1. What category of intervention is required to address this patient’s presenting problems?
2. What specific intervention is a good fit for this patient’s personality, abilities and preferences?
3. What content from the assessment and conceptualization should be drawn upon for these interventions, so that the therapeutic interventions are transferable to real life situations?
The therapist should be able to offer the patient recommendations in these areas, but ultimately, these are questions that will be answered in collaboration with the patient. The protocol may be shorter or longer depending on patients’ needs.

**Preparation for CA-CBT**

**The Organization**

Delivering effective CA-CBT may require organizational change. CA-CBT will improve the quality of treatment, but a number of barriers exist to patients receiving mental health services. Conventional ways of delivering services do not always meet the needs of diverse populations. There is a growing body of Canadian literature on differences in rates of illness, the social determinants of health in diverse populations, and barriers and facilitators of pathways to mental health care. In general, diverse populations underuse mental health services relative to their needs. Moving toward more equitable mental health systems in provinces and territories requires change at a number of levels—from policymakers through to practitioners. However, significant Canadian research demonstrates that access to care can be facilitated by a number of different interventions including broadening the scope and type of care offered, developing partnerships with community organizations and improving the cultural competence of services.

**Cultural Competence and Safety**

Cultural competence is a term often used to refer to a set of knowledge, skills and attitudes that help a clinician or a service offer equitable treatment to diverse populations. The Mental Health Commission of Canada has promoted the concept of cultural safety as a new cultural competency. This concept calls attention to the social and historical status of certain groups within a society and the implications that status has for how they perceive their interactions with individual mental health care providers and institutions (Polaschek, 1998). The aim is to draw attention to the fact that clinical encounters occur in a social and historical context. Patients from diverse populations must first feel culturally safe as part of a move toward equity in the experience and outcome of treatment.

In Canada, cultural safety refers to the experience of some ethnic minorities, recognizing how colonial and neocolonial practices have affected contemporary interactions between groups and the social status of ethnic minority groups in a multicultural context (Anderson et al., 2003). The term also recognizes how a long history of economic, educational and political inequity contributes to present-day health and social disadvantages among ethnic and racial minority populations. Though the concept of cultural safety was originally developed for indigenous populations, its extension to marginalized groups is useful (Baker, 2007). In CA-CBT, the notion of cultural safety draws attention to power dynamics that arise from ethnic and racial minority status, the dominance of Eurocentrism in health care organizations, the under-representation of racial/ethnic minority groups as providers of health care, and the historical and contemporary power relationships that exist because many immigrant
groups originate from countries that have been colonized by European nations. It thus speaks directly to the issue of power.

Developing cultural safety requires understanding how historical and current practices contributed to minority group members' unfavourable perceptions of mental health services and poorer clinical encounters. When care is not considered safe, populations are reluctant to use services and when they do use them, they can feel humiliated and alienated. Not surprisingly, this can affect outcomes.

Clearly, many health professionals treat people based on their own assumptions and stereotypes, creating prejudices that undermine effective service delivery (McKenzie, 2003; Papps & Ramsden, 1996). Cultural safety places responsibility on professionals to consider the context in which they are offering care, to examine whether their approach or service design negatively affects particular groups, to understand and deal with the fact that their interactions may be problematic, and to recast their practice in a way that minimizes possible negative impacts due to culture (Kearns & Dyck, 1996).

When diverse populations interact with the health care system, there is a meeting of two groups, unequal in status, unequal in material advantage and unequal in colonial histories. Even in circumstances where service providers are members of racial/ethnic minority groups, their affiliation with the health care system associates them with these inequities. Cultural safety provides a way to raise questions about how health professionals and systems are positioned relative to their patients and relative to the system of health care in which they practise and how that affects the care they provide. One of its most significant contributions may be in heightening awareness that professionals require specific preparation to provide safer health practices in a multicultural context and must attend to power imbalances inherent in the health care context. This preparation may include developing cultural safety policies and training in collaboration with Latin American communities and offering cultural safety training and opportunities for leadership and supervision in culturally competent and/or culturally safe practices (National Aboriginal Health Organization, 2008).

For more information and resources about what organizations can do to enhance service delivery to Latin American immigrants and other underserved communities, please refer to:

- Mental Health Commission of Canada—Improving Mental Health Services for Immigrant, Refugee, Ethnocultural and Racialized Groups: Issues and Options for Service Improvement (www.mentalhealthcommission.ca/SiteCollectionDocuments/News/en/I0.pdf)
- National Center for Cultural Competence (www11.georgetown.edu/research/gucchd/nccc/about.html)
- Cultural and Linguistic Competence Policy Assessment (www.clcpa.info/)
The Therapist

The therapeutic relationship is an essential ingredient for a positive treatment experience and has been identified by patients, irrespective of their racial and ethnic background, as the most beneficial element of treatment (Hwang, 2006; Norcross & Lambert, 2005). Our consultations with eight focus groups in the Latin American community throughout the GTA, and feedback from Latin American patients who pilot tested this manual, indicated a strong preference for culturally competent, Spanish-speaking therapists of Latin American origin. These anecdotal reports are further supported by statistics indicating that 50% of ethnic minorities do not attend a second appointment with a white therapist; early termination rates are significantly lower if the therapist is from an ethnic minority (La Roche, 2002). Furthermore, linguistic similarity between a therapist and patients has been linked to increased attendance of therapy sessions and more positive treatment outcomes than similar treatments facilitated through an interpreter (Sue et al., 1991).

Other valued therapist traits noted by the Latin American community in Toronto included:

- clinical knowledge and the ability to apply clinical interventions flexibly and responsively
- a professional yet warm and welcoming attitude, demonstrated for example by a respectful hug and a kiss on the cheek instead of a handshake
- comfort with self-disclosure (e.g., the therapist’s country of origin, and whether he or she has children) under appropriate circumstances
- comfort with accepting tokens of gratitude (e.g., small gifts and gestures).

For further reading about delivering CBT to underserved populations, please review:


Setting up a Supervisory Relationship

Therapist supervision is strongly recommended when engaging in CA-CBT. Especially for less experienced therapists, a supervisor can provide support and ensure that CBT methods are being applied competently, and monitor the therapist’s provision of culturally safe care. Supervisors are ideally more experienced with using CA-CBT methods. However, peer supervision, in which therapists discuss their patients, can also be a valuable added support. Supervision can be conducted one-on-one or in groups, whether it’s peer supervision or supervision by a senior practitioner. Supervision can also include taping sessions, observing sessions, or reviewing written process recordings and case notes. Therapists should arrange for supervision before their agency or practice begins to offer CA-CBT services, based on what is feasible, given the resources available.
The Patient

A further consideration of the cultural safety paradigm is the expectation that service users should be given the power to comment on the delivery of health services and programs and be involved in making changes. At an individual level, this acknowledges the patient’s experience as the recipient of care and, at a community level, it acknowledges the expertise that community members can contribute to designing more appropriate services and interventions (Nguyen, 2008).

In developing this CA-CBT manual, we consulted various stakeholders. Community members said they believed that improving access to mental health services for the Latin American immigrant population will require some flexibility within and between organizations. Recommendations included:

- offering culturally adapted therapy services through community agencies and organizations (e.g., churches, community health centres, community centres) that are frequented by the Latin American population or are readily accessible via public transportation
- extending service delivery periods to accommodate some patients’ desires to lengthen the termination phase of treatment (e.g., gradual tapering of sessions, booster sessions) or temporarily halting treatment until life disruptions have settled
- extending office hours outside conventional work hours (i.e., evenings, weekends) to accommodate work and child care commitments
- providing child care services or child care expense reimbursement to facilitate access by patients with young children
- conducting the CBT sessions in a comfortable and culturally inviting space (e.g., pictures of Latin America and Latin American people on the walls)
- providing directions to the location of the sessions in patient’s preferred language.

Research aimed at reducing barriers and improving the attractiveness of mental health services and programs for underserved populations also supports the following recommendations:

- Mobilize practical resources that remove the barriers to attending therapy, such as providing transportation or reimbursement for transportation (Dixon-Woods et al., 2006).
- Designate a staff person to consult with CA-CBT patients regarding their interest and suitability for adjunct services (e.g., housing, financial, employment counselling; settlement agencies) if needed (Kohn et al., 2002). At the very least, materials with this information should be made available in waiting areas and in the therapist’s office.
- If fees are necessary, offer a sliding scale to facilitate access by patients with low incomes (Sanders Thompson et al., 2004).
• Patients from ethnic minority groups are more likely to use mental health services with greater presence of ethnic minority staff (Wu & Windle, 1980). Perhaps ethnic minority staff should be actively recruited to improve the attractiveness of mental health facilities for ethnic minority patients. Efforts should be made to employ these staff in diverse capacities to avoid perceptions of tokenism.
Chapter II: Working with Patients in Latin American Communities

Introduction

The Latin American Population in Canada

The following are some general facts about Latin American communities in Canada:

• Latin Americans represent one of the fastest-growing cultural groups; for instance, between 2001 and 2006, the Latin American population grew by 40.2%, while the overall Canadian population grew by only 5.4% (Statistics Canada, 2006).

• Most Latin American people in Canada belong to the first generation, meaning that they were born outside Canada (this includes people who are non-permanent residents) (Statistics Canada, 2006).

• The Latin American community in Canada in 2006 comprised about 304,000 people. It is one of the five major groups of visible minorities in Canada, with most coming to Canada as refugee claimants. The largest concentration of the Latin American population resides in Ontario (147,135 people), with the majority living in the Toronto Census Metropolitan Area (99,290 people) (Statistics Canada, 2006).

• The most common countries of origin are El Salvador (18.6%), Colombia (15.1%) and Mexico (10.3%) (Statistics Canada, 2006). El Salvador and Colombia have histories of political violence, which confers a higher risk for depression and posttraumatic stress disorder associated with a pre-migratory history of trauma and multiple losses.

• The Latin American population in Canada is relatively young. In this community, 29% of people are under the age of 15, compared to 19% in the overall population (Statistics Canada, 2001).

• Sixty-four per cent of the Latin American community is Catholic, while 16% belong to a protestant denomination (Statistics Canada, 2001).

• Seventeen per cent of the Latin American population in Canada hold a university degree, compared with 15% of the overall population. However, this level of educational attainment is not reflected in income: average income is $7,500 less than that of the overall population (Statistics Canada, 2001).

Recruitment and Engagement of Latin American Immigrants

Judging from feedback from the Latin American patients who participated in the pilot testing of this manual, people from Latin American communities are most likely to seek treatment based on referral from someone they know and trust. For women, a referral from a family doctor, nurse, teacher or social
worker may lead them to seek treatment. Endorsement from a priest or other clergy person could be particularly influential. Men may respond to similar referral sources, but are most likely to consider seeking counselling if they first encounter it by attending the session of their spouse or another close family member.

It is important to be aware that most of the patients from this population will be women, and many will prefer to have a female therapist. Younger patients, aged 16 to 24, may prefer individual therapy with therapists who themselves are younger. Patients over 65 may be more suited to group therapy formats, as the social atmosphere of the group setting may alleviate social isolation and reinforce their engagement in the therapy process. Patients who are proficient in English may prefer therapy in English instead of Spanish.

The CA-CBT intervention differs from conventional CBT in that there is an extended period for engagement of patients. The engagement process is understood to begin with patients’ first contact with the therapist or treatment centre, and continues through the first and second sessions. The engagement process is extended in response to the potential need of patients from Latin American communities to work through stigma, preconceived notions and fears they may have about seeking treatment for mental illness in Canada. This extended process is beneficial to establishing a collaborative working alliance, which is important to the success of CBT.

First Telephone Call

Psychotherapy studies examining treatment outcomes among patients of Latin American descent identify higher rates of early termination in this patient population (La Roche, 2002). At the beginning of therapy, patients may be more concerned with the nature of the interpersonal interaction with the therapist than with relating their presenting problem. This stage may last up to two or three sessions, until the patient is satisfied that his or her work with the therapist will be a true collaboration, and the person feels safe enough to begin addressing the presenting problem. In order to avoid premature termination, it has been recommended that therapists move to actively engage patients from the very beginning of therapy (Gibbs, 1985).

Given that CA-CBT is a time-limited treatment, one way of initiating engagement as early in the treatment process as possible is to make first contact with the patient via telephone before the first session. This way, the patient will have a better idea of the person they will be meeting, which may increase their comfort level in the first session. The first telephone call may be an important first step for developing the working alliance and should be treated as more than an administrative task—it is the beginning of the treatment process.

Tasks for the first phone call include:

- confirming the first appointment and providing clear directions about where the meeting will take place
- explaining how to get there by public transportation or by car
- describing what will take place.
Ideally, this interaction should be done in the patient’s language of preference—most likely Spanish or English. The description of the first session should cover how long it will take and exactly what will happen. The first session may be longer than usual because of administrative tasks that need to be completed (e.g., registration, completing consent forms and screening tools). Explain to patients that they will be asked to fill out some paperwork when they come to the session, like when they fill out forms for the first appointment with a doctor or dentist. The patient can be asked to arrive early to complete the forms, or this time can be incorporated into the total time reserved for the first session.

CA-CBT: Building a Working Alliance

A strong working relationship is vital to CA-CBT because the therapist may be working with patients who are very sensitive to cues that they are being disrespected or not believed. Many of the patients in the communities served by this intervention have histories of negative interactions with health and social service professionals that will predispose them to be guarded in the therapeutic relationship. Among the Latin American participants who pilot tested this manual, there were noticeably more disclosures after the sixth session. The patient’s perceptions of being respected and supported in a warm, positive relationship will make a tremendous difference in whether he or she remains in treatment, and will be able to withstand the challenges that will arise when difficult emotions and experiences are evoked in the therapy.

There is a marked history of mistrust between Latin American communities and health and social services. Patients may enter therapy with fears about being judged or committed to a psychiatric institution, or even being reported to other institutions like child welfare or immigration. According to the Latin American patients who were consulted in the development of this manual, Latin American patients may be wary of situations in which they could involuntarily be put under the scrutiny of these government agencies. Therefore, it is important to talk with patients about confidentiality—and to recognize that patients may be reluctant to open up at first, until they are sure they can trust the therapist.

Facilitating the working alliance may also require some flexibility on the part of the therapist. This flexibility may mean having sessions that are shorter or longer to meet the needs of the patient. There may also need to be some flexibility in setting the agenda or following the recommended agenda for sessions. A common issue revealed during consultation with Latin American participants involved in pilot testing this manual was their tendency to arrive late to appointments. There were a number of reasons for tardiness, especially among newer immigrants, including getting lost, organizing child care or being asked to stay late at work. Two possible strategies are proposed to accommodate these factors:

• more accommodation for late arrival (e.g., end sessions 50 minutes after the appointment actually started rather than strictly at the scheduled ending time)

• asking patients to arrive 30 minutes before their scheduled appointment time.
Session 1: Greeting and Assessment

In the Waiting Room

It is ideal to have a private waiting area and a meeting space that promotes an inclusive environment. Although not always necessary, displaying artwork, magazines, newspapers and/or brochures of interest to Latin American communities may facilitate a sense of comfort and belonging. However, addressing the physical space alone is not sufficient to create a culturally safe space for Latin American patients.

The therapist should initially greet the patient formally, waiting for permission to use less formal language. If the patient has the completed assessment forms, collect them from him or her right away. If the receptionist has the completed forms, collect them before going to meet the patient.

In the Office

Members of the Latin American community consulted in the development of this manual emphasized the importance of an informal setting that does not make patients feel like they are in an “uptight” office. Some time should be spent on social graces like offering a beverage, taking the person’s coat and asking them to make themselves comfortable. For instance, they recommended furnishing and arranging the office in a way that will encourage patients to relax (i.e., by avoiding hard chairs and high tables, and by not having a desk between the patient and the therapist).

Note-taking will probably be necessary for the first few sessions as there is a great deal of information to be collected and it should be recorded. This should be explained to the patient so there is no misunderstanding about the purpose of the notes. It is important for the patient to feel like he or she is being heard and respected; therefore, make efforts to maintain eye contact and remain verbally and non-verbally responsive to what is being said. In later sessions, note-taking should be reserved for after the session so the patient feels like he or she has the unbroken attention of the therapist.

The Working Alliance

Several research studies have established that a positive working alliance is key to achieving positive outcomes from psychotherapy, regardless of modality. For treatment to be most effective, ongoing research indicates that this alliance must be established while faithfully adhering to a treatment model.

According to the members of the Latin American community consulted in the development of this manual, it is very important to create an atmosphere of respect and trust. Latin American patients may be wary of a therapist who presents himself or herself as an authority figure. Therefore, it may be particularly important for the therapist to emphasize the collaborative nature of their work together and encourage patients to express their opinions, even if they disagree with the therapist. Exhibiting a sense of humor may contribute to building the alliance, but be cautious in deciding when it should be used—follow the patient’s lead.
Self-disclosure by the therapist can also help to build a working alliance (Knox & Hill, 2003). In early sessions, this may mean sharing some information about cultural background to help the patient understand where he or she may have commonalities with the therapist. In later sessions, the therapist may disclose personal experiences that are relevant to the patient’s situation, but this must be done carefully. Self-disclosures can help a patient feel like he or she is relating to the therapist on a personal level and that the therapist understands the experiences the patient is describing. This can be particularly important with patients from Latin American communities, as they may favour an informal relationship with helping professionals. However, the usefulness of self-disclosure should always be evaluated in light of how it will contribute to the development of the therapeutic relationship with the patient. A potential danger of self-disclosure is that the patient may feel that he or she is being unfavourably compared to the therapist (Constantine & Kwan, 2003).

Prior to beginning the assessment, the therapist should remind the patient about the tasks for the day’s session. This will begin to socialize the patient to the experience of setting an agenda for each session. If there are consent forms to be completed, these should be done at the beginning of the session and the information in the forms should be used to orient the patient to the intervention process. Consent forms can be used to orient patients to the CA-CBT process, addressing issues such as confidentiality, the length of the intervention process, and the expectations that will be placed on them as patients (e.g., regular attendance, feedback about sessions). Discussing these aspects of the session is part of building a working alliance, as it ensures that patients are fully informed about the process and agree with the goals and tasks involved.

Assessment

It is important to communicate attentiveness and receptiveness to patients because they need assurance that they are being heard and are not being judged. Therapists should develop the capacity to communicate this with appropriate verbal and non-verbal responses, and eye contact.

In CA-CBT, assessment is used to gather:

- information about current feelings, physical sensations, behaviours and thoughts that could be potential targets for intervention
- information about environmental conditions that are the context for the problems and figure out what stressors maintain the situation and what strengths and resources could be strengthened to ameliorate the problem
- ethnocultural information to determine cultural identifications, culture-based expectations for poor health and good health, and ways in which the patients’ interpretation of culture influences their definition of the problems and their expectations for solving them (Kleinman et al., 2006).

The assessment interview can be semi-structured or unstructured, depending on the level of experience the therapist has with interviewing. An experienced therapist will know how to conduct a conversation with patients that gathers the necessary information while allowing them to tell the story the way they wish. A less experienced therapist may feel the need to have prompts prepared, to ensure he or she
covers the relevant ground. CA-CBT has been piloted using the Centre for Epidemiologic Studies Depression Scale (CES-D) (Radloff, 1977) to evaluate depression before and after the intervention. This or any other brief self-report instrument can be used to evaluate patients’ level of depression and can be a useful tool for initiating discussion about symptoms they are experiencing. We recommend creating an information package containing the forms that need to be filled out. The first page of the package should have a preamble saying clearly if the forms are to be handed to the receptionist or to the therapist.

In either case, it is advisable to tell the patient that you are about to have a conversation about what has been going on with them and how it is affecting various areas of their life. If the patient is properly oriented to the process, then they will understand that it is necessary to ask these questions and explore these areas to get the best possible picture of what is contributing to stress in their lives and what is available to promote health.

The CA-CBT assessment combines elements of a typical clinical interview with an ethnocultural interview aimed at exploring whether the patients’ beliefs, values and practices might be implicated in the presenting problem and/or support the treatment process. Areas to gather information about include:

**Background Information**
- name, age, gender, sexual orientation
- country of birth, languages spoken, date of arrival in Canada, immigration status
- self-identified racial or ethnic background (e.g., Latin American indigenous person, Latin American Black)
- work and education before and after arriving in Canada; current profession, work or education (e.g., ESL, college, university)
- financial supports

**Presenting Problems**
- patient’s story in patient’s own words
- onset, frequency, intensity: What happened before? What are typical situations?
- what the patient thinks caused or triggered the problems
- what thoughts, actions, emotions, physical response accompany stressful situations
- how well the patient is functioning (compared to “normal”)
  - what would other people say? who?
  - how is the patient sleeping, eating; energy, interest in activities usually enjoyed, interest in socializing—any changes?
- diet: caffeine, nicotine, sugar and processed foods
• level of alcohol or substance use
• whether these symptoms have been seen before—either in the patient or in others in the family
• what has been done to attempt to deal with the issue
  - Ask about outcomes (positive and negative) of any other consultations, including seeking support from friends and family.
  - Ask specifically about clergy, complementary health practitioners, folk healers, use of herbs, bush teas, etc., so the patient knows it is acceptable to discuss this. If any have been consulted, ask about positive or negative effects.
• the patient’s experience completing the CES-D (e.g., any surprises, most prominent symptoms, etc.)
• any thoughts about death and suicide (including intent and plan)

**Personal Context**
• current living situation (where and with whom does the patient live? does he or she have family members who stayed in the country of origin?)
• previous living situations; where the person grew up or spent most of his or her life
• relationship status, children and quality of relationships
• extended family (who? how important are they? where are they?)
• family separations or reunifications
• physical health status, past health problems (e.g., cardiovascular illness, hypertension, diabetes, thyroid problems, obesity, cancer, head trauma, neurological conditions, strokes)
• access to family doctor or other health care providers
• religious or spiritual practices
• legal history, including family, immigration or criminal court if appropriate.

**Environmental Context**
• family/friends: where and how often they are seen; whether they know about the current problems
• church, social organizations or other affiliations
• primary places for socializing
• people turned to for help
• level of comfort, happiness in current city
**Personal Goals/Values**

- vision of how life should be, purpose, meaning
- hopes for outcomes from treatment

**Non-Verbal Observations**

- appearance: grooming, appropriate dress (e.g., for weather)
- mood: sad, happy, irritable, angry
- physical tension, fidgetiness, restlessness
- energy level
- ability to establish rapport
- ability to express thoughts and feelings, and discuss ideas in an organized manner
- any evidence of delusions or perceptual hallucinations
- insight and judgment based on history and current mental state

At the end of the assessment interview, summarize what has been discussed by writing down a “problem list.” This list will be useful for sharing with the patient at various stages in the treatment. In addition, creating a summary shows the patient that he or she has been heard and understood, and it provides the opportunity to clarify, add or delete items and to set priorities. Making a list can also be a first step toward the patient seeing problems as tangible and manageable.

End the session by letting the patient know that the notes will be reviewed and discussed at the next session. Tell the patient if anyone else (e.g., a supervisor) will be reviewing the material. Offer to accept telephone calls if the patient has any questions or concerns.

This patient may have had to go to great trouble to find time to attend this session, and may have had to overcome his or her own prejudices, as well as strong objections from family, before being able to attend the session and discuss the problems. The patient should be commended for making this effort and given some encouragement that you believe something positive will result. Thank the patient for his or her time and tell the person that you look forward to seeing them again.

For a list of more detailed inquiries and more information about assessing ethnocultural factors in therapy, please review:

- McGill University Cultural Consultation Service Guidelines for Cultural Assessment and Cultural Formulation (www.mcgill.ca/ccs/handbook/assessment/cfa/)
Collateral Interview

During the assessment, the therapist should ask patients if it would be helpful for them to gather information from other sources. This could involve simply seeking permission to speak to a family doctor or previous therapist to complete details of the history and context of the presenting problem, but could also include speaking to a family member or friend who may be able to provide additional information. Speaking to other people in the patient’s life can help to evaluate the extent to which the patient is experiencing difficulties or how his or her behaviour has changed. It can also fill in blank areas that the patient may not be able to address because of poor memory or confusion associated with the depression.

It is important to be specific with the patient about what information the therapist will be seeking from the other person and how the information will be gathered (e.g., requesting records, telephone call, face-to-face interview). If the other person is a friend or family member, the therapist may want to offer the patient the option of having that person join for part of a session. The information provided by these other people can be very valuable to an assessment, but will also provide information about the patient’s social network and who, if anyone, he or she trusts to include in the treatment process.

Given the high level of stigma in the Latin American communities, it would not be unusual if the patient declines to involve any family members or friends in his or her treatment. For example, community members consulted in the development of this manual indicated that some women may have difficulty attending sessions if their partners are unwilling to support it. Offering to include the partner in a session may increase his or her comfort with the spouse’s attendance. However, assure the patient that it is completely acceptable to decline permission for others to participate. It may be possible to engage significant others later in the treatment process. For example, family or friends could help to problem-solve or help the patient to develop certain skills.

Preliminary Psychoeducation

Detailed psychoeducation about depression and cognitive-behavioural interventions will happen in the next session; however, it is a good idea to do some anti-stigma psychoeducation in this first session. As in many communities, there is significant stigma attached to mental illness in Latin American communities. Patients may have preconceived ideas about mental illness being a punishment for those of lesser faith or being an indicator of weak character (Interian et al., 2010; Levin, 2007). The first session is a good time to begin addressing these concerns. The therapist should be proactive by talking about how people are affected by stress, the availability of methods to help people cope more effectively, and how therapy can help people be more effective in dealing with daily situations.
A First Experience with “Homework”

The therapist may wish to take this opportunity to introduce the notion of “homework” in this session. Homework can be a useful CBT tool because it allows patients to practise skills outside of the intervention session. Trying out new skills in the “real world” can help patients to discover their potential for positive change and alert them to aspects of their life that will facilitate or impede positive changes. Extensive research demonstrates that completing homework greatly increases the likelihood of successful outcomes from treatment.

However, Latin American patients may not respond positively to the idea of being assigned homework. For many, homework may be an overwhelming task in light of other stressors they may be dealing with, such as housing, unemployment, immigration status, family separation, family conflict, food security, poverty, learning a new language and acculturating to the new country. Some patients may have less formal education and training experiences in their country of origin, and so be unaccustomed to the idea of completing homework. This may be particularly true for older patients.

For other patients, traditional homework may be welcome and helpful; they may use homework to augment their own methods of dealing with depression. For the patients who participated in the pilot testing of this manual, the act of putting their thoughts on paper increased their awareness of how their own thoughts may have been distorted, given the evidence or the seriousness of the situations that were affecting their mood. These patients actually did more homework than required; however, they characteristically had higher levels of education, were accustomed to doing homework, tended to be higher functioning, and reported milder symptoms of depression.

Accordingly, the most important consideration before assigning homework to Latin American patients is to evaluate whether they are capable and willing to complete traditional homework assignments (i.e., written, outside-of-session work). Therapists need to be flexible and creative, and to collaborate with patients to determine the best ways to help them access their thoughts, feelings and behaviours. If the therapist is too adamant about the patient completing homework and the patient cannot or does not complete it, the therapeutic relationship may be destabilized and the patient may experience decreased self-esteem, increased feelings of inadequacy and an increased sense of failure in adjusting to life this country. A negative experience with homework may further aggravate the patient’s feelings of hopelessness and helplessness, which will likely exacerbate his or her depression.

We suggest that homework initially be presented to patients as a type of exercise or journalling that they do between sessions. The therapist should explain that doing these exercises will increase the effectiveness of the therapy work. Although the first session is too early to identify the specific skills that patients must develop, it is not too early to send the message that they can be doing things between sessions to promote health. For patients in Latin American communities, it can be particularly valuable to try out a homework exercise that focuses on decreasing physical discomfort, such as sleep hygiene, relaxation techniques, nutrition or physical exercise. Patients from these communities may have a heightened sensitivity to the physical aspects of depression, and may value interventions that allow them to change how their bodies are feeling. At the next session, the therapist should ask what it
was like to do the recommended therapeutic exercise. This will provide further information about the person’s capacity to complete homework assignments, and may identify barriers and resources that will affect success with homework in the future.

Other potential first assignments could be:

- reviewing the problem list with a trusted friend or confidante (skill development: mobilizing social support)
- asking someone else to take on a task that is currently making the patient feel overwhelmed (skill development: assertiveness, self-care, mobilizing social support)
- protecting some downtime (skill development: assertiveness, relaxation); this will also prepare the patient for protecting time for activities to promote mental health
- practising some deep breathing exercises (skill development: relaxation)
- a short reading assignment (psychoeducation)
- something simple the patient suggests that could make the next week a little easier.

Assessment and Feedback: One Session or Two?

In CA-CBT, the assessment and conceptualization processes are spread over at least two sessions, as opposed to the one session more common to other cognitive-behavioural models. The therapist may be able to do this in a single session if the patient has completed an intake assessment with someone else or if a referring health professional has already done standardized measurements or provided extensive assessment information. In these situations, the therapist will already have a lot of information from the patient and others, and can enter the session with a preliminary conceptualization to present and discuss with the patient. However, in CA-CBT, a two-session process is recommended even if there has been some information provided by other sources. Extending the preliminary phase over two sessions is an opportunity to gather more assessment information while giving the therapist and the patient more time to build a positive rapport and working alliance.
Session 2: Developing the Conceptualization

Conceptualizing the Patient’s Situation

Conceptualizing the patient’s situation is an important step in any psychotherapy. The therapist must develop a hypothesis about what underlies the issues listed on the patient's problem list. In cognitive behavioural therapies, the conceptualization is based on the cognitive model of emotional disorders. This model focuses on negative automatic thoughts that feed into cycles of emotional distress and physical discomfort, and problematic behaviours. The conceptualization guides treatment planning by organizing and prioritizing problems or symptoms, pointing toward areas and methods for intervention and predicting potential barriers to treatment.

Cognitive-behavioural therapies are built on identifying the psychological mechanisms that underlie the patient’s presenting problems. CA-CBT involves identifying psychological mechanisms, but also identifies social and environmental determinants that create a need for psychological adaptations and, in turn, promote the patient’s presenting problems.

Steps for working toward a case conceptualization involve:

- creating a problem list that summarizes all major symptoms and problems in functioning
- proposing an underlying mechanism (e.g., core belief, assumption) that may underlie these problems:
  - What do all these problems have in common?
  - What belief would a person have who is behaving this way?
  - What are the things that promote this behaviour and what consequences does this behaviour have in the patient’s life?
- figuring out how the underlying belief might produce the problems listed
- reviewing what led up to the current problems:
  - How is the problem connected to a core belief?
  - How is the problem connected to the patient’s social circumstances?
  - How is the problem connected to environmental conditions for the patient?
- reviewing potential origins for the core belief in past experiential, familial, social or environmental situations
- considering potential psychological, social and environmental processes that may present barriers in treatment.
Patients can present with a long list of problems and experiences that may make it daunting to identify one core belief linked to them all. It is usually the case, however, that the presenting problems can be clustered together so that it is possible to identify a set of mechanisms that accounts for several of them. At this point, the therapist is trying to establish a starting point for treatment—this may be modified later based on patient feedback, new information or changes in the patient’s psychological, social or environmental situation. A guideline for understanding your patient’s main problems can be found in Appendix 2, Handout 1: Understanding the Problem.

A structured problem list might also help patients define where they are having difficulties and where they would like to focus. The patient can complete this list independently, or with the therapist, in session or as a homework assignment. Patients should be encouraged to decide which areas they would like to target during the treatment session. This problem list, or a less structured one developed with the therapist, should be revisited periodically throughout treatment to evaluate progress and revise goals. An example of a structured problem list can be found in Appendix 2, Handout 2: Problem List.

At its most basic level, the conceptualization describes the relationships between automatic thoughts, feelings and the actions that people take. It can help to explain to patients that part of what makes it difficult to deal with stress are the automatic thoughts that go through our heads when a stressful situation arises. These thoughts pop into our heads so quickly and easily that it can be difficult to notice them, but they still have a strong effect on our emotions. When reviewing stressful situations, it will be helpful to explore what automatic thoughts were going through the patient’s head at the time and how these thoughts triggered emotional and physical reactions and behaviours.

Encourage patients to consider the following:

- What makes your stress worse?
- What makes it better?
- What happens to your body when you are stressed?
- What kind of thoughts come into your head?
- How do you act when you are stressed?
- What do other people notice when you are stressed?
- What aspects of your life are affected by stress? What aspects aren’t affected?

Review this with the patient at the next session, helping the patient to make connections between positive and negative cycles in his or her life. This exercise can also be done in the session by having the patient recall stressful incidents during the past week. A worksheet for this exercise can be found in Appendix 2, Handout 3: Stress Diary.

Because CA-CBT also considers environmental influences, the conceptualization (Figure 2) needs to address how the environment has contributed to the cycle through:

- past and current experiences that form the basis for beliefs, assumptions and expectations
• environmental stressors that trigger or reactivate negative beliefs, assumptions and expectations
• environmental constraints that affect options that patients have for taking action and expressing feelings in a way that promotes health.

Figure 2. CA-CBT Conceptualization

Identifying cognitions that may benefit from restructuring and behavioural experiments can promote new skill development. Both cognitive restructuring and positive skill development will promote positive changes in emotional and physical symptoms. Treatment should also be geared to helping patients with the concrete difficulties they are experiencing in their daily lives, as the environment plays a strong role in driving patients’ problems and determining how they are able to benefit from treatment.

Persons (1989) suggests evaluating a conceptualization by asking the following questions:
• Does the conceptualization account for each problem or symptom on the problem list?
• Does the conceptualization account for the events or experiences that precipitated the problems?
  - What past or recent events have activated negative assumptions and expectations and/or taught problematic behaviours?
  - What change in the environment has promoted negative behaviours and thoughts?
• Does the conceptualization help the therapist to predict how the patient is likely to behave, feel or think in specific situations?
• Does the patient think the conceptualization fits his or her situation?
• Do the interventions suggested by the conceptualization make a positive difference for the patient?
• Do the interventions suggested by the conceptualization build on existing strengths and resources in the patient’s life?
  - What healthy beliefs and assumptions are in place?
  - How has the patient demonstrated the capacity for positive change in the past?
  - What is available in the environment to reinforce positive changes in thoughts and actions?

Identifying strengths and resources increases the sustainability of the interventions put in place to deal with the patient’s problems. Patients may approach treatment expecting to be told they are sick, abnormal or deficient in some way. A CA-CBT conceptualization must deal with this directly. Emphasizing the strengths and resources that patients have can be therapeutic in itself, because people often lose sight of the resources they have in times of stress and distress or after countless experiences of feeling disempowered. Patients need to know that the therapist sees them as more than just a set of problems, and that he or she has been noting indicators of strength, resourcefulness and resilience in their story. The therapist can explain that these positive attributes are useful adaptations to their environment that at the moment are being eclipsed by negative feelings and problems they have also been using to cope.

Given the hypotheses derived from the conceptualization, the therapist must then put together a treatment plan by addressing:
• What cognitive factors could be addressed through interventions such as cognitive restructuring and modifying self-talk?
• What behavioural factors could be addressed through interventions such as self-monitoring, assertiveness training, role rehearsal and other skill development?
• What environmental factors could be addressed by consulting with other people or other institutions? This is a very important aspect of CBT for Latin American people, as they typically require their environmental stressors to be addressed in treatment for depression. Organizations and/or institutions that can provide Spanish-speaking social workers are key to providing relief from environmental factors.
Sharing the Case Conceptualization with the Patient

The second session should begin the procedure that will become a familiar sequence of activities for each session with the patient. The therapist should check in with the patient about the previous week, including addressing questions that may have arisen from the first session and experiences with the first homework assignment if there was one. The therapist will then move to setting the agenda, but for this session, the main agenda item is to give the patient feedback from the assessment and case conceptualization.

The conceptualization is not finalized until it is shared with the patient. The therapist will present his or her hypothesis to the patient so that the treatment plan can be discussed collaboratively. Collaboration is key to this process. Collaboration strengthens the therapeutic alliance by ensuring that the work being done is based on shared understanding of, and agreement about, the goals and tasks of treatment. It also increases the likelihood of success, as the patient participates in treatment activities with a full understanding of what is being done and why.

Sharing the conceptualization with the patient involves the following steps:

1. reviewing the patient’s strengths
2. reviewing the patient’s problem list
3. sharing and discussing the conceptualization
4. reviewing treatment options.

This information should be provided as clearly and simply as possible, so that the patient can understand what is being said and has the information he or she needs to raise questions or seek any clarification. It can be helpful to use diagrams to show the links that are being made to come up with the conceptualization and the proposed treatment plan. You should also:

- ensure that you point out patients’ strengths and resources (e.g., resiliency, familial support, spirituality or religion)
- explain that the problem list is designed to be as inclusive as possible, but it is not necessary to deal with everything on it; patients can add or eliminate items as needed
- give specific examples of the links between thoughts, feelings and behaviours, using patients’ language and stories. Again, diagrams may help to explain the connections more clearly
- check that the conceptualization fits with the patients’ views of the problems and make modifications based on the patients’ feedback
- explain how CA-CBT can help with these problems, being specific about interventions directed at thoughts, behaviours, emotional/physical distress and environmental conditions (skills that could be developed)
• discuss other options (e.g., medication, settlement and immigration services, housing options, free ESL classes, financial counselling or social services) that may be available to the patients for dealing with their problems.

These recommendations are designed to ensure that patients can make informed decisions about engaging in CA-CBT. Patients should have a clear idea of what the explanation is for their presenting problems and how cognitive and behavioural interventions could bring some relief. Patients should also know what other options are available to them so that they do not feel constrained in pursuing other options or coerced into accepting this treatment.

Patients in Latin American communities may have a strong negative reaction to recommendations that medications may be useful as an alternative or adjunct to therapy. Some people in these communities perceive medication as having a high potential for addiction or believe it is suitable only for people with a severe mental illness. With this in mind, the therapist can expect that there will be resistance to the idea of considering medication or seeking a medication consultation, but discussing it as an option can be an opportunity to dispel misconceptions about what taking medication might mean for the person.

Aligning CBT Goals with Cultural Values

Part of the informed consent process involves discussing with patients how culturally adapted CBT has been designed to be culturally appropriate and consistent with their cultural values. They need to understand how interventions are tailored to people in their ethnocultural community, with the expectation that this adaptation will enhance the therapy’s effectiveness. For patients in Latin American communities, it will be important to emphasize the practicality of these interventions and their usefulness for making it easier to deal with daily situations. Explain to patients that the work they do to improve the way they are feeling will make it possible for them to enhance not just their sense of self but also the relationships in their lives, by allowing them to more positively contribute to the well-being of their friends and family members. Help patients make these connections by referring them back to goals they have articulated for themselves and their relationships. Refer to words that came from the patient as much as possible, making use of culture-specific dichos (i.e., sayings, proverbs) if this is part of the patient’s repertoire, and making links to culture-specific health promotion strategies like distraccion (distraction) and desahogo (getting things off the chest).

Community members consulted in developing this manual noted the cultural belief that a strong mindset is necessary to deal with problems; because of this, the idea that a person’s emotions and behaviours are affected by the way he or she thinks resonates with people of Latin American origin. Therefore, a good way to engage patients can be to emphasize how they will learn to take control of their emotions and life situations by strengthening their ability to mobilize positive thoughts and decrease unhelpful thinking. Interventions designed to increase social connections are also culturally consistent, because they build on cultural values of connectedness and interdependence. Reminding patients that these are reasonable goals and supports, which they would provide for other people, can be a way of engaging them in such strategies.
At its most basic, the goal of CBT is symptom reduction. CA-CBT is also focused on reducing people’s symptoms, but as a path toward achieving culturally-supported goals, such as personal contentment and more positive relationships. Therapists need to make the connection between symptom reduction and these goals so patients do not feel like they are being taught tricks to make them feel better.

A Case Example

Alejandra is a 50-year-old woman who emigrated from El Salvador 10 years ago with her daughter, Lucia, now aged 16. Her husband, Armando, remained in El Salvador. Part of her motivation for leaving was to remove herself and her daughter from his financial, physical and emotional abuse. Alejandra was a university professor in El Salvador, but has not been able to find work at her education level in Canada. She has had several jobs over the years, and has often been a victim of lay-offs and restructuring. She currently works as a salesperson in an upscale women’s clothing store.

Alejandra was recently contacted by Lucia’s school because Lucia was skipping classes. When she met Lucia’s teachers, Alejandra felt disrespected because they kept saying they could not understand what she was saying. The teachers also said that Lucia was a smart girl but was probably not getting proper “stimulation” at home. Alejandra believes that they assumed she was uneducated.

Lucia has been unwilling to discuss school issues and has been staying out late at night with friends whom Alejandra thinks are a bad influence. Lucia has a part-time job babysitting for a woman that Alejandra met at her workplace. Lucia has been committed and responsible in this job, but Alejandra worries that Lucia will not complete high school and will not be able to secure other kinds of work.

Alejandra feels inadequate as a parent. She thinks her daughter is out of control and has no respect for her. She dreads talking to Lucia because her daughter gets angry and dismissive, slams doors, etc. It is more than Alejandra can take after a long day at work. Alejandra has not discussed her worries with anyone. She has recently stopped attending church because her employer wants her to work on Sundays. She misses attending services, but also does not want to face people there because she feels like a failure. Alejandra is not sleeping at night and drinks coffee all day to feel alert. She talks about feeling “preocupada y sin esperanza” (worried and hopeless) and too much “estrés” (stress). She expresses the wish to sleep and not have to get out of bed in the morning. She says that she has little appetite because her stomach is always hurting.

Alejandra finds life in Canada very hard and does not have much hope for the future. She knows she has to make life here work because returning to El Salvador is not an option, but she does not feel she will ever have the energy to achieve her goals here.

From the details presented in the case, Alejandra has many negative cognitions about her ability as a parent and the opinions that her daughter and other people have about her. She describes physical complaints (pain, stomach upset), sleep problems, emotional distress and poor diet. Alejandra is preoccupied with risks that she sees arising from her daughter’s problems at school, taking little comfort from positive reports from the teacher about Lucia’s apparent intellect and her commitment to a part-time job. Alejandra does not address her concerns with her daughter because she is
overwhelmed by what she sees as Lucia’s anger and dismissiveness. She has frequent interactions in which she feels the loss of her status as an education professional, which makes her feel sad and possibly angry. She has stopped attending church because of the demands of her job, but is also isolating herself because of negative feelings and fatigue.

A CA-CBT conceptualization of Alejandra’s situation might include the following issues:

- **Environmental experiences contributing to depression**: Isolation, discrimination and low social status in Canada; past abuse by husband, which may predispose her to recoil from expressions of anger and to avoid expressing anger herself
- **Core beliefs**: May have expectations of poor treatment by people in Canada, as well as poor treatment/anger/abuse by family members and other people; the underlying common mechanism seems to be a belief that people will treat her badly and that she deserves to be treated badly
- **Automatic thoughts**: I’m no good; I don’t deserve better; I’m not being respected; I’ll never be respected; I’m worthless
- **Feelings**: Sadness, anger, resentment (perhaps not fully acknowledged)
- **Actions/behaviours**: Isolation, withdrawal, poor diet, low activity level
- **Environmental constraints on actions/behaviours and feelings**: Dependence on income from job; barriers to securing more lucrative and prestigious employment; negative interactions with daughter; financial stress.

The proposed interventions that follow are linked specifically to reducing the symptoms that are troubling Alejandra. An additional consideration in CA-CBT would be the value of engaging Alejandra in a discussion of meaning and purpose, to help her work through her overall sense of powerlessness.
A preliminary treatment plan for Alejandra may look something like this:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Potential Intervention</th>
<th>Goal</th>
</tr>
</thead>
</table>
| Physical complaints   | Psychoeducation  
Medical consultation with a family doctor | Reinforce understanding of link between emotions and physical discomforts  
Rule out medical causes of her physical complaints |
| Parenting stress      | Psychoeducation  
Cognitive restructuring  
Social skills training/assertiveness training | Increase understanding of contributions of daughter’s developmental stage and intergenerational culture differences to family stress  
Alter negative cognitions about failure of family, personalization, self-blame  
Initiate discussion with family about tension  
Mobilize support from her friends from church or any relatives she may have in Canada or abroad (many Latin American people communicate frequently with extended family via telephone)  
Speak to work supervisor to clarify any misunderstanding or provide reassurances that work is not affected by her mood and/or fatigue; consider requesting change in scheduling to accommodate need to be at home |
| Worry                 | Relaxation training  
Problem-solving training | Reduce anxiety and psychological distress  
Increase skills for effective resolution of concrete problems |
| Sleeplessness, fatigue| Relaxation, e.g., sleep hygiene, meditation/prayer  
Physical exercise, e.g., walking Downtime | Increase capacity for self-soothing, spiritual sustenance  
Increase sleep  
Improve physical state, decrease pain/discomfort, increase sleep |
Sessions 3 to 9: Teaching the Core Skills

Once the assessment has been completed, it is time to enter the active treatment phase of CA-CBT. At this stage, the sessions should proceed in a predictable sequence:

1. checking in with the patient
2. reviewing homework from the previous week
3. setting the agenda for that day’s session
4. working on skill development as part of the treatment plan
5. assigning new homework, if appropriate, based on the content of the session
6. closing the session with a summary and checking in.

Patients should be told about this procedure for the sessions as part of preparing them for the first active treatment session. Remind patients of this procedure when beginning the first few sessions.

Check-In

It is customary to begin sessions by checking in with the patient about how the previous week went. There will be a more formal checking-in about progress made on homework and skill development later in the session; at this point, checking in is designed to facilitate rapport and engage the patient in the process. The therapist should have recently reviewed the patient’s file to ensure that he or she can check in with attention to specific realities in the patient’s life; for example, inquiring about the well-being of significant people in the patient’s life, or asking about a recent event the therapist knows is important to the patient. Patients from Latin American communities may also want to check in with the therapist to make the interchange feel less one-sided; think ahead about what kind of information you feel comfortable sharing and what can be shared without distracting from a focus on the patient and the problems that brought him or her to session.

Although the checking-in process can be treated as simply a social courtesy, it may also help to establish an area of focus for the session. The therapist will want to transition from checking in to setting an agenda for that day’s meeting, and can conceivably suggest, “It sounds like this is something that is really on your mind. Would you like to focus on that for today’s session?”

An important aspect of check-in, particularly in the first active treatment session, is to check how patients feel about the feedback they have received about their problems. Patients can emerge from the feedback session feeling encouraged and hopeful about positive changes in the future, discouraged and overwhelmed, or somewhere in between. These feelings merit attention in the process and checking in about patients’ thoughts and reflections between sessions is a useful practice to integrate into sessions. Even if exploring this does not form the basis for setting the agenda of the day’s session, remember that patients’ beliefs about the potential for change has an impact on treatment outcome. Checking in about how patients believe the process is working for them is an important opportunity to
correct any misconceptions they may be having, foster hope and encourage positive actions and attitudes they are bringing to the process.

Reviewing “Homework”

Next, the therapist checks in with the patient about his or her experience completing the exercises or practice activities recommended the week before. Successes and problems with the exercise are discussed in detail—including barriers that may have arisen to prevent the patient from doing the exercise. Problems completing the exercises should not be treated as a failure; it is an opportunity to further assess barriers and opportunities in the patient’s life. This exercise may also identify areas that need further work. The discussion can help to establish the skill-building that will be addressed in the session.

Setting the Agenda

The therapist should prepare for the session by having potential agendas in mind, based on the treatment plan that was developed in conceptualizing the case. At the same time, the agenda should definitely be set in collaboration with the patient. Ideally, the topic for discussion can be linked to the identified problem areas and can be addressed by skill development articulated in the treatment plan.

Psychoeducation

In the first session of active treatment, many CBT manuals devote time to psychoeducation. The psychoeducation process addresses both the cognitive explanation for depression and other mental health problems and the rationale for how cognitive-behavioural therapies work. In CA-CBT, much of this should have been addressed in the second session as part of presenting the conceptualization, but this may be revisited in this session to answer any questions that have arisen for the patient and clarify any areas of confusion or uncertainty.

At this stage, psychoeducation can be used to more directly connect these concepts to the patient’s situation, addressing the cognitive contributions, but also emphasizing contributions from the environment. The therapist can draw on information the patient has provided to demonstrate how the cognitive model works and how cognitive-behavioural strategies could promote better health. The therapist can also use this opportunity to normalize the patient’s experiences, letting him or her know that many people share the same kind of difficulties under the same type of experiences. This discussion will help to further inform the patient, but can also help to build engagement and rapport by demonstrating that the therapist is listening closely to the information the patient has provided.

This is also an opportunity to review the treatment plan with the patient, orienting him or her to what will be the general process over the next 10 sessions. The therapist can review the goals of treatment and what types of tasks will be used to achieve those goals. It is a good time to talk about the length of the treatment program, ensuring the patient knows that there is flexibility to allow for earlier termination or to add a few extra sessions. If a patient is higher functioning, presenting with mild to
moderate depression, and does not present with other comorbid issues (e.g., suicidal thoughts, addictions, memories of traumatic events, domestic violence), an effective course of CA-CBT can usually be delivered in a total of 12 sessions. For patients who are less able to access their thoughts and feelings, are lower functioning, have more acculturative stress (e.g., inability to speak English; underemployment; housing, financial, family separation, immigration issues) or have less education, it may require 16 to 20 sessions to provide them with adequate time to learn the material, to address unexpected comorbidities that may be impacting the treatment, or complete the interventions.

Although this process is called psychoeducation, it should not be approached as a didactic process. Cognitive-behavioural therapies are built on collaboration between the patient and the therapist, including in the psychoeducation process. Although the therapist is contributing expertise in the form of knowledge about how the cognitive model works and what strategies are useful in it, the patient is bringing expertise about how his or her world works and what are useful strategies for surviving in it. The therapist should approach the psychoeducation process as a consultative process. This includes checking in with the patient about his or her thoughts, ideas and hypotheses about what is going on and what will help. This consultative process will contribute to the treatment process both by conveying respect that will help the therapeutic alliance and by generating additional information to further refine the treatment plan. Outcomes of this process may include setting priorities for future work, identifying specific skill sets to be developed, and learning more about strengths and resources that can be mobilized.

It is not too early to start talking about termination in the first session. Alert the patient to the plan to use the last few sessions to prepare for maintaining the gains made in treatment.

Skill Development

The therapist and patient will have determined the focus of work for that day’s session. As indicated earlier, the main interventions available in CA-CBT are psychoeducation, self-monitoring, relaxation techniques, cognitive restructuring, social skills training and problem-solving skills. The specific interventions to be used in any session will be determined by what the patient identifies as the issue to be addressed and the tasks he or she would like to use to build skills for dealing with it more effectively. The conceptualization and treatment plan should prepare the therapist to have a repertoire of potential interventions to use based on what content the patient brings to a session.

Assigning “Homework”

The session can be used to practise skills that will be the basis for homework or to work with patients on skills that may be too labour-intensive to do at home. For example, some patients may welcome the opportunity to do self-monitoring by keeping a thought record, but many will find it too labour-intensive to complete during the week when they have competing demands. If patients are feeling overwhelmed, the therapist could let them use the session for doing this kind of work and then develop a homework exercise that is less demanding on their time and energy.
Toward the end of the session, the therapist should work with the patient to establish a therapeutic exercise to do before the next session. With patients from Latin American communities, time should be scheduled during the sessions to discuss what therapeutic exercises may be helpful, so the therapist can problem-solve with the patient ways to reduce barriers to completing the exercise. Scheduling the exercise time also communicates its importance. Talk to patients about what will help them to follow through on the commitment; for example, setting up reminders in a calendar, or attaching the activity to an existing commitment in the schedule, etc. Self-monitoring or journalling activities could be combined with activities such as downtime, going for a walk, prayer or meditation.

Closing the Session

Therapists should close sessions by reviewing the work that has been done in the session, tying it to the overall goals of the treatment. Both the patient and the therapist will benefit from regularly reviewing the treatment goals, articulating what is being done to accomplish them, and reviewing areas in which the patient is making positive progress.

The therapist should reserve time after the session to document progress and add the session notes to the patient’s file.

Sessions 10 to 12: Termination

Because CBT interventions are time-limited, there is a great deal of emphasis on preparing patients to learn skills that they can practise on their own. In sessions 3 to 9, the therapist should have been regularly reminding patients of the movement toward termination. For some patients, this will be anxiety-provoking. For others, it will motivate them to work toward their goals. In both cases, it is good to remind the patient that one of the goals of treatment is to give them the skills to deal with situations without the assistance of the therapist. For the therapist, the time limit should be a reminder to continually evaluate each session in terms of its utility in progressing toward the treatment goals.

Patients are often ambivalent about terminating treatment. In the last few sessions, it is common to see behaviours such as denying the termination is happening or avoiding its discussion, introducing new problems or returning to old problematic patterns, becoming angry with the therapist or feeling sad and abandoned, or missing sessions to extend the treatment or take control of ending the relationship on the patient’s terms. As these behaviours are common reactions to termination, they should not be treated as signs of pathology. Instead, they can be discussed with patients in terms of how they respond to stress, or how the behaviour may be linked to issues that have been discussed in the treatment process. In this way, termination continues the learning process and skill development that the patient has worked on in treatment.

Ending may be difficult for the therapist as well. Although the process was started with an explicit timeline, the therapist may feel like there is still much work to be done with the patient, or may worry
that he or she has not done enough for the patient. It is important for the therapist to work through these issues as well, perhaps discussing them with a peer or supervisor. It may be important for the therapist to evaluate, with someone else, if his or her concerns are based on the patient’s issues (suggesting a need to extend treatment), or based on the therapist’s own feelings.

Conventional therapeutic approaches usually discourage contact with patients after termination. In CA-CBT, it could be culturally inconsistent to suggest that because there has been a therapeutic relationship, there should be no future contact between patient and therapist. This is especially unrealistic in small communities where the patient and therapist are likely to run into each other in other venues. The therapist should respect boundaries by not initiating contact with patients after termination, but should not discourage patients from initiating casual contact after sessions have ended. Some patients may wish to continue some informal contact, perhaps dropping in to say hello, or calling to let the therapist know that they are doing well. Such contacts are not inappropriate and are only a concern if the therapist believes that the patient is continuing to depend on the relationship because he or she lacks confidence about being able to be on his or her own. Accordingly, an important task of termination is to help the patient establish that confidence and help the patient to determine the difference between normal difficulties he or she might face after termination and situations in which it may be advisable to seek further help.

Preparing Patients to Be Their Own Therapist

Part of preparing patients for termination is building their confidence for picking and using strategies to deal with everyday stressors. This process is started by always collaborating with patients in decisions about what skills are to be learned and how and where they should be applied. As the treatment progresses, patients should be assuming more leadership in this process, building on their growing familiarity with the techniques and knowledge about themselves and their environments from their experience doing the homework exercises. The problem list and/or the conceptualization developed at the beginning of the treatment can be used to guide later sessions, with the therapist asking patients to make suggestions for discussion topics, in-session activities and between-session exercises. The therapist gradually moves into a more supervisory role, monitoring and reinforcing the patient’s successful use of coping skills. Sessions move toward focusing on how patients are coping successfully with situations that were previously distressing. Together, the therapist and the patient identify the thoughts, emotions and actions that are being mobilized to make successful coping possible.

As the treatment moves into termination sessions, the patient should be doing this independently, using the therapist (and potentially, other people in his or her life) as consultants to the process. The therapist, in turn, reinforces this by encouraging the patient to make decisions, praising initiative and calling attention to the patient’s growing skills. Support patients’ growth by helping them think through options and evaluate alternatives. If a plan needs some improvement, guide patients to appropriate changes by asking questions that will get them to work through the possibilities, their pros and cons, etc.
The therapist can orient patients to the idea of being their own therapist through concrete strategies such as role-playing, in which the therapist acts as a patient and the patient presents recommendations like a therapist. Discussing potential problem situations and how patients would address them is another concrete way to demonstrate to patients that they have made progress in being able to face difficult situations. Patients may also provide situations during check-in that can be used as examples of growing competence.

In all of these ways, the therapist should be communicating the confidence that he or she has in the patient’s ability to move forward positively. Patients will benefit from receiving positive reinforcement from the therapist, but it is even more important for the therapist to call patients’ attention to the positive reinforcement coming from other people in their life.

Tasks for the Last Few Sessions

In the final sessions of treatment, important tasks include reviewing progress, setting future goals, establishing realistic expectations, and ensuring the patient knows what to do if depression returns.

Reviewing Progress

It’s easy for patients to lose sight of the progress they have made during the sessions so the therapist must help them to see how far they have come. This can be done informally by discussing the issues that first brought the patient to treatment and comparing the past situation to the present. It can also be done in a more structured way by reviewing the problem list that was made at the beginning of therapy, or reviewing the assessments the patient has completed. Looking at where they started and comparing it to the present situation can be a very empowering way for patients to recognize the work they have done.

Setting Future Goals

Patients may be inclined to see the termination of treatment as the end of the work they are doing on themselves; to counter this, setting future goals will help to communicate that they are in a lifelong process of improving themselves and their relationships. The termination sessions are a good time to talk about how accomplishments made during treatment can be generalized to other situations. These final sessions can also be used to set goals in new areas, with discussion of how skills they have learned can be adapted to these new situations. In either case, the therapist will be encouraging the patient to see how skills in areas such as problem-solving, self-monitoring and relaxation will continue to be useful to them. It is also a way to reinforce the idea that it is important to keep practising the skills so that they are available in times of increased pressure or stress.

Setting Realistic Expectations

Some patients may be anxious about terminating treatment because they feel they still have problems that have not been solved. During termination, they need to learn that the ultimate goal is not to have
any more problems, but to have the skills and resources to deal with problems. Again, it is important for them to recognize that they have a repertoire of skills and resources available to them that they may not have had before or used effectively before. Now, they are in a position to help themselves in times of stress and, with regular practice, may even be able to prevent emotional distress and depression. Even so, there may be times that those skills and resources get overwhelmed, so patients also need to know what to do in particularly difficult times.

Discussing What to Do if Symptoms Return
Part of setting realistic expectations is to be open with patients about the possibility that they may experience symptoms of depression again. Increases in stress may overwhelm their newly developed skills, or changes in the environment may make it more difficult for them to practise what they have learned for staying well. In such situations, patients should know that they should seek help. The help they need may be to have a “booster” session with a therapist, or start another course of treatment. It is important that they understand that relapses are not a personal failure, but are common occurrences. The individual, social and environmental issues that precipitated depression in the first place can bring it back again.

Termination is a good time to talk with patients about their “early warning signs.” In retrospect, it can be easier to identify the signals that their functioning is beginning to decline. Just as the name implies, early warning signs are a warning to do something before their functioning worsens. Patients can benefit from making a list of what strategies have been most helpful to them during treatment, and discuss how they will know when it is a good time to consult that list.

Termination may also be a good time to talk with patients about who else in their life can be part of a plan to promote mental health and prevent future relapse. Encouraging patients to discuss this issue with people close to them will help build skills for seeking social support—another important strategy for remaining well. A family doctor might be someone who could be enlisted in a health promotion plan. Patients should also know that they can check in with the therapist as well. The therapist may be able to provide perspective on what is going on with the patient and reinforce strategies learned during the treatment, suggest a booster session, or recommend resuming treatment.

Ultimately, patients should be helped to put together a plan for staying well and responding to changes in their mental health. This plan should include health promoting activities, identified social supports and resources and contacts they can access if they experience difficulties.
Terminating Treatment: When Is the Right Time?

CA-CBT is typically delivered over 12 weekly sessions, but research has demonstrated that some patients can achieve benefits with fewer sessions while other patients may need more sessions. The timing of termination may deviate from the expectation of 12 weeks for several reasons: patients may not be able to reserve the time necessary to complete 12 weekly sessions; they may grasp the concepts quickly and not require as many sessions; or they may encounter personal or family difficulties that suggest a need to extend treatment. As noted at the beginning of the manual, the therapist may need to be flexible; both therapist and patient should not feel that deviating from the 12-week expectation in any way reflects a failure of treatment.

If a therapist and patient decide to terminate treatment before 12 weeks because the patient is doing well and is ready to function without therapist support, termination is relatively straightforward. It is more difficult, however, if early termination is prompted by difficulties in the therapeutic relationship; for example, failure to develop a working alliance or poor engagement with the treatment process. Although such a situation can be disappointing for both therapist and patient, it is in the interests of the patient to terminate rather than continue. Termination may make it possible for the patient to seek help elsewhere or with someone else with more positive outcomes. Other times, patients are not ready to benefit from treatment because their life situation is too chaotic or they have not reached a stage of readiness for change. Terminating therapy and encouraging patients to seek help again if circumstances change is preferable to attempting to move ahead and generating frustration, feelings of failure, or negative attitudes toward treatment in general and CBT in particular. A positive experience of collaboratively making the decision to suspend treatment will pay off later when the patient feels more ready and has a positive attitude to returning to treatment.

Extending treatment might be indicated if a new situation arises in the patient’s life that was not part of the original conceptualization. The patient and therapist need to discuss if these new demands can be met with the existing repertoire of skills, or require setting new goals and implementing new interventions. Extending the treatment four or five more sessions may be sufficient. Alternatively, booster sessions may be sufficient if the patient simply needs more time to build confidence in using newly acquired skills.

Therapists anticipating that a patient may be highly anxious about terminating treatment may also consider modifying the termination sequence by reducing the frequency of sessions toward the end of the active treatment phase. Meeting with the therapist every other week toward the end of treatment may address a patient’s feeling that he or she needs more time, while providing the opportunity to experience coping without the therapist’s support for longer periods.

Patients may also approach termination with ambivalence: they may value feeling able to deal with problems independently, but may miss having a relationship in which they were able to be completely open about personal struggles and their experience of depression. This ambivalence may play out through patients becoming less forthcoming toward the end of the treatment, as they mentally prepare to move forward without the therapist’s support.
With this in mind, the therapist should encourage discussion of the ambivalence about ending the sessions. This may be another time when it makes sense to revisit the idea of what it means to be “strong” and how that does not include not seeking help when needed, or not ever having any problems again. Reinforce the strength that is demonstrated by taking care of oneself and how this contributes to important goals such as being a strong member of one’s family and community.

The timing of termination should be determined by the progress that therapist and patient feel is being made toward the treatment goals. This is a good topic for regular discussion throughout the treatment process, both for the purpose of evaluating progress and for demystifying the decision-making process that will determine when treatment will end.

Endings from a Cultural Perspective

Some patients from Spanish-speaking communities may find the idea of having no contact with the therapist difficult to accept. Having spent several weeks confiding in the therapist about personal issues and sharing challenges and triumphs, the patient may feel great warmth and gratitude that is difficult to confine within the conventional boundaries of a therapeutic relationship. The desire to maintain contact and express these feelings of warmth and gratitude should be understood in its cultural context, as reflecting common values like personalismo, which defines personal, informal ways of relating, and the development of confianza, trust and confidence in the therapist. The culturally-influenced desire to feel a connection with the therapist need not be read as a misunderstanding of the professional relationship; rather, it should be understood as an indication of the strength of the working alliance.

With this perspective, therapists should not be reluctant to accept the patient’s expression of connectedness, and can also feel comfortable expressing feelings of warmth and positive regard for the patient. The patient may wish to present the therapist with a gift at the end of treatment, as a show of gratitude for the help that has been provided. This is consistent with cultural values, and accepting the gift graciously is a culturally appropriate response (assuming there are no concerns about the gift being too substantial). Giving a gift may be the patient’s way of letting the therapist know that he or she has accepted termination. Therapists may also wish to consider providing patients with a small termination gift, or a card that reinforces some aspect of the treatment process, wishes the patient well, and/or reassures the patient that help is available in the future if needed.
Chapter III: CA-CBT Interventions

Self-Monitoring

Patients often need help to become more aware of the thoughts and behaviours that are contributing to negative emotions and those that are promoting positive mental health. Self-monitoring tools—essentially, asking patients to track their feelings, thoughts, and behaviours—can help raise their awareness. The therapist should review a past situation to show patients how to monitor their feelings, thoughts and behaviours, and then provide them with handouts so they can do their own self-monitoring between sessions.

Identifying Feelings and Thoughts

In CA-CBT, we use the term “feelings” to refer to the emotional and physical states that arise in stressful situations. Sometimes feelings can be described with words such as “afraid,” “nervous,” “sad,” “happy” or “excited.” Sometimes they are better described with words like “jumpy,” “sick,” “tired” or “stressed”. It can be difficult to separate the emotional reactions from the way the body reacts, but we can use cognitive and behavioural interventions to help with both.

Often people feel poorly because they have trouble identifying their feelings and expressing them. When they hold feelings inside, it makes them feel emotionally and physically unwell. Often the physical sensations—tension, fatigue, headaches, stomach aches—are more noticeable than our emotions. Patients can learn to identify these sensations as possible signals of strong emotions. Holding on to emotions without expressing them is something that people learn to do because they are not taught how to expressing feelings safely, or they have had negative experiences when they try to express feelings. Learning strategies for dealing with feelings can offer patients ways to deal with stress more effectively.

Since few people are taught how to deal with their feelings, it takes practice. To help patients become adept at identifying feelings and symptoms of emotional distress, advise them to keep a record of situations where they experience strong emotional and/or physical reactions and to rate the intensity of these reactions. A guideline for this exercise can be found in Appendix 2, Handout 4: Identifying Feelings.

The automatic thoughts and images that accompany everyday situations give rise to different feelings. Often referred to as self-talk, this chatter is based on the beliefs, principles, assumptions and rules that people have learned and used to navigate their relationships with themselves, other people, and the environment around them. Since thoughts are such a large component of emotional experience, it is important to help patients notice how their thoughts affect their feelings. It can be a valuable exercise to have patients who are open to completing written homework record their self-talk and think about
how their personal experiences have taught them to look at and understand the world in a certain way. An example of such an exercise has been made available in Appendix 2, Handout 5: Noticing & Exploring Self-Talk. Practise this with the patient, and then suggest he or she try doing it independently between sessions.

Cognitive Restructuring

Cognitive Distortions and Myths

Cognitive-behavioural therapies commonly target a specific category of thought patterns called cognitive distortions. One of the barriers to relieving depression, anxiety or other negative mood states is that patients have learned unhelpful patterns of thinking—cognitive distortions, which reinforce negative feelings. Common cognitive distortions are:

- **All-or-nothing thinking**: Thinking about bad events in terms of them “always” being true, or good events “never” happening or a bad situation staying that way “forever” (e.g., “Nothing good ever happens to me”)
- **Overgeneralizing**: Taking a single negative event and assuming it is true all the time (e.g., “All doctors in Canada are cold and impersonal”)
- **Mental filter**: Only paying attention to the bad events that happen and overlooking good events that are just as relevant (e.g., ruminating about not obtaining a job, after successfully obtaining permanent residency status in Canada)
- **Disqualifying the positive**: Rejecting positive statements from other people (e.g., responding to a compliment on your work with “It must have just been luck”)
- **Jumping to conclusions/catastrophizing**: Seizing on one piece of information to conclude that the worst has happened (e.g., “My kid is not doing well in school because his English is not good enough, therefore he will never do anything productive in this country”)
- **Magnification/minimization**: Seeing negative events as hugely important and positive events as insignificant (e.g., preoccupation with a negative comment about grammar made by an ESL teacher, but dismissing actual progress made in learning English since coming to Canada)
- **Emotional reasoning**: Letting the way something makes you feel distort your perception of the situation (e.g., feeling nervous about a refugee hearing or driving test makes you feel you are not prepared or would be better off not attending)
- **Should statements**: Holding yourself to an unreasonable standard (e.g., “I should do this right every time”)
- **Labelling**: Applying negative labels to the self inappropriately (e.g., making a mistake and telling yourself that you are a failure in Canada)
• **Personalization**: Taking personal responsibility for bad events happening to other people. (e.g., your mother or your husband or your child is stressed out and you blame yourself for encouraging the family to immigrate to Canada).

• **Fallacy of change**: Believing that you can change others when, in fact, you can only change yourself or thinking that everything will get better for you if someone else changes (e.g., believing that your love or effort can stop someone from doing negative things)

• **Fallacy of fairness**: Feeling resentful because you think you know what is fair but others will not agree with you (e.g., thinking that your partner should do more to help with the housework because he should see and appreciate what you do)

• **Fortune-telling**: Believing that you know ahead of time how something will turn out (e.g., not wanting to go for a job interview because you already “know” you are not going to get the job)

• **Mind reading**: Imagining what someone is thinking and then reacting as if it were real (e.g., feeling bad because your spouse is quiet and you think this is because he doesn’t love you anymore; you react to this belief instead of asking why is he or she quiet).

Therapists need to be careful about labelling these thought patterns as cognitive *distortions* because patients may perceive this as implying that all of their problems are “in their heads.” What we call cognitive distortions are unrealistically negative thoughts that have been learned in negative situations. Patients may have learned this way of thinking from someone who judged, criticized or rejected them. Or they may have learned to think this way to cope with multiple negative experiences and situations in which they were taught to blame themselves or become distressed rather than try to change situations beyond their control or influence. Rather than talking with patients about their “distortions” or “distorted thinking” that must be replaced by “rational” or “modified” thoughts, it may be more helpful to talk to them about thoughts they have that are “extreme” or “unhelpful,” or “not useful” (Williams & Garland, 2002). This wording will help patients realize that their thoughts are not based on reality and are contributing to their negative feelings and behaviours. Talking with patients about what kind of situations evoke these thoughts and where they may have come from can help them to understand the thoughts as learned ways of responding that can be replaced with new learning that will promote more positive feelings and behaviours.

Pictograms can be a useful way to begin discussion about cognitive distortions that patients apply in everyday situations. Patients benefit from learning to identify the thoughts and beliefs that contribute to their negative feelings. In the Appendix 2, Handout 10, you will find pictograms of the most commonly described cognitive distortions. These pictograms can be used to engage patients in discussions about learned patterns of thinking that may be undermining their mental health, and also as reminders about how to label their unhelpful cognitive distortions.
Modifying Cognitive Distortions and Negative Self-Talk

Negative feelings and reactions can be fuelled by the way people interpret events and what they then, in turn, tell themselves about these events. Messages we deliver to ourselves are called “self-talk.” People experiencing depression, anxiety and other mental health problems often have an internal monologue going through their head that is full of negative self-talk. Sometimes the things they are saying to themselves originate from negative words that have been said to them by others or from bad past experiences.

Negative self-talk contributes to negative emotions by colouring the way people perceive external events. Therapists can show patients how these negative thoughts are connected to negative feelings (e.g., being afraid, unsure or stressed) and negative behaviours (e.g., getting angry, giving up or blaming others). This can open their eyes to how changing that self-talk can similarly promote changes to more positive feelings and behaviours.

You will repeatedly be helping patients to make connections between their emotions (A = affect), their behaviours (B = behaviours) and their thoughts (C = cognitions). Presenting a simple figure linking these three elements and providing patients with examples from their life, are good ways to train them to make similar connections on their own. Eventually they will then be able to work out how to make changes that will promote positive outcomes in these three areas. This can be achieved with a very simple diagram and repeated reference to the cycle, using words they are comfortable with. An example of such a diagram can be found in Appendix 2, Handout 7: The A-B-C Cycle.

It is important for patients to understand that negative self-talk is usually automatic—it happens so fast and so smoothly that the person is barely aware of it, but does feel the negative effects. Negative self-talk usually takes the form of:

- worrying: “what if” thoughts, anticipating the worst
- criticism: pointing out shortcomings, flaws, name-calling, blaming
- hopelessness/helplessness: what’s the point, I can’t, it will never change
- perfectionism: I should have, it must be, I have to.

Negative self-talk has to be actively countered by positive self-talk. A first step is to identify when negative self-talk is happening, and then learn to challenge these thoughts with positive, supportive statements. Patients must actively practise this skill of unlearning a problematic cognitive style and learning a health-promoting cognitive style. With practice, they can learn to recognize when the negative self-talk is operating and deliberately replace it with positive self-talk before it leads to negative feelings and behaviours.

Work with patients to identify a negative thought, evaluate it and then replace it with positive self-talk. Patients may find it helpful to link positive counter-statements to ideals they value. For example, among religious patients, religious values may counter cognitions that devalue the individual who sees himself or herself as a creation of God. More traditional patients may resonate with the notion of
familismo to challenge cognitions that suggest that other family members do not care about the person.

Positive self-talk should:

- begin with an “I” (this reinforces the patient’s ability to manage his or her situation)
- be stated in the present tense
- be credible (i.e., based on something the patient really, truly believes)
- be positively worded (e.g., “I am a person that can succeed at this” is better than “I will not fail at this.”)

<table>
<thead>
<tr>
<th>Negative self-talk</th>
<th>Evaluative questions</th>
<th>Positive self-talk</th>
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</table>
| 1. I fail at everything I try to do.  
2. My family doesn’t care about me. I’m all alone. | - What is there to suggest this is true (evidence for)?  
- What are the chances of that happening?  
- What’s the worst thing that could happen?  
- What is there to suggest this is not 100% true or 100% likely to happen (evidence against)? | 1. I am successful at many things and if I fail, I can go on to do something else.  
2. I have family who have supported me before and will support me now. |

Or

<table>
<thead>
<tr>
<th>Unrealistic negative thought</th>
<th>Evaluative questions</th>
<th>Positive/More balanced counter-statements</th>
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</table>
| 1. No one will ever give me a job because I am an immigrant.  
2. I haven’t heard from my family in a week; something terrible must have happened | - What is there to suggest this is true (evidence for)?  
- What are the chances of that happening?  
- What’s the worst thing that could happen?  
- What is there to suggest this is not 100% true or 100% likely to happen (evidence against)? | 1. Many immigrants have had difficulty finding work at first, but they eventually are successful.  
2. It is likely that they have had difficulty getting communication out and I can keep trying to reach them. |

Positive self-talk should be reinforced outside of the sessions. Some people like to write short forms of the statements and leave notes for themselves. For example, a patient may have a post-it note on a mirror that says, “I am liked and respected by many people.”
A common homework exercise is to have people practise modifying their thoughts between sessions. Patients are given a piece of paper with two columns. In one column, they record when they have had negative self-talk or unrealistic negative thoughts. In the other column, they write down positive counterstatements. This exercise will help teach them a three-step process for promoting health:

1. Notice when the negative thoughts and self-talk are happening.
2. Stop and interrupt the thoughts to ask questions about whether it’s a realistic or fair thought.
3. Replace the negative thought/self-talk with a deliberate positive statement.

In Appendix 2, Handout 6: Thought Record, you will find an example of a more detailed recording worksheet that can be used with patients to facilitate a discussion in the therapy session and for patients to record their experiences independently.

**Behavioural Experiments**

Patients may need to try out new behaviours so they can accomplish goals they have set, or replace previous behaviours that reinforced a cycle of negative thoughts and feelings. Often they have not been able to do these behaviours on their own because they were anxious and preferred to avoid the situation. However, avoiding the situation just strengthens the fear associated with it.

When the therapist and patient have determined what new behaviour to try out, they can work together to design a set of experiments that will help the patient to discover what happens when he or she tries something new. These experiments are modelled after *exposure therapy*, a behavioural intervention in which a patient identifies the negative thoughts and feelings evoked in the situation and learns to replace them with positive thoughts while progressively engaging in the new behaviour. The steps for designing a behavioural experiment are:

1. Work with the patient to describe the situation and what he or she anticipates will happen when trying out this new behaviour. Focus on the thoughts and feelings associated with the situation.
2. Work with the patient to develop strategies that can be used in the situation and use their existing repertoire of coping behaviour to overcome the negative thoughts and feelings (e.g., positive self-talk, deep breathing, visualization, spiritual practices, etc.)
3. Try out the new behaviour in the therapy session. Work with the patient to break the action into small steps that can be executed in sequence with pauses to evaluate the need to use the strategies discussed or to engage in a calming strategy.
4. Practise this experiment several times, so the patient can get more practice and try using different strategies.
5. Have the patient try out the new behaviour on his or her own in between sessions. Work with the patient to determine if the at-home experiment will involve doing one or several steps of the new action.
In Appendix 2, Handout 8: Your Experiment, you will find a worksheet that can be used to help patients work through these steps, or record the outcome of experiments done between sessions.

**Problem-Solving Skills**

The core of problem-solving skills is to coach patients through a sequence of activities that will change an overwhelming situation into a set of manageable problems that can be addressed through clear, definable actions. Patients may think that they have very few options, until they learn through this process to recognize a fuller range of choices.

Choosing not to take action should be recognized as a viable course of action: the therapist may want to remind patients of the serenity prayer as a tool for making peace with situations that can’t be resolved by individual action. At the same time, the therapist should help patients to recognize that they may not be powerless in some situations and may be able to take action independently or with help from others.

Patients should identify a problem they would like to try solving. Content that is discussed during the check-in or homework review may identify a problem linked to the treatment goals, but patients should choose the example that will be used for the exercise.

The process will seem cumbersome at first, but assure the patient that with practice, it will become easier.

**Problem-Solving: Step-by-Step**

Guide patients through this six-step problem-solving process:

1. Define the problem. Make sure it is very specific and, if necessary, broken up into smaller problems that you can work through one at a time.

2. Brainstorm ways to deal with the problem. Put down everything you can think of, no matter how unlikely.

3. Choose the best option by looking at the pros and cons of each solution.

4. Generate a detailed action plan for the best option. Address the who, what, why, when and where of the plan.

5. Put the plan into action. Rehearse it in your mind or with the therapist, and then do it.

6. Evaluate your success. If this plan didn’t work, go back to #3 and try the next best option.
Relaxation Techniques

The following relaxation techniques are effective strategies for reducing stress. However, the full benefits of these exercises can only be attained with ongoing practice.

Breathing Exercises

Breathing exercises can be a good place for people to start learning how to manage physiological tension. These exercises take about five minutes and should ideally be practised at least once a day. The exercises teach the patient to put the body in a more relaxed state, with daily practice resulting in a more generalized state of relaxation. These exercises are also useful because they can be practised almost anywhere and can be used whenever the patient feels stressed or tense.

Abdominal Breathing

• Get into a comfortable sitting position. Loosen any tight clothing.
• Place the hand on the abdomen.
• Inhale through the nose attempting to get air deep into your lungs. You should feel your hand rise as air reaches down to your diaphragm.
• Exhale through the nose or mouth (whichever you prefer), letting your body go slightly limp.
• Do three sets of 10 breaths.

Yoga Breathing

• Inhale to a count of five.
• Hold your breath to a count of five.
• Exhale slowly, over a count of five.
• Take two normal breaths.
• Repeat the cycle until five minutes have passed.

Progressive Muscle Relaxation

Progressive muscle relaxation is another exercise that can teach patients to reduce tension in their bodies. It can be a useful exercise before bed, as it may make it easier to go to sleep. Patients may find it helpful to do this exercise while listening to a recorded guide; ideally, the agency can provide CDs with recorded instructions. Patients with access to computers can also download progressive muscle relaxation audio instructions. There are several available online without cost through iTunes or at websites such as:
When teaching this exercise, the therapist should have a script available to take the patient through the relaxation sequence. Some readily available online sites include:

- www.innerhealthstudio.com/progressive-muscle-relaxation-exercise.html
- www.allaboutdepression.com/relax/

The following exercise has been adapted from The Anxiety & Phobia Workbook (Bourne, 2005). The therapist can guide patients, using the following instructions:

You will do each muscle group once, but feel free to repeat an area if it feels especially tense or tight. This exercise will take about 20 to 30 minutes.

For each muscle group, hold the tension for five to 10 seconds, then release for 10 to 20 seconds. You should not feel any pain when you are tensing the muscles. As you exhale, imagine the tension in your body flowing away. Picture the muscle becoming smooth and loose after you release the tension.

1. Take three deep abdominal breaths, exhaling slowly each time. Picture tension flowing away from your body as you exhale.
2. Fists: Clench, holding them for 10 seconds, then releasing for 20 seconds.
3. Biceps: Tighten by drawing your forearms toward your shoulders, as if you are “making a muscle.”
4. Triceps: Tighten by extending the arms out straight and locking your elbows.
5. Forehead: Tighten by raising your eyebrows as high as you can.
6. Eyes: Clench your eyelids tightly shut.
7. Jaw: Open your mouth as wide as you can, as if you are yawning.
8. Neck: Pull your head back as if you are going to touch your head to your back.
9. Shoulders: Raise your shoulders up toward your ears.
10. Shoulder blades: Bring your shoulder blades together in the back.
11. Chest: Take a deep breath and hold it.
13. Lower back: Arch your back up. Skip this muscle group if you have a lower back pain problem.
14. Calf muscles: Gently pull your toes toward you.
15. Feet: Curl your toes downwards.
16. Mentally scan your body to see if there is any area where you still feel tension. If there is, repeat the exercise in that area.

17. Taking deep breaths, imagine waves of relaxation washing through your body from the top of your head to your toes.

Visualizations

Visualizations can be a good way of evoking a sense of peace and distracting yourself from negative or anxious thoughts. Help patients to design a visualization that is unique to them—perhaps a place they remember, or a place where they have always wanted to be. Do not restrict them to places that are realistic; for example, they can imagine themselves floating in a bubble, or suspended underwater. Help them to paint in the details of their visualization with instructions such as:

- Imagine a place where you remember feeling very relaxed and peaceful or can imagine yourself feeling relaxed and peaceful. Close your eyes and picture the way the scene looks, sounds and feels.
- Picture yourself walking toward the scene and entering it. Notice how you immediately feel more peaceful as you step into the scene.
- Take in the colours that surround you. Notice which colours are brightest and most prominent.
- Tune in to the sounds that you hear in that place. Imagine the different sounds, tuning in to each element. Picture yourself turning toward the sounds so you can hear them better.
- Imagine the lighting in the place. Think about how it would light the things around you, how it would light you and feel on your skin.
- Imagine the temperature in the place and how your body feels. Think about what sensations you would feel on your skin. Visualize what you might be touching, or what you could reach out to touch.
- Think about what you would smell. What is it? Where is it coming from?
- Think about whether you are alone, or if there is someone there with you.

Meditation

Meditation can be useful for both diminishing troubling thoughts and decreasing tension in the body. Developing the discipline to focus in the present, without being pulled into judgment or worry about past or future, is a very powerful tool for diminishing the negative effects of anxiety, depression and other discomforting emotions. Meditation practices have recently received strong endorsement in the mental health field and the practice of mindfulness meditation is often recommended as an adjunct to treatment for mental disorders. Patients may wish to join a meditation group facilitated by someone who teaches mindfulness, or may enjoy learning mindfulness at a Buddhist centre that offers free or inexpensive instruction. Mindfulness instruction is also available in books such as Jon Kabat-Zinn's Full
Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness (2005), through CDs and in mp3 files, which can be downloaded free of charge at sites such as iTunes.

Patients should be encouraged to find a method that suits them best from the many types of meditation available. Meditation can be used as a completely secular practice, or as part of a spiritual practice. For example, it can be used to begin or end existing prayer practices, as a way to start or end the day, or to begin or end another exercise such as progressive muscle relaxation. Meditation usually takes 20 to 30 minutes and is recommended as a daily practice to achieve full benefit. That may seem like a long time for a beginner, so reinforce that even five minutes per day can be a good way to start. The time can be tracked by setting a timer, or by doing meditation with a recording that indicates when the time is over.

The basic outline of a meditation practice is as follows:

- Find a quiet environment where there is less noise or distractions. You can meditate in a silent space or—if you prefer—you can play quiet music or relaxing noises in the background (e.g., ocean waves).
- Get yourself into a comfortable sitting position. You can sit in a chair or on a cushion on the ground with your legs crossed. It is important that you are physically comfortable. Lying down is not recommended, as you are supposed to maintain a relaxed alertness during meditation; however, work in the position that you find comfortable.
- Find something to hold your focused attention. Many people will choose to focus on their own breath, paying attention to the cycle of it moving in and out of the body. Some like to find a mantra, a word or phrase they can repeat every time they exhale (e.g., “Peace” or “in God’s hands.”) A picture or candle placed in front of the person can be a focus. It can also be effective to picture an image in the mind, and focus the attention on it.
- Close your eyes if that is comfortable and does not interfere with focusing your attention on the object you have chosen.
- Breathe deeply, without force, keeping your attention on the object of focus.
- When thoughts or daydreams come to the mind, observe them as if they are clouds passing by. Do not hold on to them, or try to push them away—just watch them drift by. Even people very experienced with meditation have distracting thoughts. With practice, it becomes easier to watch your thoughts drift by without reacting or judging. Do not be troubled if there are distracting thoughts; simply return your attention to the object of focus.
- End the meditation by reflecting on the good that you have done for yourself by doing the practice. Some may also wish to end by reflecting on the practice as a way to benefit themselves and all those that that come into contact with them. A prayer may be another way that some people choose to end the meditation practice.
Using Prayer as a Meditation Practice

Some patients may be more comfortable with the idea of praying than meditating. Prayer can have the same benefits as meditation, as it is an opportunity to still the mind and to cultivate detachment from problems by turning them over to a higher power. Praying can be a palatable adaptation of meditation practice for patients who are religious.

Encourage patients to incorporate a breathing practice into their prayer. In the same way that they can deal with distracting thoughts during meditation, they can refocus on breathing or on a phrase or ritual that will return them to the prayer practice. Encourage them to begin and end the prayer practice by reflecting on the good it does for them and how it will make them cope better and be better in their relationships with other people.

A potential integration of prayer and meditation could be:
- thanking God for the time and space to speak with him or her
- praying for himself or herself
- praying for others
- thanking God for the way that prayer will benefit the patient and the people around him or her.

Stress Inoculation

Stress inoculation is a technique that the therapist can use to prepare patients for a real-life situation that they anticipate will be stressful or for exposure to a situation that the therapist is creating to desensitize the patient to a stressful situation. The more detailed and realistic the therapist makes the situation in the practice, the more likely the patient will be inoculated against stress in the real situation.

Help the patient to make a list of the negative thoughts and self-talk that emerge when facing a stressful situation.

Prepare positive, tension-reducing self-statements to use:
- before a stressful situation
- during a stressful situation
- after a stressful situation, to help patients recognize and commend themselves for having attempted to cope.

Patients should identify stressful situations that they would like to rehearse and prepare. Examples that might serve as good role-plays include:
- meeting with a family doctor
- a discussion with a family member
• a discussion with an employer
• a job interview
• dealing with a disrespectful person
• asking someone for help.

Social Skills Training

Social skills training refers to a wide range of cognitive-behavioural interventions designed to help patients practise skills for social interactions and build their confidence for these interactions. Assertiveness training is one of the most common forms of social skills training. Learning assertiveness may help patients from Latin American communities who are easily intimidated in situations where they feel uncertain of themselves or disrespected by others. Other areas for social skills training may include:
• asking for help
• praising someone
• expressing anger or disappointment
• standing up for self or others
• setting limits on someone else’s behaviour
• approaching someone for friendship
• seeking services.

Social skills training typically involves identifying a situation that is causing stress or distress, breaking down the aspects of the situation that are linked to the distress (thoughts, behaviours) and working with the patient to develop potential strategies for responding that counter negative thoughts, behaviours and/or impulses used in the past. The therapist should encourage the patient to rehearse interactions in session and then practise the strategies between sessions in the “real world.”

Assertiveness Training: Special Considerations

Assertiveness is defined by the following behaviours (Wood & Mallinckrodt, 1990):
1. socially appropriate refusals to give in to the requests of others
2. appropriate expressions of opinions and feelings
3. appropriate expressions of one’s own requests.

It differs from aggressiveness in that it is not motivated by anger and it does not operate at the expense of other people’s feelings or needs. In Canada, assertive behaviour is considered appropriate and
necessary for functioning effectively in mainstream environments such as workplaces and government institutions. Many patients from racial minorities struggle with assertiveness because it is not consistent with the way they have been taught to present themselves or interact with authority figures. Unfortunately, this means that they may hold in feelings of frustration or feel powerless in dealing with situations where they are being exploited or treated inappropriately. Feeling powerless and holding in anger and frustration can be a particular concern in situations of discrimination because discrimination-related stress can contribute to mental and physical health problems (Harrell, 2000).

It may be helpful to position assertiveness as a skill set to develop for functioning effectively in Canadian culture. Even with this description, however, some patients may not feel this is a goal for them—the therapist must avoid imposing this as a goal which, essentially, suggests that mainstream values are superior to the patient’s. If a patient identifies assertiveness training as a skill to be developed, then it will be useful for the therapist to role play typical situations in which the patient identifies it as useful (work situations, family situations, etc.) and include developing responses for misperception of the patient’s intent. The patient can be prepared to mobilize responses that allow him or her to stand firm while addressing responses from people who will try to suggest the behaviour is inappropriate or aggressive. In this way, CA-CBT addresses the cultural context for assertiveness, recognizing that Latin American patients may perceive it as risky behaviour and may encounter others who respond very negatively to them asserting themselves.

Self-Care

Physical Exercise

As well as the many physiological benefits of exercise, it can also promote a more positive emotional state. Physical exercise works on the body to improve its ability to decrease stress, increase energy and eliminate substances that contribute to feeling tense, tired and unhealthy. It also has been proven to improve mood, concentration and feelings of self-control and self-esteem.

Patients should consult with their physicians to ensure that they are in sufficient health to engage in an exercise program and to discuss what type of exercise is most suitable to their physical health level. Walking 30 minutes a day is a good start. Patients could integrate this into their daily schedule by, for instance, taking a walk at lunchtime or getting off of the bus or subway a few stops early and walking to their destination.

Encourage patients to keep a record of their exercise and promote it as an important part of their health practices. Strategize with them about obstacles they may perceive to getting more active, or cognitions that may get in the way of them following through on a plan to exercise. Encourage them to exercise with others, as this may increase their motivation and the frequency of positive social connections. Staying socially connected may be particularly important in the winter when many patients from Latin American communities feel oppressed by the darkness and cold. Encourage
patients to find a way to get out into environments where they will be exposed to sunlight. This could mean going for walks in the middle of the day, or even going for a walk in a shopping mall that has skylights to let in natural sunlight.

Nutrition

The traditional Latin American diet (i.e., whole grains, vegetables and fruits) contributes to good overall health. However, people’s diet often changes when they move to a new environment. Those with poor eating habits can be more vulnerable to negative mood states. It is worthwhile to talk to patients about their diet and inform them about foods that may contribute to negative physical and emotional states and foods that contribute to positive physical and emotional states. However, in doing so, be sensitive to how the patient’s financial circumstances may be affecting their food choices.

Encourage patients to moderate their use of caffeine and alcohol and to eat fruits, vegetables, whole grain breads and cereals, milk, cheese, yogurt, poultry, fish, eggs, meats, beans and nuts when they can. No food needs to be completely eliminated from the diet, but being more mindful about their diet can help make a difference in how they feel. It may also help to speak to patients about teas, tonics or herbs that have benefited them in the past, and how they might integrate them into an improved diet.

Sleep Hygiene

Sleep problems are exacerbated by creating negative associations with the bedroom and bedtime routines. Sleep hygiene is designed to structure the sleep routine so that negative associations are replaced with positive ones. It is important for patients to follow each of the following six steps. Once sleep problems are resolved, it may be possible to relax on some aspects of this routine.

1. Go to bed when you feel sleepy. Do not go to bed based on time, or other people’s activities. Wait until you are showing signs of fatigue, (e.g., yawning, heavy eyes) and then head to bed.

2. Only use the bedroom for sleeping. The bedroom should not be used for watching TV, reading books, working, talking with your partner or doing anything that is not associated with sleep. The one exception to this can be sex, which may relax you before sleep. Once you are in the bedroom, turn off the light and try to go to sleep.

3. After 20 minutes, if you are not asleep, get up. It is important to not stay in bed lying awake, because you want to break the association between sleeplessness and the bed. Move to another part of the house where you can quietly relax, perhaps by reading a book or listening to quiet music. Do not eat, drink or watch TV, as these are all stimulating activities. Wait until you feel sleepy and then return to the bedroom.

4. Return to the bedroom, turn off the light and try to go to sleep. If 20 minutes pass without falling asleep, get up again and return to the other room. This may need to happen more than once the first few nights, but make yourself get out of bed if you’re not falling asleep. It will pay off in the long term.
5. Get up at the same time every morning, including on weekends. Set an alarm to ensure that you do not sleep past the time you have selected. This will be hard if you feel like you haven’t slept much the previous night, but it’s important to prepare your body for a better sleep experience that night.

6. Do not sleep during the day. Again, this may be difficult if you are feeling tired, but you are trying to strengthen the association between sleep and your bed and nighttime. Sleeping in other places or at other times will weaken that association.

Downtime

Often patients have little break from their stressors and need to learn to feel entitled to a break from work or other demands. With pressure to keep busy and with many demands on our time, it can feel self-indulgent to take time for ourselves. However, this attitude only contributes to our feeling more overwhelmed, undervalued and stressed. One of the most important skills that patients can learn is to take time out from work and other responsibilities to rest and recharge: this can be presented as a health practice. As much as they are able, patients should be encouraged to try to protect downtime each day, perhaps starting with as little as 15 minutes a day, and working up to one hour per day. Depending on personal circumstances, some patients may be able to work on planning downtime for one day a week or one week every three to four months. Whatever the personal circumstance, many patients will need support and encouragement to do less than they usually expect of themselves so they can protect this time for their health. See Appendix 2, Handout 9 for a chart for scheduling downtime. Downtime can be spent in rest, recreational and/or relationship activity. Rest activities could involve sitting in the park, listening to music or taking a nap. Recreational activities could, for example, mean playing a game, reading a book, watching a movie or going for a walk. Relationship time could be spending time with a friend, going to a social occasion or otherwise doing something that involves being with another person without a specific goal or responsibility on the agenda. Work with patients to generate ideas for what they can do with the time they protect for themselves. For most patients, it will be most realistic to work toward one hour per day or every other day. As the therapy progresses, they may want to revisit the possibility of arranging longer periods of downtime.

Finding Meaning and Purpose

Sometimes people may lose their sense of meaning and purpose in the migration process. Separation from family and/or from the work and roles that were meaningful to them before leaves them feeling lost in the new environment. In The Anxiety & Phobia Workbook (2005), Edmund J. Bourne advocates for exploring issues of meaning and purpose in an effort to help patients find available resources on spirituality or in redeveloping a sense of purpose in their lives. In CA-CBT, this can be used to help people reconnect with spiritual or cultural values that will orient them toward resilience, persistence and in endeavoring to work on themselves and their relationships.

By connecting with these values, the patient can be helped to evaluate what he or she is doing that is consistent with the values, and what stands in the way of doing more. From such a discussion, it may be
possible to identify skills that can be developed, behavioural experiments that should be conducted, or undermining thoughts that should be addressed through restructuring.

Questions that can begin such a discussion include:

• What makes you feel fulfilled as a person?
• What are your most important values?
• What would you like to accomplish?
References


Appendix 1: Resources for Psychoeducation

Reading Materials


**Online Resources**

www.checkupfromtheneckup.ca: A website aimed to raise awareness about mood disorders

www.facingus.org: A website aimed to support wellness for individuals living with mood disorders

www.mindyourmind.ca: A mental health website created by youth for youth

www.moodgym.anu.edu.au: A training program to learn cognitive-behavioural skills for preventing and treating depression

www.heretohelp.bc.ca/other-languages: A mental health website that contains psychoeducation resources for patients in a number of languages including Spanish

www.rcpsych.ac.uk/mentalhealthinfo/translations/spanish/tcccbt.aspx: The website for the Royal College of Psychiatrists contains psychoeducation resources for patients in a number of languages including Spanish

www.cpaaronbeck.com: This website for the Centro de Psicología Aaron Beck contains information for patients about cognitive behavioural therapy in Spanish.

Appendix 2: Intervention Tools

Handout 1—Understanding the Problem

This is a guideline that therapists can use with patients to refine the case conceptualization. It can also be started in the session and finished or refined by patients in between sessions.

Problems

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

Environment: Recent changes / Stressful situations / Past events

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____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

Thoughts: Things that go through my head

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Feelings: Emotions and physical reactions

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____________________________________________________________________________________________________________________

Behaviours: Things I do, or don’t do

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____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________
Handout 2—Problem List

This problem list can help you define where you are having difficulties and would like to focus your work. For each item, circle a number from 0 (no difficulties) to 10 (the worst you can imagine). Each section also includes spaces for you to add other problems.

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<tr>
<td>Medical Problems</td>
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</tbody>
</table>
Handout 3—Stress Diary

At the end of each day, rate how stressed you have felt by giving yourself a score between 1 and 10 using the scale below.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barely Noticed</td>
<td>A Little</td>
<td>Medium</td>
<td>A Lot</td>
<td>Most I’ve Experienced</td>
<td></td>
<td></td>
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</tbody>
</table>

Write some notes about why you felt the way you did in the box to the right. Consider the following:

- What made your stress worse?
- What made it better?
- What happens to your body when you are stressed?
- What kind of thoughts came into your head?
- How do you act when you are stressed?
- What do other people notice when you are stressed?
- What aspects of your life are affected by stress? What aspects aren’t affected?

At the end of the week, review the information you have recorded with your therapist.
Handout 4—Identifying Feelings

Keep a record of situations where you experience strong emotional and/or physical reactions and rate the intensity of that reaction using the scale provided.

Situation 1:

What is happening?

________________________________________________________________________

When?

________________________________________________________________________

Where?

________________________________________________________________________

Who’s there?

________________________________________________________________________

Emotions / Physical sensations:

Angry              scared              nervous              vexed              tired              jumpy

Intensity:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barely Noticed</td>
<td>A Little</td>
<td>Medium</td>
<td>A Lot</td>
<td>Most I've Experienced</td>
<td></td>
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</tbody>
</table>
**Handout 5—Noticing & Exploring Self-Talk**

This is an exercise to help patients make connections between self-talk and core beliefs. It is a good exercise for debriefing stressful situations in session. Testing the alternate belief can be a homework assignment for the patient.

| Situation:  |
| What is happening? When? Where? Who’s there? |

| Feelings: |
| Physical and emotional |
| Rate intensity (0–10 scale) |

| Self-Talk: |
| Thoughts going through your head |

| Beliefs/Assumptions/Rules: |
| What do those thoughts say about me? |
| What do those thoughts say about other people? |
| What do those thoughts say about the way the world works? |

| What is the proof that these beliefs/assumptions/rules are true? |

| Is there evidence that these beliefs/assumptions/rules are not 100% true? |

| What is a possible alternate belief? What supports this alternate belief? |

| How could I test this alternate belief? (action plan) |
## Handout 6—Thought Record

It is advisable for the therapist to complete this exercise in session with the patient, and to provide the patient with a modified form or worksheet with fewer categories/columns to complete between sessions. For example, a sheet recording just the situation, the negative thoughts and the counter-statements that were developed or planned for future use is still a good basis for discussion at the next session. In addition, several phone-based thought record applications can be found in the Apple application store under the Health and Fitness category including: iCBT, eCBT Mood, and Triple Column.

<table>
<thead>
<tr>
<th>Situation:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What’s going on?</td>
<td></td>
</tr>
<tr>
<td>Where are you?</td>
<td></td>
</tr>
<tr>
<td>When did this happen?</td>
<td></td>
</tr>
<tr>
<td>Who is with you?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Thoughts/Beliefs</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Evidence to support those beliefs</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Evidence against that thought</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Positive re-statement</th>
<th></th>
</tr>
</thead>
</table>

| Feelings after the positive re-statement (scale 1–10) |  |
Thought Record (cont.)

<table>
<thead>
<tr>
<th>Situation: What was going on at the time?</th>
<th>Thoughts: What self-talk or negative thoughts came to mind?</th>
<th>Positive / More balanced counter-statement:</th>
</tr>
</thead>
<tbody>
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</table>
Handout 7—The A-B-C Cycle

Negative feelings can be fuelled by negative or unhelpful thoughts and behaviours. In the same way, positive thoughts and behaviours can promote more positive feelings. This handout shows the connections between your feelings, or affect (A), your behaviours (B), and your thoughts, or cognitions (C).
**Handout 8—Your Experiment**

To change negative or unhelpful behaviours, you may need to experiment gradually with new behaviours. This handout will help you design an experiment that will help you discover what happens when you try something new.

<table>
<thead>
<tr>
<th>Experiment</th>
<th>Possible problems or bad experiences</th>
<th>Strategies to overcome those problems</th>
<th>What happened?</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Behaviour</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Step 3</td>
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<tr>
<td>Step 4</td>
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</tbody>
</table>

Rate your bad feelings: (1–10)
- Barely Noticed
- Worst Ever
**Handout 9—Scheduling Downtime**

Encourage patients to schedule downtime activity, helping them to work through competing demands that could get in the way.

<table>
<thead>
<tr>
<th>Downtime</th>
<th>...with 15 minutes/day</th>
<th>...with 30 minutes/day</th>
<th>...with 1 hour/day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rest activity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recreational activity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship activity</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Handout 10—Pictograms

The therapist may want to supply the patient with relevant pictograms to keep or post in a place where it will make the patient more aware of when it is happening. These pictograms have been designed to be easy-to-understand cues for each concept, but the patient may have other ideas for representations that communicate the idea most clearly for him or her.

The therapist should help patients come up with examples of ways they apply distortions or myths in their lives; these distortions can be listed on the handout during a session, or used as the foundation for an exercise to be conducted between sessions. When the patient is aware of these negative patterns of thinking, cognitive restructuring can be used to counter them. Statements that challenge these negative thoughts can be brainstormed in session, recorded on the handout, and/or developed by patients between sessions.
Overgeneralizing

Magnifying and Minimizing
Mental Filter

Disqualifying the Positive
All-or-Nothing Thinking

Labelling or Mislabelling
Emotional Reasoning

“Should” Statements
Jumping to Conclusions / Catastrophizing

Personalizing
Personalizing