Culturally Adapted Cognitive Behavioural Therapy (CA-CBT) for Black Populations:

A Manual for Mental Health Practitioners (2024)

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An updated second edition of "Cognitive-Behavioural Therapy for English Speaking People of Caribbean Origin: A Manual for Enhancing the Effectiveness of CBT for English-Speaking People of Caribbean Origin in Canada (2011)."

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Foreword / message from founders

CBT is an effective tool for the treatment of many mental health problems. Unfortunately, there is evidence that it does not work equally well for all recipients. Some cultural or racialized groups have worse outcomes from CBT than others. This is partly due to social factors impeding access to care and undermining recovery. But some of the disparity in outcomes is also undoubtably due to factors that are amenable to mitigation by clinicians and clinical services..

Cultural adaptation of CBT is an evidence-based strategy that keeps the core elements of CBT in place but modifies them to improve outcomes. Adaption of CBT often entails working with communities to understand their illness models and their language of distress. This adaptation ensures that the touch and feel of therapy, including the examples that are presented, resonate and are welcoming. Adaptation also includes updated knowledge for therapists. They need to appreciate the modifications to treatment that could improve community access and outcomes. An extensive literature review shows that this approach has worked in numerous countries and for many different groups around the world.

The Black population of Canada has significant mental health needs and is less likely to have their needs met than most other racialized groups. Access to, and outcomes from, psychotherapy have been shown to be particularly problematic for Black populations in high-income countries internationally as well as in Canada. Canada's first mental health strategy specifically called for improved services for immigrant, refugee, ethnocultural and racialized populations. In 2011, we answered that call and calls from the community by developing a manual for culturally-adapted CBT for the Black population.

We are honoured to present this updated guide, which builds off the first edition published in 2011. These works are the culmination of years of dedicated research, clinical practice, and collaboration with communities and professionals that share our commitment to culturally responsive mental health care.

While this manual is designed specifically for therapists treating Black clients, the therapeutic processes explored will be familiar to practitioners. Our intention is to build on the solid foundation of CBT, enriching it with culturally specific insights and strategies that make it more relevant and effective for Black populations.

This manual includes robust research on anti-Black racism and the mental health landscape for Black populations in Canada. We recognize that not all therapists may be familiar with this research, history and struggle. A deep emotional connection and understanding are essential to engage Black clients in a safe and trusting manner. Supervision and consultation with subject matter experts and colleagues will also provide a platform for practitioners to discuss these topics, fostering a more empathetic and vulnerable approach to practice.

This manual is not a static document; it is a living resource that will evolve with ongoing research and feedback from practitioners and clients. We invite you to share your experiences, insights and challenges as you integrate CA-CBT into your practice. Your contributions are vital to the refinement and success of this approach.

Our vision is to create a more inclusive and effective mental health care system, where every individual receives services that honour their cultural identity and lived experiences. By empowering therapists with this manual, we hope to enhance the mental health and well-being of Canada's Black population and inspire further innovations in culturally adapted therapies.

Thank you for your dedication to this important work. Together, we can make a meaningful difference.

With deepest respect and gratitude,

Dr. Kwame McKenzie

Dr. Akwatu Khenti

Special thanks to

Dr. Carolina Vidal, MD, MSc, FRCPC, PhD

Dr. Natasha Williams, C. Psych-Clinical Psychologist and Clinical Director at Allied Psychological Services

Ontario Health

Acknowledgments

We acknowledge the 2011 team whose rigorous research, community engagement through focus groups and interviews, and diligent pilot testing shaped the foundational "Culturally Adapted Cognitive-Behavioural Therapy (CA-CBT) Manual for English-Speaking People of Caribbean origin in Canada." Those pioneering efforts laid the groundwork for this subsequent update. Special thanks to Dr. Carolina Vidal, MD, MSc, FRCPC, PhD.

Funded by Ontario Health in 2023, this manual features relevant cultural modifications to CBT practices based on the current literature.

We would like to also acknowledge the strategic guidance of the Advisory Committee, the expertise of subject matter experts and the efforts of the project team.

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About this manual

This manual aims to assist and support your delivery of cognitive behavioural therapy for members of Black communities across Canada. The manual is written for therapists with a background in counselling, nursing, psychiatry, psychology, social work or other helping professions.

It is meant to add to and leverage your

- existing skills in interviewing and building a working relationship with your clients
- knowledge of the fundamentals of CBT
- cultural awareness and understanding of cross-cultural dynamics
- existing conceptualization of intersectionality and anti-Black racism.

This manual will help you understand and work with the complexities and subtleties that can arise in the delivery of CBT to Black populations. it offers important contextual information about Black populations in Canada and recommendations for therapeutic stances, interventions and tools that may assist you in improving treatment outcomes.

There is no simple formula for providing effective culturally competent therapy; we are all always learning and developing.

To maximize effectiveness, you should be fully versed in cognitive-behavioural therapy (CBT) before attempting to implement the recommendations in this manual.

For more information on standard CBT theory, process and interventions, and training opportunities, please see the following example(s):

- Dobson, K. S., & Dozois, D. J. (Eds.). (2021). Handbook of Cognitive-Behavioral Therapies. Guilford Publications.
- Beck, J.S. (1995). Cognitive Therapy: Basics and Beyond. New York: Guilford Press.
- Ledley, D., Marx, B. & Heimberg, R. (2005). Making Cognitive-Behavioural Therapy Work: Clinical Process for New Practitioners. New York: Guilford Press.
- www.padesky.com
- www.per-ce.net/professional.php

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Background and Context

CBT has been proven to be an effective treatment worldwide. However, study after study have shown that its effectiveness varies among cultural groups and that adaptation of CBT can improve the equity of outcomes.

Adaptation of CBT often entails working with communities to understand their illness models and their language of distress. The adaptation also ensures that the touch and feel of therapy, including the examples that are presented, resonate and are welcoming. Therapists also need to understand what modifications to the implementation and presentation of therapy could improve community access.

In the context of this manual, “Blackness” refers to a social construct that can deeply shape how a person of African and/or Caribbean background experiences the world around them (U.S. Department of Health and Human Services, 2011). Race is often misunderstood as a biological characteristic; however, the racial differences we see in terms of mental health have nothing to do with anything inherent in a person (U.S. Department of Health and Human Services, 2011). Rather, race serves as a proxy for the broader systemic forces of culture, racialization and racism present in society. Therefore, the the term "Black" encapsulates a range of racializing experiences as well as the liberation efforts of the racialized. It refers to a diverse group a diverse group of people who share a common experience of racialization, including the systemic and individual impacts of racism and discrimination, and who may have cultural commonalities. This diversity includes various ethnicities, nationalities and cultural backgrounds, each with unique histories and experiences. By recognizing this particular social construction of race, we aim to address the challenges and needs of Black populations in Canada in the context of mental health care.

Socio-political contexts currently and historically disadvantage and exclude Black populations from reaching their full health potential. This includes oppression, colonialism, racism and segregation, much of which extends to the experience of mental health care inequity today (Mental Health Commission of Canada, 2021). In addition, less use of psychological services and poorer outcomes from psychological interventions have been reported for Black populations living in high-income countries. This is supported by research in Ontario where assessments of culturally adapted CBT for Black populations have improved outcomes.

Introduction

We are pleased to present the second edition (2024) of the manual previously entitled "Cognitive-Behavioural Therapy for English-Speaking People of Caribbean Origin: A Manual for Enhancing the Effectiveness of CBT for English-Speaking People of Caribbean Origin in Canada," which was produced and then pilot tested in 2011.

The original manual was developed by Dr. Akwatu Khenti, Dr. Kwame McKenzie and Dr. Carolina Vidal. The work was supported by Immigration, Refugees, and Citizenship Canada (IRCC) (then known as Citizenship and Immigration Canada [CIC]), CAMH, Black communities and therapists working with Black communities in Ontario. The 2011 manual has been used as the basis of training for hundreds of therapists and to support special initiatives.

Lessons learned from the pilot testing, and from follow-up consultations with the English-speaking Caribbean therapists who deliver CA-CBT interventions and their clients, have enhanced this manual.

This second edition has been updated to reflect

1. considerations and experiences of training and implementing culturally adapted cognitive-behavioural therapy (CA-CBT)
2. an updated review of the literature for Black populations in Canada
3. changes in context such as the increased recognition of the need for anti-black racism training.

This updated CA-CBT manual for Black populations reflects an intensive development process that included a detailed literature review, focus groups with Black people living in the Greater Toronto Area (GTA) and interviews with mental health workers who provide services to Black populations.

The following chapters outline how CBT can be delivered in a manner that is more relevant to, and consistent with, the values and life context of Black populations 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 describes Black populations living in Canada, and reviews anti-Black racism and intersectionality.

Chapter II, "CA-CBT Considerations," presents the process of CA-CBT with Black clients from beginning to end, from first contact to after termination. This chapter also details how conventional CBT approaches can be adapted for Black populations.

Chapter III, "Tools and Resources," reviews specific CA-CBT interventions by category: 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 client handouts.

Chapter I: CA-CBT and Black Populations in Canada

Cultural adaptation of CBT starts with the premise that CBT works and the core elements do not need to be changed, given the vast evidence base attesting to its effectiveness. Instead, these elements can be enhanced or tailored to better meet the needs of diverse Black clientele. In particular, understanding the world view, illness models and language that different cultures use to describe and understand their psychological state is imperative for equity of effectiveness.

Improving the therapist's understanding of important social determinants, how they may impact treatment and the skills and approaches needed to ensure they do not impact outcomes is fundamental. In addition, removing any impediments to access and full participation in CBT can improve its real-world implementation and outcomes.

Cognitive-behavioural therapies have certain elements in common:

- They assume that unhelpful thoughts contribute to problematic behaviours and negative emotional and physical responses that cause problems in dealing with everyday life.
- They are designed to help the client 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 client's problems.
- Although the process may involve discussing events that have happened in the past, the focus is on events that are occurring 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 client and the therapist, and possibly with the assistance of significant others in the client's life.

In addition, CA-CBT strives to be holistic. The approach considers and considers emotional and physical states together, using the word "feelings," as many groups see the two as intertwined. Such is the case for Black people of Caribbean heritage (e.g., Sobo, 1996). It is also important to be aware of the influence of the 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.

Figure 1. Cognitive-Behavioural Explanation of Symptoms

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 diagnosis. Instead, it focuses on 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 that is common to most cognitive-behavioural therapies:

1. Engage/orient the client to the process of treatment and assessment.
2. Perform an assessment and define the problem.
3. Define a treatment plan.
4. Implement treatment.
5. Terminate treatment.

At its core, CA-CBT emphasizes that the therapist needs to make clinical judgments about appropriate matches between the client's presenting problems and cognitive, behavioural or social interventions. The therapist is required to socially locate themselves in the therapeutic dynamic; they must understand how intersecting identities impact the client's presentation and inform their thoughts and behaviours. In doing so, the therapist must ask themselves some of the following questions:

- What category of intervention is required to address the client's presenting problems?
- What specific intervention is a good fit for the client's personality, abilities and preferences?
- 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 client recommendations in these areas, but ultimately, these questions will be answered in collaboration with the client.

Empowerment is a key concern when deploying CA-CBT for populations that experience discrimination. When working with Black populations, the therapist needs to negotiate collaborative arrangements that empower the client and improve their treatment outcomes. Because of this, the length of treatment for CA-CBT with Black populations may be shorter or longer, depending on the client's needs and desires.

Preparation for CA-CBT

The Organization

Delivering effective CA-CBT may require organizational change. For instance:

- There may be access issues.
- Spaces may not be welcoming.
- Practitioners may not be oriented to issues related to anti-Black racism.
- Protocols may not be in place to address anti-Black racism if it's expressed.

CA-CBT will improve the quality of treatment, but a number of barriers exist to clients getting care that effectively meets their needs. 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 or have delayed access to mental health services relative to their needs (Ontario Health, 2023).

Moving toward more equitable mental health systems across Canada requires change at a number of levels—from policy-makers through to practitioners. Canadian research demonstrates that access to care can be facilitated by several different interventions, including broadening the scope and type of care offered, developing partnerships with community organizations, improving the cultural capability of services and improving the quality of care and outcomes from care.

Cultural Capability

Several terms aim to capture the ability of services to offer care to diverse populations.

Cultural competence is a term often used to refer to a set of knowledge, skills and attitudes that help a clinician or a service provide responsive treatment to meet the particular needs of members of diverse cultural backgrounds.

The Mental Health Commission of Canada promotes the concept of cultural safety. 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 and may reproduce relationships and anxieties that are shaped by racialized experiences. Clients 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 is relevant to the experiences of Indigenous, Black and racialized groups, 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. Notably, discrimination against Black people in public spaces was legal throughout the centuries until expressly disallowed with human rights legislation in the post-1960s period.

Though the concept of cultural safety was originally developed for Indigenous populations, its extension to racialized and/or marginalized groups is useful (Baker, 2007). In CA-CBT, the notion of cultural safety draws attention to several factors. For instance:

- the power dynamics that arise from racism
- the dominance of Eurocentrism in health care organizations
- the under-representation of certain racialized groups as providers of health care
- the historical and contemporary power relationships that exist because many immigrant groups originate from countries that have been colonized by European nations

Cultural safety thus speaks directly to the issue of power.

The dynamics engendered by racism promote stereotypes about emotionality, anger, pain thresholds and intellect (to name a few). This has resulted in sustained patterns of implicit bias expressed in erroneous assessments.

Developing cultural safety requires understanding how historical and current practices contribute to racial stereotypes and anxieties that can impede communication and therapeutic relationship building. Trust building may be a bigger challenge precisely because of the persistence of racializing encounters, therefore influencing racialized persons' unfavourable perceptions and the realities of mental health services and poorer clinical encounters. When care is not considered safe, members of Black and racialized populations are reluctant to use services. When they do use them, retention rates may be shortened due to feelings of humiliation and alienation or perceived racism. Not surprisingly, this can affect outcomes.

Clearly, many health professionals treat people based on their own assumptions and stereotypes, creating anxieties that undermine effective service delivery (McKenzie, 2003; Papps & Ramsden, 1996). Cultural safety places responsibility on professionals to (Kearns & Dyck, 1996):

- consider the context in which they are offering care
- examine whether their approach or service design negatively affects particular groups
- understand and deal with the probability that their interactions may be harmful
- recast their practice in a way that minimizes possible negative impacts due to culture.

Racialized outcomes may result from the meetings of two groups that are unequal in status, unequal in material advantage and unequal in colonial histories. Even in circumstances where service providers are members of populations that experience discrimination, their affiliation with the health care system associates them with these inequities. Cultural safety practices provide a way to raise questions about how health professionals and systems are positioned relative to their clients and relative to the system of health care in which they practise and how that may affect 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 Black populations 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 Black populations and other populations that experience discrimination, refer to the following resources:

- Mental Health Commission of Canada (MHCC). (2016). The Case for Diversity: Building the Case to Improve Mental Health Services for Immigrant, Refugee, Ethno-cultural and Racialized Populations, Ottawa, ON: Mental Health Commission of Canada. Available http://www.mentalhealthcommission.ca/sites/default/files/2016-10/case_for_diversity_oct_2016_eng.pdf Accessed October 21, 2016
- National Center for Cultural Competence (www11.georgetown.edu/research/gucchd/nccc/about.html)
- Cultural and Linguistic Competence Policy Assessment (www.clcpa.info/)

The Therapist

Given a plethora of stereotypes and stigma rooted in social history and marked by oppressive power dynamics (e.g., colonization, slavery, racism), Black clients may hold a healthy suspicion of their therapist. For example, some Black clients may be particularly attuned to indicators of perceived racial bias, or have an awareness of racial privilege that may anticipate racist or "colour-blind" attitudes among therapists of dissimilar racial origins. Other Black clients may feel mistrustful of same-race therapists who are perceived to overplay or deny their ethnoracial heritage (Comas-Diaz & Jacobson, 1991). For this reason, critical self-awareness of anti-Black racism is essential for quality care. Watkins and Andrews (2021) highlight the need for therapists to take time to examine their own biases and come to terms with the impact of social positionings and perspective on the dynamics within therapy.

Although community members consulted in the development of this manual expressed a preference for meeting with a therapist who looks like them and has had similar experiences to them, there is a dearth of Black therapists in Canada. Community members also emphasized the desirability of meeting with someone who does not approach their life stories with preconceived notions and can engage with them on a "level playing field." These reported preferences are consistent with the findings of studies examining the influence of therapist-client race matching on treatment outcomes. These findings indicate that while racial matching has a considerable influence on the length of treatment (e.g., lower drop-out rates after the first session), it has much less of an influence on successful treatment outcomes (Mental Health Commission of Canada, 2016; Maramba & Hall, 2002; Sue et al., 1991).

The therapeutic relationship is thus an essential ingredient for a positive treatment experience. Clients, irrespective of their racial and ethnic background, identify this relationship as the most beneficial element of treatment (Hwang, 2006; Norcross & Lambert, 2005). Accordingly, for some Black clients to achieve therapeutic benefits, it is likely more important for them to be matched with a therapist who is self-aware of racial bias and social positioning. Well-informed providers can demonstrate sensitivity to Black sociocultural realities and personal circumstances, and engage in respectful but informal ways of relating, that compensate for a lack of racial and cultural matching. However, one size does not fit all, and for others the perceived need for a matched therapist may be paramount.

For further reading about delivering CBT to other populations that experience discrimination, review the following resources:

- Eamon, M.K. (2008). Empowering Vulnerable Populations: Cognitive-Behavioural Interventions. Chicago, IL: Lyceum Books.
- Muñoz, R.F. & Mendelson, T. (2005). Toward evidence-based interventions for diverse populations: The San Francisco General Hospital prevention and treatment manuals. Journal of Consulting and Clinical Psychology, 73, 790–799. doi: 10.1037/0022-006X.73.5.790

- Naz, S., Gregory, R. & Bahu, M. (2019). Addressing issues of race, ethnicity and culture in CBT to support therapists and service managers to deliver culturally competent therapy and reduce inequalities in mental health provision for BAME service users. The Cognitive Behaviour Therapist, 12, e22.
- Kunorubwe, T. (2023). Cultural adaptations of group CBT for depressed clients from diverse backgrounds: A systematic review. The Cognitive Behaviour Therapist, 16, e35.

Setting up a Supervisory Relationship

Therapist supervision is strongly recommended when engaging in CA-CBT. Such supervision can help the therapist apply techniques that are informed by an understanding of the institutional and societal effects of anti-Black racism and poor social determinants on clients attitudes and behaviours. Especially relevant 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 clients, can also be a valuable added support. Supervision can be conducted one-on-one or in groups, whether through 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 and given the resources available.

The Client

A further consideration of the cultural safety paradigm is the expectation that the experiences of clients should inform service delivery. This includes any prior experiences of perceived discrimination. At the outset, the therapist should identify their experiences with past providers and cultural expectations and incorporate them into planning. Clients 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 client's experience as the recipient of care. 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 believe that improving access to mental health services for Black populations will require some flexibility within and between organizations. Recommendations include the following:

- Extend service delivery periods to accommodate some clients' 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.
- Extend office hours outside conventional work hours (i.e., evenings, weekends) to accommodate work and child care commitments.
- Provide child care services or child care expense reimbursement to facilitate access by clients with young children.
- Seek partnership with community agencies, as community settings may be preferable to attending appointments at a hospital or mental health centre.
- Engage places of worship, primary care settings and community centres in mental health promotion campaigns aimed at improving knowledge about and attitudes toward mental health, and disseminating information about available resources for seeking help. These efforts may make it easier for people in the community to disclose mental health problems to their clergy, physicians, family and friends, who are often their first resource for seeking help and referrals.

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 clients 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 clients with low incomes (Sanders Thompson et al., 2004).
- Actively recruit staff that are representative of the people being served to increase likelihood of service use and break systemic barriers (Wu & Windle, 1980; Ontario Agency for Health Protection and Promotion, 2023). Efforts should be made to employ these staff in diverse capacities to avoid perceptions of tokenism.

Black Populations in Canada: Experiences and Considerations

In providing safe and equitable mental health care for Black populations, it is important to first have a general understanding of the history, distribution and diversity within these populations. There is no such thing as a "typical" Black person or Black experience. Such generalized stereotypes can be incredibly harmful and lead to unsafe interactions between clients and clinicians that can further exacerbate inequities. We know, however, that a dominant shared experience of being Black in Canada is experiencing anti-Black racism throughout the life course in both personal and professional settings. It therefore becomes imperative for mental health clinicians and service providers to understand the basic concepts of anti-Black racism and be able to reflect on how this may impact their practice and therapeutic relationships.

The identity of Black people of African and/or Caribbean descent has evolved over the past centuries both in terms of imposed names and self-defined groups. Civil and human rights struggles led to the emergence of Black or African Canadian as preferred terminology. The term Black refers to individuals of African heritage who may also self-identify as Black, African or Caribbean. The Ontario Human Rights Commission (2013) defines Black as: "A social construct referring to people who have dark skin colour and/or other related racialized characteristics. The term has become less of an indicator of skin colour and more of racialized characteristics." Ironically, dark skin is only one element of a constellation of features that provoke acts of anti-Black racism. Hair texture, facial phenotype and cultural expression often determine the social construction of Blackness.

The concept of racialization is key. There is no reason why differences in skin colour or culture should matter in a fair society. Racialization refers to the process by which a society gives meaning to skin colour or other factors. Racialization adds an element of power on top of perceived difference. It is not just that society produces the category Black; it is the fact that being a member of the Black group can confer a disadvantage.

Canada's Black population is incredibly diverse, with individuals tracing their roots to a wide range of cultural backgrounds. While some have been in Canada for many generations, others have arrived more recently. Notably, 40.9% of Black Canadians are born to immigrant parents (Statistics Canada, 2022). This immigration has come from all parts of the world, including Africa, the Caribbean, Europe, and the United States.

There are English-speaking, French-speaking, and Spanish- and Arabic-speaking groups, alongside generational differences that impact culture. Grasping the scale of diversity is not easy. For instance, Africa is home to many of the world's major religions and is a culturally diverse continent with over 3,000 languages. There is no such thing as a typical African Canadian. And as cultural groups change over time in response to their Canadian environment, new sub-cultural groups are formed and others merge.

Historically, the Black populations have been at a disadvantage when it comes to their mental health. Research links increased rates of stress to many factors, including the impacts of interpersonal and structural racism, colonization, the world economic system, the long-term impacts of slavery, and odious public assumptions about Black psyches and intellect (e.g., Blacks do not suffer from depression, Blacks are deficient in cognitive capacity, Blacks use and traffic in drugs more than other groups), coupled with traumas resulting from enslavement, oppression, colonialism, racism, and segregation (Mental Health Commission of Canada, 2021). Throughout the centuries, the Black church played a significant role in countering racial narratives, validating Black lives and mental wellbeing. This invaluable role has been diminished recently as fewer people depend on the church for support, notwithstanding the persistence of anti-Black racism with racialized mental health effects.

The Mental Health Commission concluded that Black people experience alarming and disproportionate rates of psychological distress and mental health symptoms and illness (Mental Health Commission of Canada, 2021).

It is difficult to assess rates of specific mental illness in surveys cross-culturally in Canada, and a perceived measure where respondents rate their mental health is often favoured. In such surveys, the rates of poor mental health for Black populations in Canada is greater than the white population and other racialized populations. According to a 2020 survey by Statistics Canada on mental health during the COVID-19 pandemic, Black respondents were more likely to report having fair/poor mental health as compared to white respondents (27.9% versus 22.9%, respectively). Black populations across Canada were also more likely to report barriers to accessing mental health care or supports (Moyser, 2020). And in a recent analysis of data, Black populations were half as likely to use free, structured psychotherapy services than the white population.

According to the 2021 census (Statistics Canada, 2022)

- 1.5 million people (4.3 per cent of Canada's total population and 16.1 per cent of the racialized population) identify themselves as Black.
- Over 40.9 per cent of the Black population are Canadian-born, including individuals with multi-generational Canadian roots as well as children of immigrants.
- 32.6 per cent of the Black population were born in Africa—Nigeria (7.1 per cent), Ethiopia (2.8 per cent) and the Democratic Republic of the Congo (2.4 per cent) are the leading places of birth in Africa.
- 21 per cent were born in the Caribbean and Bermuda (mostly Jamaica) (8.8 per cent) and Haiti (7.2 per cent), respectively.
- The Black population reports more than 300 different ethnic or cultural origins, with 25.6 per cent reporting more than one ethnic or cultural origin. The most commonly reported origins include African (15.7 per cent), Jamaican (13.0 per cent), Haitian (10.8 per cent) and Canadian (5.9 per cent).
- In terms of language, Black people in Canada report diversity with over 450 languages spoken; English (58.9 per cent) and French (21.6 per cent) are the most commonly spoken languages.
- In terms of religion, Black Canadians are more likely to identify as Christian (25.9 per cent), Catholic (18.1 per cent), Muslim (11.9 per cent) or Pentecostal (8 per cent). Around 18 per cent of Black Canadian are not affiliated to any religion.
- About 32.4 per cent of the Black population aged 25 to 64 years holds a bachelor's degree or higher, which is comparable with the total working-age population (32.9 per cent).

Anti-Black Racism

The Concepts of Race and Racism

Ideas of race and racism have evolved within Western societies during the past 500 year to justify and sustain colonization, enslavement and segregated discrimination. Decision-makers have used the socially constructed concept of race to divide humans into categories according to a set of common visible traits (e.g., skin colour, shapes of eyes, nose or face). These categories are not based on genetics, biology or science (OHRC, 2005); instead, they are designed to advance varied political and economic agendas. Racism rationalized use of the concept of race to deny rights and freedoms of individuals and groups to maximize economic exploitation of their labour and creativity. A direct consequence is the emergence of stereotypes and public stigma that sustain racializing encounters and experiences.

Anti-Black racism refers to policies and practices rooted in the fabric of Canadian society (e.g., government, education, health care, justice, finance, media) that mirror and reinforce beliefs, attitudes, prejudice, stereotyping and/or discrimination toward people of Black-African descent. Many think anti-Black racism is an American concept. However, Dr. Akua Benjamin, a social work professor at Toronto Metropolitan University (formerly Ryerson University), first used the term to explain the tenacity of many racial disparities and the source of contemporary stereotypes that hinder Black progress (Benjamin, 2003). It seeks to highlight the unique nature of systemic racism on Black Canadians, along with the history and experiences of anti-racism over the past decades and centuries (BHA, 2021).

Historical and Social Contexts

Systemic racism and implicit biases are deeply rooted in centuries-old Eurocentric ideologies of white superiority. Nevertheless, they continue to manifest in patterns of disciplining and institutionalization within the education, child welfare and criminal justice systems. Racism is based on a deep-seated European belief in white supremacy, which can be traced back hundreds of years. Because of this history and legacy, white people, culture and societies are perceived to be the standard that all other people, cultures and societies are compared to and against, with Black people consistently judged to be wanting (Ontario Human Rights Commission, 2016; Garner, 2009; Newman, 2012).

Black populations in Canada are disadvantaged. They are the only population in which the third generation are more likely to live in poverty than the first generation. Egregious social and economic differences exist, with food security and poverty spiraling out of control. Health outcomes do not match the potential of the population. Many focus on the possible reasons for such oppression, colonialism and segregation, as well as longstanding patterns of legally acceptable discrimination in housing, employment and income that have both social and mental health effects(Mental Health Commission of Canada, 2021). Others concentrate on the lack of concerted government action to deal with social and health disparities as the reasons for persistent differences. This lack of focus is largely rooted in institutional racism embedded within these systems. Wellesley Institute refers to institutional racism as an ecological form of discrimination that results in inequitable outcomes for different racialized groups (McKenzie, 2010). The disadvantage experienced by Black populations in Canada can therefore be understood as systematic neglect manifested by institutional anti-Black racism.

History requires us to recognize Black experiences with racism as uniquely different from other experiences with racism. Racism occurs due to the scale of the dehumanization reflected in quasi-science ideas and social disparities, embedded and reproduced in every facet of society. It is manifested in explicit and implicit forms of anti-Black racism that operate at individual, community

and system levels. These manifestations of anti-Black racism continue to disadvantage and exclude Black populations from reaching their full mental health potential.

Anti-Black Racism and Social Determinants of Health

Mental health is determined by a variety of social environmental factors, such as housing, financial security, education, work, access to services and more. These are commonly referred to as the social determinants of health. Social determinants of health can be described as risk and protective factors for collective health outcomes, depending on whether a community is advantaged or disadvantaged historically and currently. Population groups experiencing social, cultural, political and environmental inequalities can experience inequitable health outcomes. Disparities in several social determinants for Black populations continue to exist in Canada, driven by anti-Black racism (PHAC, 2020). The following table provides some examples of disadvantage in select social determinants.

Racial disparities experienced by Black populations for select social determinants of mental health in Canada

Determinant	Findings
Health care funding	Despite the clear increased need for mental health supports in the face of adversity, Ontario spends less per person on the mental health of Black populations than white populations (MHCC, 2016).
Income	According to the 2021 census, despite Canadian-born Black population having similar educational attainment to the Canadian-born non-racialized population, they earn only $0.76 cents for every dollar earned by the latter (Wall & Wood, 2023). Almost one-quarter (24 per cent) of Black Ontarians qualify as “low income” as compared to 14.4 per cent of the general racialized Ontario population. Second-generation Black Canadians earn 10–15 per cent less than second-generation white Canadians, even when results are adjusted to reflect educational levels (Black Health Alliance, n.d).
Employment	Despite having similar qualifications, a study in Quebec found that those with Franco-Quebecois names were called back for an interview 28.3 per cent more often than those with African names (Eid, 2012).

Education	Black and racialized newcomer students are more likely to be streamed into non-academic programs regardless of their actual goals and aspirations (James & Turner, 2017).
Child welfare	Black children and youth are 40 per cent more likely to be investigated compared to white children, despite having similar rates of child maltreatment (Bonnie, & Facey, 2018).
Criminal justice	Black individuals are disproportionately represented in correctional and forensic mental health settings. Despite only representing 4 per cent of adults in Canada, 9 per cent of offenders under federal jurisdiction were Black (Statistics Canada, 2022). This overrepresentation is attributed to racism at all levels of the system, from racial profiling to the exercise of the imposition of pretrial incarceration and disparities in sentencing. Black adults make up about 5 per cent of the adult population in Ontario, but they account for 14 per cent of admissions to custody and 8 per cent of admissions to community services in that province. Black men account for 15 per cent of male admissions to custody and 9 per cent of community services, whereas Black women account for 8 per cent of female admissions to custody and 5 per cent of community services (Statistics Canada, 2022). Black and other racialized peoples are more likely to be denied bail and serve longer time than white people who commit the same offense.
Housing	Landlord discrimination against Black tenants is a common barrier to adequate housing. Studies in Toronto and Montreal reveal exclusionary screening methods, refusal to rent or imposing financial barriers to renting (e.g., increasing first and last month's rent), and increased eviction rates (Leon, Blasubramaniam & Roche, 2023; Lewis, 2022; Leon, 2020; Teixeira, 2008; Cousineau, 2018 as cited in Government of Canada, 2020).
Food security	Among racialized groups, Black Canadians have the highest rate of food insecurity, with almost 4 in 10 (38 per cent) reporting being food insecure. Those with a disability are the most at risk, with more than half (55 per cent) reporting food insecurity (Uppal, 2023).

Anti-Black Racism and Mental Health

Mental Health Outcomes

A 2019 study based on Canadian Community Health Survey data reported that the prevalence of everyday discrimination attributed to race was significantly higher among those who self-identified as Black (30.8 per cent) compared to those who self-identified as white (2 per cent) (Hyman et al., 2019). Likewise, according to the 2022 Toronto Social Capital Study, Black Torontonians faced more discrimination on a regular basis than white residents, with racism being the most common form of discrimination. The study showed that compared to other racialized groups, Black Torontonians were more likely to be looked down upon and reported more frequent discrimination in the form of microaggressions and everyday events of racism. For example, compared to white Torontonians, Black people experienced others being fearful or afraid of them at least a few times a month (9 per cent vs 18 per cent).

There is a growing body of research suggesting a positive correlation between racial discrimination and declining mental health (Williams & Mohammed, 2013; Williams, 2019). Despite gaps in data and research on the specific intersections of anti-Black racism and mental health, existing evidence demonstrates racial disparities for Black populations:

- In Ontario, Caribbean immigrants have a 60 per cent higher risk of psychosis and refugees from East Africa have a 95 per cent higher risk of psychosis (Anderson et al., 2015a). These rates do not reflect the rates of psychosis in their countries of origin, which suggests that social factors associated with migration may contribute to the risk of psychotic disorder (Anderson et al., 2015a).
- According to a 2020 Statistics Canada survey, 32 per cent of individuals from Black populations compared to 24 per cent of white counterparts report experiencing symptoms of anxiety (Mental Health Commission of Canada, 2021).
- Black Ontarians of Caribbean descent have a longer delay in receiving evidence-based services for psychosis than people of white European descent (Anderson et al., 2015b).
- Black Ontarians experience a higher level of aversive pathways to care (e.g., via emergency room, ambulance or police) than white populations (Fante-Coleman & Jackson-Best, 2020).

Mental Health Care/Services

Despite the disparities outlined above, a 2018 survey of Black Canadian residents found the following (Mental Health Commission of Canada, 2021):

- 35 per cent experience significant psychological distress, of whom 34 per cent have never sought mental health services.
- 38.3 per cent of Black Canadian residents with poor or fair self-reported mental health used mental health services compared with 50.8 per cent of white Canadian residents (between 2001 and 2014).
- 60 per cent report they would be more willing to use mental health services if the mental health professional were Black. This demonstrates the need for culturally relevant mental health services.
- 95.1 per cent feel that the underuse of mental health services by Black Canadian residents is an issue that needs to be addressed.

This underuse can be attributed to a variety of factors. Interactions with the mental health care system are often the site of racist experiences. This can occur at an interpersonal level when a client seeking care experiences explicit and implicit forms of anti-Black racism through their interactions with nurses, physicians, non-clinical staff, volunteers and even other clients. These spaces can begin to feel unsafe, with the potential to worsen client outcomes and deter clients from seeking care. When these individual negative experiences are shared with community members, it creates a ripple effect. Mistrust of the system can worsen if there are no accessible avenues for clients to report these experiences, and particularly if their experiences go unheard or are dismissed (Griffith et al., 2021).

For Black people, mistrust of health systems stems from historical and ongoing social and economic injustice and inequities (Pederson, 2023). A systematic review of 37 published papers on implicit bias in health care providers suggests evidence of pro-white and anti-Black bias among a variety of health care professionals. This results in disparities in treatment recommendations, impaired therapeutic relationships and poor empathy and patient-provider communication (Maina et al., 2018).

Anti-Black racism can also be present more subtly in the clinical structures and processes in which mental health care is delivered. Mental health services are often designed with biases inherent to Western models of care that are rooted in colonial histories. They can therefore perpetuate negative stereotypes and unintentionally cause harm to Black clients (Metzl, 2009; Meerai et al., 2016).

Representation in Health Care

Historical instances of violence and anti-Black racism continue to manifest themselves today. This has led to the exclusion of Black students from successfully entering medical schools in Ontario and to a lack of Black people occupying positions of leadership within the health sector. From 1918–1965, certain universities (e.g., Queen's) banned Black applicants to their medical programs (Canadian Press, 2019). This further exacerbates the issue that has been cited countless times regarding the lack of representation throughout the sector to reflect the populations it serves (BHA & HCSL, 2020).

Addressing Internalized Racism

Addressing anti-Black racism in structured psychotherapy can take many forms. One involves using strategies to tackle internalized racism. Two articles (Steele & Newton, 2022; Wallace et al., 2020) discuss this topic, focusing on African American women experiencing depression and anxiety.

Addressing internalized racism within CBT involves deconstructing the source of the client's negative schemas and core beliefs, and helping them learn to respond with self-compassion while they develop new, and more positive, ways of viewing themselves and others. Using a case study of a 27-year-old African American graduate woman experiencing depression and anxiety at work (Steele & Newton, 2022) and a 36-year-old married African American woman presenting with depression and panic episodes (Wallace et al., 2020), the articles discuss strategies to address internalized racism in CBT:

- Understand the client's lived experience through their cultural lens and validate their experience of oppression.
- Help the client make culturally preferred changes that minimize stressors, increase personal resources and build skills for more effective interactions with the social environment.
- Create a list of culturally related strengths and supports in the therapeutic process.

- Build a culturally responsive therapeutic relationship using a broaching technique (i.e., a consistent and ongoing openness by the therapist to invite the client to discuss and explore issues of diversity to not only explore concerns, but also to discuss cultural concerns). For example, incorporate discussions of race and racism and their impact on mental health as a part of the psychoeducation component of CBT, and identify cultural strengths to cope with the client's distress.
- Focus on empowerment goals such as affirming an individual's cultural identity, consciousness-raising and claiming their voice in a system of oppression during the goal-setting phase.
- Offer culturally appropriate psychoeducation, cognitive restructuring and behavioural exercises focused on reducing the client's symptoms of anxiety and depression.

Intersectionality

As mental health professionals, our understanding of cultural diversity and its impact on mental health outcomes is critical. Recognizing the complexities of identity and experience, particularly within Black populations, is essential for providing effective care. One such lens through which we can understand these complexities is intersectionality. Coined by Kimberlé Crenshaw in 1989, intersectionality refers to the interconnected nature of social categorizations such as race, class and gender as they apply to a given individual or group, which create overlapping and interdependent systems of discrimination or disadvantage. Intersectionality provides a lens through which we can comprehend the multifaceted nature of identity and its intersections with social structures.

In the context of providing CA-CBT for Black populations, understanding intersectionality is essential. Black individuals do not exist within a vacuum; they navigate a multitude of identities and societal structures that influence their experiences of mental health and well-being. Therefore, incorporating intersectionality into CA-CBT is crucial for improving treatment experiences and outcomes for Black clients.

Understanding Intersectionality

Intersectionality emphasizes that individuals hold multiple social identities that intersect and interact, shaping their experiences and opportunities. Intersectionality highlights the concept of multiple marginalizations, wherein individuals may face compounded forms of discrimination and disadvantage due to the intersection of various identities. In the case of Black populations, this can manifest as experiences of racism, sexism, classism and other forms of oppression. It is crucial to recognize that experiences of discrimination and marginalization are not uniform; they vary based on the unique intersections of identities.

> Intersectionality helps us recognize that oppressed social status is not merely a product of individual perceptions, attitudes and behaviours; rather, our social identities are also wrapped in complex structures of systemic inequalities and/or privilege (Wilson et al., 2019).

Incorporating Intersectionality in CA-CBT

Mental health professionals must recognize and validate the various intersecting identities that Black clients hold. Black individuals are not solely defined by their race, but are also shaped by factors such as gender, sexual orientation, socioeconomic status, disability and more. For instance, a Black woman's experience of depression may differ significantly from that of a Black man due to the unique intersections of race and gender, as well as other factors such as socioeconomic status and access to resources. Mental health professionals must be attuned to the unique and varying presentation of these intersecting oppressions and their impact on the client's mental health.

Incorporating intersectionality into CA-CBT for Black populations is imperative for several reasons:

- **Addressing unique experiences:** Black individuals may face distinct forms of discrimination and oppression based on the intersection of their identities. For example, 2SLGBTQ1+ people from Black communities experience higher rates of homelessness compared to white sexual minority people (5.9 per cent vs 1.5 per cent) (Wilson et al., 2020). Statistics from the United States (Mahowald, 2021) show that

  - 25 per cent of Black 2SLGBTQ1+ individuals report experiencing discrimination when interacting with law enforcement
  - 78 per cent of Black 2SLGBTQ1+ individuals report that discrimination has affected their ability to be hired to some degree, while 56 per cent report that discrimination has affected their ability to retain employment
  - 95 per cent of Black 2SLGBTQ1+ individuals report that discrimination has negatively affected their psychological well-being.
  - Acknowledging and validating these experiences may help to build rapport and trust with clients. Building the therapeutic alliance is a critical component to culturally adapted care.

  Mental health professionals must acknowledge and validate these experiences to build rapport and trust with clients. Building the therapeutic alliance is a critical component to culturally adapted care.

- **Tailoring treatment approaches:** Intersectionality informs the cultural adaptations needed to make CBT more relevant and effective for Black populations. This may involve integrating culturally specific coping strategies, addressing racial trauma and considering socioeconomic factors in treatment planning.
- **Challenging biases and assumptions:** An intersectional approach prompts the mental health professional to examine their biases and assumptions about the client's identity. By acknowledging their own positionality, mental health professionals can foster a more collaborative and respectful therapeutic relationship with Black clients, focused on providing them with the specific supports they need.

Applying Intersectionality in CA-CBT

There are several ways to apply intersectionality in CA-CBT for Black populations:

- **Cultural sensitivity and awareness:** Mental health professionals should engage in ongoing education and self-reflection to deepen their understanding of intersecting identities and cultural nuances within Black populations. They must recognize how historical and systemic factors have and continue to impact mental health. This includes recognizing and validating the cultural norms, values and beliefs of Black clients within the therapeutic process, and understanding and using culturally appropriate coping strategies and non-stigmatizing language (Watson-Singleton et al., 2019). The literature suggests using culturally familiar language and resources, such as culturally familiar scenarios or role-plays, during sessions (Lechner et al., 2013). This entails understanding how cultural factors intersect with other identities to shape the client's worldview and experiences.
- **Assessment and formulation:** Assessing and formulating cases through an intersectional lens enables clinicians to develop tailored treatment plans that address each client's unique needs. Mental health professionals should consider how intersections of identity and various social experiences have contributed to how symptoms present. By acknowledging the impact of societal stigma surrounding mental health within the Black community, professionals can work collaboratively with their Black clients to challenge and overcome these barriers.
- **Collaborative goal setting:** Collaborating with clients to set treatment goals involves considering their cultural values, strengths and barriers. This collaborative approach empowers clients to actively participate in their healing journey and advocate for themselves within various systems, including health care, education and employment, to address systemic barriers to mental health and well-being.

Incorporating and applying intersectionality in CA-CBT for Black populations is not a one-size-fits-all approach, but rather an ongoing process of understanding and responding to the complex interplay of identities and experiences. By recognizing the intersections of race, gender, class and other social factors, mental health professionals can provide more effective and culturally responsive care that honours the diverse lived experiences of Black clients. Through ongoing self-reflection, education and collaboration with clients, mental health professionals can leverage intersectionality to promote health equity and improve treatment experiences and outcomes for Black individuals facing depression and anxiety.

Chapter II: Therapeutic considerations

During the development of the original manual (2011), English-speaking Caribbean community members were consulted and reported that:

- high rates of stigma concerning mental illness in the community means that emotional problems or seeking help for emotional problems is not usually disclosed to friends or families
- withdrawal, anger, irritation and complaints about nerves and nervous problems, and feeling bad, pressured, low-spirited and vexed are common indicators of emotional distress
- religion and/or spirituality tends to be highly valued and is often turned to as a resource for maintaining personal strength in times of distress and hardship.

There are a number of factors that lead Black people to delay seeking help for mental health conditions.

A major barrier is a lack of culturally competent care, leading to misdiagnoses and ineffective treatments that worsen mental health issues (Pederson, 2023). Misdiagnoses can erode trust in the healthcare system, making individuals more reluctant to seek help (Cénat, 2024; Boros, 2024). Additionally, Black people often do not see themselves reflected in the healthcare system, increasing their hesitance to access services (Fante-Coleman, Wilson, Cameron, Coleman, Travers, 2022). Black adults also experience longer wait times for care due to a shortage of providers in their communities and financial barriers (Faber, Osman, & Williams, 2023).

Economic struggles disproportionately affect Black families, often pushing mental health care lower in priority which may result in the perception that these concerns are non-essential (Public Health Agency of Canada, 2020). Compounding these issues is the cultural stigma surrounding mental health within Black communities, which is rooted in historical and systemic racism (Mental Health Commission of Canada, 2021). This stigma can lead individuals to perceive their mental health struggles as normal responses to situational hardship rather than legitimate health concerns. Together, these factors contribute to a cycle of delayed care, where Black adults may only seek help in crises when their mental health conditions have become more severe and complex.

Outreach to spiritual and religious leaders and public education are highly recommended to reduce mental health stigma and promote earlier interventions. Partnerships with Black community organizations to address stigma and build trust are also essential.

Those consulted also identified immigration and settlement-related issues as a significant stressor affecting the community, such as:

- emotional reactions and social difficulties related to adjusting to an unfamiliar culture
- realization of their new-found racial minority status
- coping with experiences that happen to them because of their racial minority status
- experiencing trauma, grief and losses caused by family separation and reunification
- experiencing stress from being unable to find employment comparable to their level of education and the associated financial consequences
- dealing with intergenerational conflict
- adjusting to changes in the physical environment (e.g., cold weather in winter).

Research shows that many of these attributes hold true for Black communities in general. For example, a 2020 study found that stigma associated with mental illness is high among African, Caribbean and Black communities in Ottawa, with 40 per cent believing that seeking mental health treatment is a sign of personal failure (Ottawa Public Health, 2020).

One of the most important considerations in CA-CBT for Black populations is that the populations are diverse. There is no typical member of Black populations, regardless of whether they are of more recent African or Caribbean heritage. Most members of Black populations are not immigrants or refugees. Many are at the intersections of different identities and that intersectionality could be key in therapy. They may be first generation, second generation or third generation. They may be a person for whom race and racism are important, or a person for whom religion, ethnicity and cultural heritage is important, or a person whose career trumps everything.

There is no simple recipe for providing CBT in Black populations. Flexibility in the application of cultural adaptations is important, and understanding the client in front of you, and their specific social and cultural environment, is key.

Part 1: Pre Therapy

Working with Clients from Black Populations: Engagement and Therapeutic Alliance

Psychotherapy studies examining treatment outcomes among clients of African descent identify higher rates of early termination/low retention as characteristic of this client population (Sue & Lam, 2002). At the start of therapy, this client population may initially be more concerned with the nature of the interpersonal interaction with the therapist than relating their presenting problem. Trust building activities and a focus on clarifying expectations throughout the process may help strengthen retention (Green et al. 2020). This may last for two to three sessions, until the client is satisfied that their work with the therapist will be a true collaboration and feels safe enough to begin the task of addressing the presenting problem. To avoid premature termination, therapists should focus on actively engaging clients from the very beginning of therapy through to the end (Gibbs, 1985; Hays, 2019).

CA-CBT interventions differ from conventional CBT in that an extended period for engagement of Black clients is recommended. The engagement process is extended so that clients from Black communities can have time to work through reservations they may have about seeking therapy due to issues of trust, safety and power (Parham, 2002; Sue, 2010). This extended process is beneficial for establishing the collaborative working alliance that is so important to the success of CBT treatments. The engagement process begins with the first contact that the client has with the therapist or treatment centre, and continues through the first and second sessions.

For further reading, review the following resources:

- Model, S. (2008). *West Indian Immigrants: A Black Success Story?* New York: Russell Sage Foundation.
- Ottawa Public Health. (2020). Mental Health of Ottawa's Black Community Research Study. Ottawa. Available online https://www.ottawapublichealth.ca/en/reports-research-and-statistics/resources/Documents/MHOBC_Technical-Report_English.pdf

Making Initial Contact

Given that CA-CBT is a time-limited treatment, one way of initiating engagement as early in the treatment process as possible is to have the first contact with the client via telephone/Zoom before the first session. This way, the client will have a better idea of the person they will be meeting, which may increase their comfort level when attending the first session.

The initial telephone or video conferencing call may be an important first step for developing the working alliance and should be treated as more than an administrative task; rather, it is the beginning of the treatment process (Watkins & Andrews, 2021). Tasks for the first contact include confirming correct pronunciation of names, setting the first appointment and providing clear directions about where the meeting will take place and what will occur. The mental health professional can demonstrate cultural and racial responsiveness by asking questions about previous experiences with services, the client's cultural perception of counselling, and potential support from their culture for dealing with sadness, hopelessness, negative incidents, etc.

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 measure). Explain to the client 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. Ask the client to arrive early to complete the forms, or incorporate this time into the total time reserved for the first session.

Building a 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.

A strong working relationship is vital to CA-CBT because the therapist may be working with clients who are very sensitive to cues that they are being disrespected or not believed. Many of the clients 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. There is a marked history of mistrust between members of Black populations and health and social services due to persistent discrimination. Clients may enter therapy with fears about being judged or committed to a psychiatric institution, or even being reported to other institutions such as child welfare or immigration. Black clients may also be wary of situations in which they could involuntarily be put under the scrutiny of these government agencies.

It is important to communicate attentiveness and receptiveness to the client as they need assurance that they are being heard and are not judged. The therapist should develop the capacity to communicate this with appropriate verbal and non-verbal responses, and eye contact. The client's perceptions of being respected and supported in a warm, positive relationship will make a tremendous difference in whether they remain in treatment, and if they will be able to withstand the challenges that will arise when difficult emotions and experiences are evoked in the therapy. It is also important to talk with clients about confidentiality—and to recognize that clients may be reluctant to open up until they are sure they can trust the therapist.

According to the members of the community consulted in the development of this manual, Black clients may be wary of a therapist who presents themselves as an authority figure. Therefore, it may be particularly important for the therapist to emphasize the collaborative nature of their work and to encourage the client to express their opinions, even if they disagree with the therapist. Black clients may also prefer therapeutic interactions that are more casual and intimate than "professional." Exhibiting a sense of humour may contribute to building the alliance, but be cautious in deciding when it should be used—follow the client's lead.

Based on their experience of training therapists on CA-CBT, Naz et al., (2019) state that it is important for the therapist to accurately understand and communicate the client's understanding of their cultural worldview and incorporate the same in the assessment and treatment plan. Therapists need to consider the world view of the client and should ask how the client understands their personal experiences with respect to their world view. A client's world view encompasses the collection of attitudes, values, stories and expectations about the world around them and informs their every thought and action (Gray, 2011). These can then be incorporated into assessment and treatment services accordingly. If they are not known then the therapist can be misaligned to the client. Taking time to understand the world view of the client and using language, theories and images that are understandable and accessible is an important component in therapeutic relationship building (Steele & Newton, 2022) and should generally be raised early on in therapy but after the initial rapport has been established (Naz et al., 2019).

Self-disclosure by the therapist can also help build a working alliance (Knox & Hill, 2003). In early sessions, this may mean sharing some information about cultural background to help the client understand where they may have commonalities with the therapist. In later sessions, the therapist may disclose personal experiences that are relevant to the client's situation, but this must be done carefully. Self-disclosures can help a client feel like they are relating to the therapist on a personal level and that the therapist understands the experiences the client is describing. This can be particularly important with clients from Black 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 client's development. A potential danger of self-disclosure is that the client may feel that they are being unfavourably compared to the therapist (Constantine & Kwan, 2003; Audet, 2011).

Facilitating the working alliance may require some flexibility on the part of the therapist. This flexibility may mean having shorter or longer sessions to meet the needs of the client. There may also need to be some flexibility in setting the agenda or following the recommended agenda for sessions.

Part 2: Therapy Related

Cultural Adaptation Considerations across CBT Sessions: An Overview

Session 1/2: Greeting and Assessment

In the Waiting Room

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

The therapist should initially greet the client formally, waiting for permission to use less formal language. If the client has completed the assessment forms, collect them right away. If the receptionist has the completed forms, collect them before meeting with the client.

In the Office

Members of the Black community consulted in the development of this manual emphasized the importance of an informal setting that does not make clients feel like they are in an "uptight" office. For instance, they recommended furnishing and arranging the office in a way that will encourage clients to relax (e.g., by avoiding hard chairs and high tables, and by not having a desk between the client 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. Explain this to the client so there is no misunderstanding about the purpose of the notes. It is important for the client to feel like they are 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 client feels like they have the unbroken attention of the therapist.

Assessment

Prior to beginning the assessment, the therapist should remind the client about the tasks for the day's session. This will begin to familiarize the client with 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 client to the intervention process. Consent forms can be used to orient the client 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 clients (e.g., regular attendance, feedback about sessions). Discussing these aspects of the session is part of building a working alliance, as it ensures the client is fully informed about the process and agrees with the goals and tasks involved.

In CA-CBT, assessment is used to gather (Kleinman et al., 2006):

- 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 client's interpretation of culture influences their definition of the problems and their expectations for solving them.

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 the client 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 they cover the relevant topics.

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. CA-CBT has been shown to be effective at improving clinical outcomes using the Edinburgh Postnatal Depression Scale and Beck Depression Inventory (Jesse et al., 2015), the CES-D and the Hamilton Depression Rating scale (Ward & Brown, 2015). You can use any of these brief self-report instruments to evaluate the client's level of depression and as 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.

Before starting the assessment, tell the client 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 client is properly oriented to the process, 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 client's beliefs, values and practices might be implicated in the presenting problem and/or support the treatment process. The CA-CBT assessment provides a good opportunity for the therapist to gather more information about culture-specific definitions of the client's problems and to consider how to integrate this information into the conceptualization of the client's problems and their interventions.

Make sure to gather information from the following areas:

Identity

- name, age, gender
- racial and ethnic background, languages spoken, acculturation – The therapist should explore the client's experiences with racism and how that possibly impacts their mental health, their coping strategies and their overall well-being by asking questions like "*Can you share how your experiences with racism have impacted your mental health?"* or *"How do you cope with racial stressors in your daily life?"*
- religious and spiritual practices

- work, education
- nationality, immigration history and status (if applicable)

The therapist should explore and assess the client's unique background and experiences to understand how their intersecting identities of race, gender, sexuality, socioeconomic status and immigration history, if applicable, influence their mental health and presenting issues. Ask questions like, "What forms of discrimination or barriers do you encounter in your daily life?"

Presenting Problems

- Tell me about what has been happening.
- What happened before this started? What are typical situations (onset, frequency, intensity)?
- What do you think caused these problems?
- What thoughts, actions, emotions and physical response accompany stressful situations?
- How well are you functioning compared to "normal"?
    - What would other people say? (Who?)
    - How are you sleeping and eating? What is your energy level and interest in socializing and doing other activities? Any changes in these areas?
- How often do you consume caffeine, nicotine, sugar and processed foods?
- How often do you use alcohol or other substances?
- Have you seen these problems before—in yourself or in others? Do they run in the family?
- What has been done to attempt to deal with these problems?
    - 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, and more so the client knows it is acceptable to discuss alternative forms of healing or health practitioners. If any have been consulted, ask about positive or negative effects.
    - Inquire about experience completing any screening instruments (e.g., CES-D, discussed on page 31). Were there any surprises? What are the most bothersome symptoms?
    - Any thoughts about death or suicide?

Personal Context

- current living situation
- previous living situations/where the client grew up or spent most of their life
- relationship status, children
- sexual orientation

- extended family
- family separations or reunifications
- physical health status, past health problems
- hobbies, activities
- faith practice
- legal history
- access to family doctor or other health care providers

Environmental Context

- family/friends – where, when and how often they are seen; knowledge of current problems
- church or other affiliations (e.g., how do they currently practise their religion? How often do they attend religious activities?)
- primary places and people 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
- vision of how the client should be, what they should be doing, etc.
- hopes for outcomes from treatment
- empowerment goals such as affirming cultural identity, consciousness-raising and claiming their voice in a system of oppression
- positive and adaptive cultural values and contexts

Non-Verbal Observations

- mood (e.g., sad, happy, flat emotion)
- physical tension, fidgeting
- energy level
- orientation
- irritability, anger, threatening behaviour
- appearance (e.g., grooming, appropriate clothing, such as for the weather)

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

- McGill University Cultural Consultation Service Guidelines for Cultural Assessment and Cultural Formulation. Available: www.mcgill.ca/ccs/handbook/assessment/cfa/
- Ponterotto, J.G., Gretchen, D. & Chauhan, R. (2000). Cultural identity and multicultural assessment: Quantitative and qualitative tools for the clinician. In L.A. Suzuki, P.J. Meller, & J.G. Ponterotto (Eds.), Handbook of Multicultural Assessment: Clinical, Psychological, and Educational Applications (p. 67). San Francisco, CA: Jossey-Bass.
- Hays, P.A. & Iwamasa, G.Y. (Eds.). (2006). Culturally Responsive Cognitive-Behavioral Therapy: Assessment, Practice, and Supervision. American Psychological Association. https://doi.org/10.1037/11433-000
- DSM-5 Cultural Formulation Interview. Radhakrishnan, R. (2016). DSM-5® Handbook on the Cultural Formulation Interview. American Journal of Psychiatry, 173(2), 196–197. https://doi.org/10.1176/appi.ajp.2015.15091121

Collateral Interview

During the assessment, the therapist should ask the client if it would be helpful for the therapist 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. It could also include speaking to a family member or friend who may be able to provide additional information. Speaking to other people in the client's life can help evaluate the extent to which the client is experiencing difficulties or how their behaviour has changed. It can also fill in blank areas that the client may not be able to address because of poor memory or confusion associated with depression or anxiety.

It is important to be specific with the client 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 client the option of having that person join for part of a session. The information provided by these other people can be a valuable part of the assessment. In addition, it also provides information about the client's social network and who, if anyone, they trust to include in the treatment process.

Given the level of stigma in Black communities, it would not be unusual if the client declines to involve any family members or friends in their treatment. Community members consulted in the development of this manual indicated that disclosing mental health problems or help-seeking to family or friends will often result in being labelled "crazy" or "lazy." It may be possible to engage family members later in the treatment process. For example, a friend could help problem-solve or help the client develop certain skills. However, assure the client that it is completely acceptable to decline permission for others to participate.

At the end of the session, the therapist should let the client know that they will review and discuss the notes during the next session. Tell the client if anyone else (e.g., a supervisor) will be reviewing the material. The therapist should offer to accept telephone calls if the client has any questions or concerns.

End the session by letting the client know that they will review and discuss the notes during the next session. Tell the client if anyone else (e.g., a supervisor) will be reviewing the material. The therapist should offer to accept telephone calls if the client has any questions or concerns.

The client may have had to go to great trouble to find time to attend this session. They may also have had to overcome personal prejudices and strong objections from family before being able to attend a session and discuss these problems. The therapist

should commend the client for making this effort and provide encouragement that something positive will result. Thank the client for their time and tell the client that you are looking forward to seeing them again.

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 Black communities (Ottawa Public Health, 2020). The client may have preconceived ideas about therapy being for people who are weak or superficial or may see any allusion to mental distress as an indication that they are "crazy" or losing their minds. 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 better deal with daily situations.

In the focus groups we held for this manual, we encountered Black clients who were concerned about how coming to therapy affects them feeling like a "strong Black man" or a "strong Black woman." These images have sustained Black populations through many difficulties, but they may also undermine them by making it difficult to admit when they are struggling (Schreiber et al., 1998). The therapist should be prepared to deal with this by emphasizing that depression is not something that happens to weak people, but rather is a biological and psychological experience that can happen to even the strongest personalities when their coping resources are overwhelmed. The therapist may incorporate discussions of race, racism and its impact on mental health as a part of the psychoeducation while identifying cultural strengths to cope with the client's distress. The strength that has sustained them through other difficult experiences will be mobilized to help them through this period of difficulty. This type of explanation can resonate for people with cultural beliefs that support the mind/body connection and cultural values that emphasize using personal strength to persevere in times of trouble.

A case study of a 36-year-old married African American woman presenting with depression and panic episodes (Wallace et al., 2020) suggests that offering culturally appropriate psychoeducation, along with cognitive restructuring and behavioural exercises, helped reduce the client's symptoms of anxiety and depression as measured on the Patient Health Questionnaire (PHQ 9) and self-reported by the client.

A First Experience with "Personal Project"

The therapist may wish to introduce the notion of a "personal project" in this session. A personal project is essential to the CBT process because it allows the client to practise skills outside of the intervention session. Trying out new skills in the "real world" can help the client 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 personal projects greatly increases the likelihood of successful outcomes from treatment.

The term "personal project" is a cultural consideration to the term "homework" used in traditional CBT. Some clients in Black populations may not respond positively to the idea of being assigned "homework". Some may feel it is disrespectful to be assigned homework like a school child; for others, it may not feel feasible to add any more work to what they already have to accomplish during the week. It can be helpful to present personal projects to the client as a type of exercise or journaling that they do between sessions.

Although the first session is too early to identify the specific skills the client must develop, it is not too early to send the message that they can be doing things between sessions to promote their mental health. At the next session, ask the client what it was like

to do the recommended exercise. This will provide further information about their capacity to complete personal projects and may identify barriers and resources that will affect success with personal projects in the future.

For clients from Black populations, it can be particularly valuable to try out a personal project exercise that focuses on decreasing physical discomfort (e.g., sleep hygiene, relaxation techniques, nutrition or physical exercise). Clients 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. Descriptive studies suggest that using culturally familiar techniques such as deep breathing exercises and guided imagery techniques can be useful (Lechner et al., 2012). If using audio visual resources as a part of personal projects, ensure that the resources resonate with the client in terms of the characters, tone and voice (Watson-Singleton et al., 2019). The therapist should explain that doing these exercises will increase the effectiveness of the therapy work.

Other potential first assignments could include:

- 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 making the client feel overwhelmed (skill development: assertiveness, self-care, mobilizing social support)
- protecting some downtime (skill development: assertiveness, relaxation), which will also prepare the client to allocate time for activities to promote mental health
- practising deep breathing exercises (skill development: relaxation)
- doing a short reading assignment (psychoeducation)
- doing something simple that the client has suggested to make the next week a little easier (self-care).

Assessment and Feedback: One Session or Two?

In CA-CBT for Black populations, 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 believe they are able to do this in a single session if the client 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 may already have a lot of information from the client and others, and believe they can enter the session with a preliminary conceptualization to present and discuss with the client.

However, in CA-CBT, a two-session process is recommended even if other sources have provided some information. Extending the preliminary phase over two sessions is an opportunity to gather more assessment information, while giving the therapist and the client more time to build a positive rapport and working alliance.

Session 3: Developing the Conceptualization

Conceptualizing the Client's Situation

Conceptualizing the client's situation is an important step in any psychotherapy. The therapist must develop a hypothesis about what underlies the issues listed on the client'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 client's presenting problems. CA-CBT involves identifying psychological mechanisms, but also includes identifying social and environmental determinants that create a need for psychological adaptations and, in turn, promote the client's presenting problems.

Steps for working toward a case conceptualization include the following:

- Create a problem list that summarizes all major symptoms and problems in functioning.
- Propose 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 client's life?
- Figure out how the underlying belief might produce the problems listed.
- Review what led up to the current problems:
    - How is the problem connected to a core belief?
    - How is the problem connected to the client's social circumstances?
    - How is the problem connected to environmental conditions for the client?
- Review potential origins for the core belief in past experiential, familial, social or environmental situations.
- Consider potential psychological, social and environmental processes that may present barriers in treatment.

The client 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 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 client feedback, new information or changes in the client's psychological, social or environmental situation. A guideline for understanding the client's main problems can be found in Appendix 2, Handout 1: Understanding the Problem.

A structured problem list might also help the client define where they are having difficulties and where they would like to focus. The client can complete this list independently or with the therapist, in session or as a personal project. Encourage the client 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 explain to the client 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 client's head at the time and how these thoughts triggered emotional and physical reactions and behaviours.

Encourage the client 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 client at the next session, helping them to make connections between positive and negative cycles in their life. This exercise can also be done in the session by having the client 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 the client has for taking action and expressing feelings in a way that promotes health.

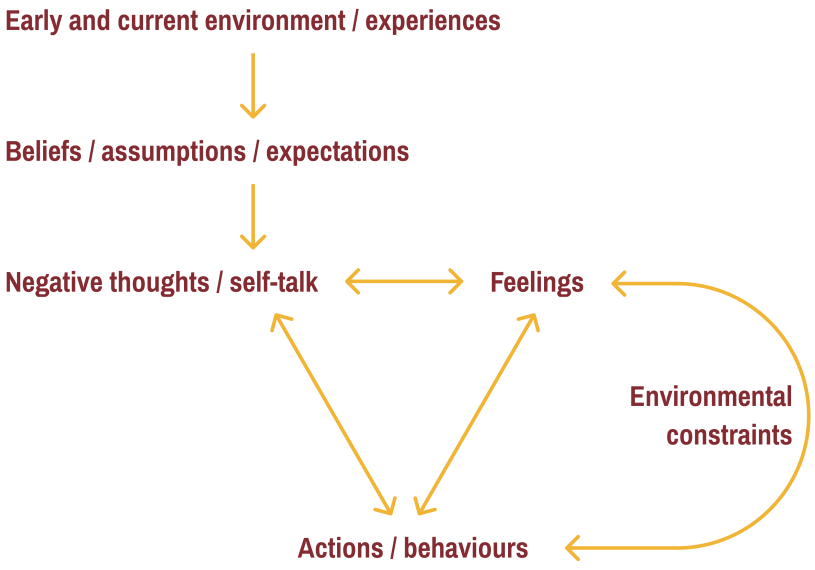

Figure 2. CA-CBT Conceptualization

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 the client with the concrete difficulties they are experiencing in their daily lives, as the environment plays a strong role in driving the client's 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 client is likely to behave, feel or think in specific situations?
- Does the client think the conceptualization fits their situation?
- Do the interventions suggested by the conceptualization make a positive difference for the client?
- Do the interventions suggested by the conceptualization build on existing strengths and resources in the client's life?
    - What healthy beliefs and assumptions are in place?
    - How has the client 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 client's problems. The client 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 client's strengths and resources 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. The client needs to know that the therapist sees them as more than just a set of problems, and that the therapist 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 the following:

- 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?

Sharing the Case Conceptualization with the Client

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

The conceptualization is not finalized until it is shared with the client. The therapist presents their hypothesis to the client so they can discuss the treatment plan collaboratively. Collaboration is key to this process; it strengthens the therapeutic alliance by ensuring 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, since the client participates in treatment activities with a full understanding of what is being done and why.

Sharing the conceptualization with the client involves the following steps:

1. Review the client's strengths.
2. Review the client's problem list.
3. Share and discuss the conceptualization: As the therapist shares the conceptualization with the client, they should use the client's experience within the conceptualization so that they can see themselves in the model. Attempting to explain the conceptualization in a "textbook" style may not adequately resonate with the client. For example, try incorporating the client's experiences with oppression into the case formulation, and identifying specific ways these experiences contribute to their mental health issues.
4. Review treatment options.

Provide this information as clearly and simply as possible so the client can understand what is being said and has the information they need 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. The therapist should also do the following:

- Point out the client's 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; the client can add or eliminate items as needed.
- Give specific examples of the links between thoughts, feelings and behaviours, using the client's language and stories. Again, diagrams may help explain the connections more clearly.
- Check that the conceptualization fits with the client's views of the problems and make modifications based on the client's 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 services, financial counselling) that may be available to the client for dealing with their problems.

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

Clients in Black populations may have a strong negative reaction to recommendations that medications may be useful as an alternative or adjunct to therapy. Mistrust with the health care system, perceptions of medicines (including concerns about medication side effects) and past negative experiences with medication are some of the reasons associated with negative perception of medication (Pederson, 2023). Some people in these communities perceive medication as being suitable only for those who have a severe mental illness or are too lazy to work on their problems. They may also believe that medications are likely to cause more harm than benefit. With this in mind, the therapist can expect there will be resistance to the idea of considering medication and of seeking a medication consultation. However, discussing it as an option can be an opportunity to dispel misconceptions about what taking medication might mean for the client.

Aligning CBT Goals with Cultural Values

Part of the informed consent process involves discussing with the client how CA-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 clients in Black populations, it may be important to emphasize the practicality of these interventions and their usefulness for making it easier to deal with daily situations. Explain 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 the client make these connections by referring them back to goals they have outlined for themselves and their relationships.

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 are affected by the way they think often resonates with members of Black populations. Therefore, a good way to engage the client 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. Remind the client that these are reasonable goals and supports that they would provide for other people as 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 the client does not feel like they are being taught tricks to make them feel better. The use of metaphors, proverbs and specific examples that are particularly relevant to the client's life may be especially helpful in getting them to connect with the CBT material.

Case Example

Liz is a 35-year-old woman who migrated from Jamaica 10 years ago. She works as a registered nurse assistant at a downtown hospital. She has a 14-year-old daughter, Camille, from a relationship she had in Jamaica, and an 8-year-old son, Marcus, from her current marriage. Her daughter was living in Jamaica with her maternal grandmother until two years ago. Camille would visit Liz twice a year when she first migrated to Canada, but contact became less frequent after her marriage and the birth of her son. She finally felt able to bring Camille to Canada two years ago because her situation here was stable and she believed that Camille's transition would be smoother if she entered the school system at junior high level. At first the reunion was joyous, but things have been declining over the last year.

Liz has been seeing her family doctor because she has headaches, other body pains, digestive problems and insomnia, but she suspects that these are physical signs of her emotional stress. She says that because of these sleep and health problems she is short-tempered and always fighting with her husband and shouting at the children. Many of the marital conflicts are brought on by problems with Camille, who is doing poorly in school, fights with her younger brother and is very defiant with her stepfather. Liz thinks that Camille hates her for leaving her behind in Jamaica and resents her stepfather and stepbrother. She lies awake wondering what would have happened if she had not left Jamaica, had not left Camille in Jamaica and had not remarried in Canada. She feels overwhelmed by the situation and feels there is no one she can share it with.

She also believes that her work performance is suffering, as she is always tired and in a bad mood—her supervisor has commented on this and she is worried there will be consequences. She works evening shifts and worries about what is going on at home when she is not there. There has been no violence at home, but she says that she feels on edge whenever she is in the house and even more on edge when she is gone.

Liz sees herself as someone who can persevere through anything, but she is worn down by the family problems and does not feel strong enough to deal with them. She says her dream of having a reunited family has turned into a nightmare.

In this case example, we see that Liz recognizes that she is under emotional stress and that it is affecting how she feels physically and emotionally. Although she does not talk about feeling depressed, her descriptions of physical problems, stress, anger and irritation are consistent with the idioms of psychological distress documented among North American populations of African descent and identified by the community members consulted in the development of this manual. Liz indicates feelings of hopelessness about her family situation, but also displays some confidence in her own personal strength and awareness that her personal resources are being overwhelmed.

A CA-CBT conceptualization of Liz's presenting problem might include some of the following factors:

- Environmental experiences contributing to depression – Work schedule, job stress and interpersonal tension with supervisor, conflict with husband and daughter. For example: exploration of concerns about anti-black racism at Liz's place of employment. Black women are often treated unfairly at work and this may influence her perception of her performance and any associated repercussions in the workplace.
- Core beliefs – I'm responsible for everything that's happening
- Automatic thoughts – It's all my fault; everyone is blaming me; I deserve to be blamed
- Feelings – Sadness, anger, guilt, anxiety
- Actions or behaviours – Isolation, irritability
- Environmental constraints on actions/behaviours and feelings – Maintaining family peace (including well-being of her son).

The proposed interventions and preliminary treatment plan that follow are linked specifically to reducing the symptoms that are troubling Liz, and also to her desire to fulfil larger goals of family harmony and personal well-being.

Problem	Potential intervention	Goal
Physical complaints	Psychoeducation	Reinforce understanding of link between emotions and physical discomforts.
Parenting stress	Psychoeducation Cognitive restructuring Social skills training/ assertiveness training	Increase understanding of contributions of developmental stage and separation/reunion to family stress. Alter negative cognitions about failure of family, personalization, self-blame. Initiate discussion with family about tension. Mobilize support from husband for co- parenting of both children. 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 rumination and agitation. 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 4 to 10: 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, each session should proceed in a predictable sequence:

1. Check in with the client.
2. Review personal project from the previous week.
3. Set the agenda for that day's session.
4. Work on skill development as part of the treatment plan.
5. Assign new personal project based on the content of the session.
6. Close the session with a summary and check in.

The therapist should tell the client about this procedure for the sessions as part of preparing them for the first active treatment session. Remind the client of this procedure when beginning the first few sessions.

Check-In

It is customary to begin sessions by checking in with the client about how the previous week went. A more formal check-in will take place later in the session about progress made on personal projects and skill development; at this point, checking in is designed to facilitate rapport and engage the client in the process. The therapist should have recently reviewed the client's file to ensure they can check in with attention to specific realities in the client's life (e.g., inquire about the well-being of significant people in the client's life, or ask about a recent event that is important to the client). Clients from Black populations 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 client and the problems that brought them to the session.

Although the checking-in process can be treated as simply a social courtesy, it may also help 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 the check-in, particularly in the first active treatment session, is to determine how the client feels about the feedback they have received about their problems. The client 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 the client's 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 the client's beliefs about the potential for change has an impact on treatment outcome. Checking in about how the client believes 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.

Review "Personal Project"

Next, the therapist checks in with the client about their experience completing the exercises or practice activities recommended the week before. Discuss successes and problems with the exercise in detail, including barriers that may have arisen to prevent the client 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 client's life. This exercise may also identify areas that need further work. The discussion can help establish the skill-building that will be addressed in the session.

Set 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 be set in collaboration with the client. Ideally, link the topic for discussion to the identified problem areas and addressed it through 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 be addressed in the second session as part of presenting the conceptualization. The therapist may wish to revisit the topic in this session to answer any questions that have arisen for the client and clarify any areas of confusion or uncertainty.

At this stage, use psychoeducation to more directly connect these concepts to the client's situation, addressing the cognitive contributions, but also emphasizing contributions from the environment. The therapist can draw on information the client 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 client's experiences, letting them know that many people share the same kind of difficulties under the same type of experiences. This discussion will help further inform the client, but can also help build engagement and rapport by demonstrating that the therapist is listening closely to the information the client has provided.

In addition, this is an opportunity to review the treatment plan with the client, orienting them to what will be the general process over the next 10 sessions. 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 client knows that there is flexibility to allow for earlier termination or to add a few extra sessions. If the client 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 12-13 sessions. For clients who are less able to access their thoughts and feelings, are lower functioning, have more acculturative stress (e.g., underemployment, or housing, financial, family separation or 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 client 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 client is bringing expertise about how they 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 client about their 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 also not too early to start talking about termination, alerting the client to the plan to use the last few sessions for preparing the client to maintain the gains made in treatment.

Develop Skills

The therapist and client 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 client identifies as the issue to be addressed and the tasks they 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 client brings to a session.

Assign Personal Project

The session can be used to practise skills that will be the basis for personal projects or to work with the client on skills that may be too labour-intensive to do at home. For example, some clients 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 the client is feeling overwhelmed, the therapist could let them use the session for doing this kind of work and then develop a therapeutic exercise that is less demanding on their time and energy.

Toward the end of the session, the therapist should work with the client to establish a therapeutic exercise to do between sessions. With clients from Black populations, time should be scheduled during the sessions for therapeutic exercises so the therapist can problem-solve ways to reduce barriers to completing the exercise with the client. Scheduling the exercise time also communicates its importance. Talk to the client about what will help them follow through on the commitment (e.g., setting up reminders in a calendar, attaching the activity to an existing commitment in the schedule, etc.). Self-monitoring or journaling activities could be combined with activities such as downtime, going for a walk, prayer or meditation.

Close the Session

Close the sessions by reviewing the work that has been done in the session, tying it to the overall goals of the treatment. Both the client 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 client is making positive progress. The therapist should reserve time after the session to document progress and add the session notes to the client's file.

Sessions 11 to 13: Termination

Typically, termination sessions consist of a review of the client's treatment progress, reinforcement of gained skills, creating a plan of how the client will leverage culturally appropriate resources, and discussion of signs of relapse of symptoms that may indicate the client needs to return for therapy (Wallace et al., 2021).

Because CBT interventions are time-limited, there is a great deal of emphasis on preparing the client to learn skills they can practise on their own. In sessions 3 to 9, the therapist should have been regularly reminding the client of the movement toward termination. For some clients, 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 client that one of the goals of treatment is to give them the skills to deal with situations without the therapist's assistance. 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.

Clients 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 client's terms. As these behaviours are common reactions to termination, they should not be treated as signs of pathology. Instead, discuss them with the client 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 client 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 client, or may worry that they have not done enough for the client. It is important for the therapist to work through these issues as well, perhaps discussing them with a peer or supervisor. The therapist should evaluate, with someone else, if their concerns are based on the client's issues (suggesting a need to extend treatment) or based on the therapist's own feelings.

Conventional therapeutic approaches usually discourage contact with the client after termination. In CA-CBT, it could be culturally inconsistent to suggest that there should be no future contact between client and therapist because a therapeutic relationship has been formed. This is especially unrealistic in small communities where the client and therapist are likely to run into each other in other venues. The therapist should respect boundaries by not initiating contact with the client after termination, but should not discourage the client from initiating all casual contact after sessions have ended. Some clients 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 the client is continuing to depend on the relationship because they lack confidence about being able to be on their own. Accordingly, an important task of termination is to help the client establish that confidence and help the client determine the difference between normal difficulties they might face after termination and situations in which it may be advisable to seek further help.

Prepare the Client to Be Their Own Therapist

Part of preparing the client for termination is building their confidence for picking and using strategies to deal with everyday stressors. This process is started by always collaborating with the client in decisions about what skills are to be learned and how and where they should be applied. As the treatment progresses, the client 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 personal project exercises. Use the problem list and/or the conceptualization developed at the beginning of

the treatment to guide later sessions, with the therapist asking the client 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 client's successful use of coping skills. Sessions move toward focusing on how the client is coping successfully with situations that were previously distressing. Together, the therapist and client identify the thoughts, emotions and actions that are being mobilized to make successful coping possible.

As the treatment moves into termination sessions, the client should be doing this independently, using the therapist (and potentially, other people in their life) as consultants to the process. The therapist, in turn, reinforces this by encouraging the client to make decisions, praising initiative and calling attention to the client's growing skills. Support the client's growth by helping them think through options and evaluate alternatives. If a plan needs some improvement, guide the client to appropriate changes by asking questions that will get them to work through the possibilities, their pros and cons, etc.

Orient the client to the idea of being their own therapist through concrete strategies such as role-playing, in which the therapist acts as a client and the client presents recommendations like a therapist. Discussing potential problem situations and how the client would address them is another concrete way to demonstrate to the client that they have made progress in being able to face difficult situations. The client may also provide situations during check-in that can be used as examples of growing competence.

In all these ways, the therapist should be communicating the confidence they have in the client's ability to move forward positively. The client will benefit from receiving positive reinforcement from the therapist, but it is even more important for the therapist to call the client's 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 client knows what to do if depression returns.

Review Progress

It is easy for clients to lose sight of the progress they have made during the sessions, so the therapist must help them see how far they have come. This can be done informally by discussing the issues that first brought the client 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 client has completed. Looking at where they started and comparing it to the present situation can be a very empowering way for the client to recognize the work they have done.

Set Future Goals

The client 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 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. Use these final sessions to set goals in new areas, discussing how the client can adapt the skills they have learned to these new situations. In either case, the therapist should encourage the client 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 they are available in times of increased pressure or stress.

Set Realistic Expectations

Some clients 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 the client to recognize they have a repertoire of skills and resources available to them that they may not have had before or used effectively. Now, the client is able 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 the client also needs to know what to do in particularly difficult times.

Discuss What to Do if Symptoms Return

Part of setting realistic expectations is to be open with the client 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 the skills they have learned to help them stay well. In such situations, the client should know that they should seek help. The help they need may involve a "booster" session with a therapist or the start of another course of treatment. It is important that the client understands 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 the client 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. The client 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 the client about who else in their life can be part of a plan to promote mental health and prevent future relapse. Encouraging the client 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.

The client should also know they can check in with the therapist as well. The therapist may be able to provide perspective on what is going on with the client and reinforce strategies learned during the treatment, suggest a booster session or recommend resuming treatment.

Ultimately, the therapist should help the client 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 clients can achieve benefits with fewer sessions, while others may need more sessions. The timing of termination may deviate from the expectation for several reasons: the client 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 the therapist and client should not feel that deviating from the 12-week expectation in any way reflects a failure of treatment.

If the therapist and client decide to terminate treatment before 12 weeks because the client 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 (e.g., failure to develop a working alliance or poor engagement with the treatment process). Although such a situation can be disappointing for both the therapist and client, it is in the interests of the client to terminate rather than continue. Termination may make it possible for the client to seek help elsewhere or with someone else with more positive outcomes. Other times, the client is 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 the client 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 client feels more ready and has a positive attitude to returning to treatment.

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

If the therapist anticipates that a client may be highly anxious about terminating treatment, they may 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 client's feeling that they need more time, while providing the opportunity to experience coping without the therapist's support for longer periods.

The client 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 with the client 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 includes seeking help when needed, and does not include not ever having any problems again. Reinforce the strength that is demonstrated by taking care of themselves and how this contributes to important goals such as being a strong member of their family and community.

Determine the timing of termination by the progress therapist and client feel is being made toward the treatment goals. This is a good topic for regular discussion throughout the treatment process, both to evaluate progress and to demystify the decision-making process that will determine when treatment will end.

Chapter III: Resources and Tools

Self-Monitoring

Clients 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 the client to track their feelings, thoughts and behaviours—can help raise their awareness. The therapist should review a past situation to show the client 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, the term "feelings" refers 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 the client 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, stomachaches —are more noticeable than the emotions. Clients 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 express feelings safely, or they have had negative experiences when they try to express feelings.

Learning strategies for dealing with feelings can offer clients ways to deal with stress more effectively. Since few people are taught how to deal with their feelings, it takes practice. To help the client 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 the client notice how their thoughts affect their feelings. It can be a valuable exercise to have the client write down 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 is available in Appendix 2, Handout 5: Noticing & Exploring Self-Talk. Practise this with the client, and then suggest they 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 the client has learned unhelpful patterns of thinking —cognitive distortions—which reinforce negative feelings. In other words, cognitive distortions are unrealistically negative thoughts that have been learned in negative situations. Common cognitive distortions include the following:

- 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 men are bad")
- mental filter – only paying attention to the bad events that happen and overlooking good events that are just as relevant (e.g., ruminating about an argument with a friend during your surprise birthday party organized by other friends)
- disqualifying the positive – rRejecting 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., a friend is late, so you think she must have gotten into a terrible car accident and died)
- magnification/minimization – seeing negative events as hugely important and positive events as insignificant (e.g., a person playing a game of chess can recount every bad move in great detail, but pays no attention to the many good moves that were made in the same game)
- emotional reasoning – letting the way something makes you feel distort your perception of the situation (e.g., feeling nervous about taking a test convinces you that you are not prepared for the test)
- 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 [self-talk] that you are a stupid loser)
- personalization – taking personal responsibility for bad events happening to other people (e.g., your partner is stressed and you decide it must because of something you are doing or not doing; this is all my fault)
- 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 they 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 to a social event because you already "know" you will have a bad time)
- mind reading – imagining what someone is thinking and then reacting as if it were real (e.g., feeling bad because your friend has not responded to an e-mail message you sent and thinking it is because he is angry with you)

The therapist needs to be careful about labelling these thought patterns as cognitive distortions because the client may perceive this as implying that all their problems are "in their heads." This may be particularly true among clients from Black populations as there is an unfortunate history of Black populations being labelled as deficient based on mainstream ideologies about what is the correct way of being (Henry, 1993). Consequently, clients may be sensitive to any suggestion that they are being minimized or subjected to racist assumptions (McLean et al., 2003).

The client 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 instead of trying to change situations beyond their control or influence. Rather than talking with the client about their "distortions" or "distorted thinking" that must be replaced by "rational" thoughts, it may be more useful to talk to them about thoughts they have that are "extreme" or "unhelpful" (Williams & Garland, 2002). This wording will help the client realize that their thoughts are not based on reality and are contributing to their negative feelings and behaviours. Talking with the client about what kind of situations evoke these thoughts and where they may have come from can help them understand the thoughts as learned ways of responding that can be replaced with new learning that will promote more positive feelings and behaviours.

The client may identify with the notion of having been taught ideas that are wrong and corrosive, as this interpretation resonates with the way many people of Black populations experience the school system in Canada and elsewhere (Dei et al., 1997). The idea that they now have an opportunity to replace this distorted information with more realistic and balanced information may be used to engage the client in a discussion of how they have been taught to accept discontentment and lack of success and how this may have served as a protective strategy in the past.

In a world where there is racial injustice (Henry, 1994), ideas that blame the individual justify the status quo and prevent members of minority groups from addressing injustices that affect their lives but continue to have consequences on their health and well-being. If these ideas are recognized as false learning, then individuals may find better ways to cope with life events that happen to them because of their vulnerable status.

Pictograms can be a useful way to begin discussion about cognitive distortions, or personal myths, that the client applies in everyday situations. The client benefits from learning to identify the thoughts/myths/beliefs that contribute to their negative feelings. In Appendix 2, Handout 10, you will find pictograms of the most commonly described cognitive distortions. These pictograms can be used to engage the client 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. The therapist can show the client 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.

The therapist will repeatedly be helping the client 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 the client 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 the client 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 they do 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 must be actively countered by positive self-talk. The first step is to identify when negative self-talk is happening, and then learn to challenge these thoughts with positive, supportive statements. The client 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 the client to identify a negative thought, evaluate it and then replace it with positive self-talk. The client may find it helpful to link positive counter-statements to ideals they value. For example, religious values may counter cognitions that devalue the individual who sees themself as a creation of God, or family-oriented values may challenge cognitions that suggest a client's family may not care about them.

Positive self-talk should:

- begin with an "I" (this reinforces the client's ability to manage their situation)
- be stated in the present tense
- be credible (i.e., based on something the client 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").

The following chart provides examples of negative self-talk, evaluative questions and positive self-talk.

Negative self-talk	Evaluative questions	Positive self-talk
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.

Unrealistic negative thought	Evaluative questions	Positive/More balanced counter-statements
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 client may have a sticky note on a mirror that says, "I am liked and respected by many people" or can slip a note inside a journal or Bible that says, "God created me exactly as he wished me to be."

A common personal project exercise is to have the client practise modifying their thoughts between sessions. Give the client a piece of paper with two columns. In one column, they record when they have negative self-talk or unrealistic negative thoughts. In the other column, they write down positive counterstatements. This exercise helps 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 is a realistic or fair thought.
3. Replace the negative thought/self-talk with a deliberate positive statement.

Appendix 2, Handout 6: Thought Record provides an example of a more detailed recording worksheet. Use it with the client to facilitate a discussion in the therapy session and for the client to record their experiences independently.

Behavioural Experiments

The client 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 may just strengthen it.

When the therapist and client have determined new behaviours to try out, they can work together to practice new routines that will help the client discover what happens if the practices work to change expected outcomes. These experiments are modelled after exposure therapy, a behavioural intervention in which a client identifies the negative thoughts and feelings evoked in particular situations and learns to replace them with positive thoughts while progressively engaging in the new behaviour.

Here are the steps for designing a behavioural experiment:

1. Work with the client to describe the situation and what they anticipate will happen when trying out this new behaviour. Focus on the thoughts and feelings associated with the situation.
2. Work with the client to develop strategies 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 client 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 client can get more practice and try using different strategies.
5. Have the client try out the new behaviour on their own in between sessions. Work with the client to determine if the at-home experiment will involve doing one or several steps of the new action.

Appendix 2, Handout 8: Your Experiment provides a worksheet to help the client 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 the client 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. The client may think they have very few options until they learn, through this process, to recognize a fuller range of choices.

Recognize choosing not to take action as a viable course of action. The therapist may want to remind the client of the serenity prayer as a tool for making peace with situations that cannot be resolved by individual action. At the same time, the therapist should help the client recognize that they may not be powerless in some situations and may be able to take action independently or with help from others.

The client should identify a problem they would like to try solving. Topics discussed during the check-in or personal project review may identify a problem linked to the treatment goals, but the client should choose the example they will use for the exercise.

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

Problem-Solving: Step-by-Step

Guide the client 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 client 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 the client can practise them almost anywhere and use them whenever they feel 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 clients to reduce tension in their bodies. It can be a useful exercise before bed as it may make it easier to go to sleep. The client may find it helpful to do this exercise while listening to a recorded guide; ideally, the agency can provide recorded instructions (e.g., links to podcasts). Clients can also download progressive muscle relaxation audio instructions. There are several available online through sources such as Apple Music.

When teaching this exercise, the therapist should have a script available to take the client through the relaxation sequence.

The following exercise is adapted from The Anxiety & Phobia Workbook (Bourne, 2005). The therapist can use the following instructions to guide the client.

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 5 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.*
12. *Stomach – Suck in your stomach.*
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 for clients to evoke a sense of peace and distract themselves from negative or anxious thoughts. Help the client 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 paint in the details of their visualization with instructions such as the following:

- 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 received strong endorsement in the mental health field and the practice of mindfulness meditation is often recommended as an adjunct to treatment for mental health disorders. However, note that research indicates that religious affiliation may be a barrier to adoption of such practice because of the linkages with Eastern Buddhism. Many Black people may not be comfortable with the practice because of spiritual concerns (Biggers et al., 2020).

The client 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), and in mp3 files that can be downloaded free of charge at sites such as iTunes.

Encourage the client 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, the client can use it 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 client can track the time 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"). You can place a picture or candle in front of you to be a focus. It can also be effective to picture an image in the mind and focus your attention on it.
- Close your eyes if it's comfortable and doesn't 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 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 practicing this method of focused attention. 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 clients 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. Prayer may be a preferred alternative to meditation practice for clients who are religious. Spirituality and religious practices can also be leveraged to cultivate resilience, instill hope and foster connections.

Encourage clients to incorporate 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 them
- praying for themself
- praying for others
- thanking God for the way that prayer will benefit the client and the people around them.

Stress Inoculation

Stress inoculation is a technique that the therapist can use to prepare the client 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 client to a stressful situation. The more detailed and realistic the therapist makes the situation in the practice, the more likely the client will be inoculated against stress in the real situation.

Help the client 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 the client recognize and commend themselves for having attempted to cope.

The client 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 clients 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 clients that 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 client to develop potential strategies for responding that counter negative thoughts, behaviours and/or impulses used in the past. The therapist should encourage the client 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):

- socially appropriate refusals to give in to the requests of others
- appropriate expressions of opinions and feelings
- 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. However, many clients 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.

A significant experience that needs to be considered is the racialized interpretation of Black assertiveness that often involves the perception of angry Black men and women. Black adolescents and young adults may have experienced harsh discipline for the same attitudes and behaviours that are commended in white peers (Riddle & Sinclair, 2019). Historically, Black populations have been compelled to withhold expressing their attitudes and feelings for fear of harsh reprisals and sometimes fatal consequences. Many who have behaved assertively have often been perceived as aggressive because of racist thinking about Black people being inherently violent and dangerousness. In turn, Black people may have been socialized to stay silent for self-preservation.

Asserting themselves may also be intimidating if there has been a history of harsh reprisals in the country of origin. Recent immigrants may not be aware of consequences of self-assertion in this new country.

Black clients may need two sets of assertiveness: one to assert themselves and another to counter racialized responses. Unfortunately, this means that Black clients 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 clients may not feel this is a goal for them. The therapist must avoid imposing assertiveness as a goal, as this would suggest that mainstream values are superior to the client's. If the client 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 client identifies it as useful (e.g., work or family situations). The role play should also include responses the client can use to address people who may misinterpret their assertiveness as aggressive or inappropriate behaviour. In this way, CA-CBT addresses the cultural context for assertiveness, recognizing that Black clients may perceive it as risky behaviour and may encounter others who respond very negatively to them asserting themselves.

The therapist should support client's empowerment goals to advocate for themselves within their communities and in larger societal contexts. This might include affirming their cultural identity, consciousness-raising, claiming their voice (Hayes, 2006), connecting them with resources or supporting their involvement in social justice initiatives, and developing a sense of agency and empowerment by recognizing their strengths and resilience in the face of adversity.

Self-Care

Physical Exercise

Limited access to physical activity environments in racialized neighbourhoods may serve as a barrier to healthy living for many Black clients. Innovate solutions may need to be crafted for attention to physical activity in individual recovery plans (Hasson et al., 2022). 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.

The client should consult with their physician 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. The client could integrate this into their daily schedule by, for instance, taking a walk at lunchtime or getting off the bus or subway a few stops early and walking to their destination.

Encourage the client 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 clients from Black populations feel oppressed by the darkness and cold. Encourage the client 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

Often people's diet changes when they move to a new environment or are experiencing financial challenges. Those with poor eating habits can be more vulnerable to negative mood states. It is worthwhile to talk to the client 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 client's financial circumstances may be affecting their food choices.

Encourage the client 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 the client about teas, tonics or herbs that have benefited them in the past and how they might integrate them into an improved diet.

However, as stated in Chapter 1, Black Canadians have the highest rate of food insecurity. One of the contributing factors for food insecurity is income. For individuals from low-income households, barriers to access to healthy food options include the high cost of produce and the availability of fresh produce in neighbourhoods that are not well served (Roberts, 2020). In Toronto, Ontario, neighbourhoods with high Black populations experience less access to community gardens, and green space, and are more likely to have fewer options for fresh produce (Toronto Black Food Sovereignty Plan, 2021).

Some services and supports for better access to nutritious food include:

- Black Food Toronto (https://blackfoodtoronto.com) – a communitybased non-profit organization championing Food Justice and Food Sovereignty for Toronto's African, Caribbean and Black community.
- Afri-Can FoodBasket (https://africanfoodbasket.ca/) – Black-led, Black-serving and Black-mandated (B3) organization that champions reducing hunger, enhancing cultural food access and promoting health and wellness through food and nutrition initiatives within African, Caribbean and Black (ACB) communities across the Greater Toronto Area.
- FoodShare (https://foodshare.net/) – Canadian not-for-profit organization that delivers programs that address hunger and advocates for better policy from government. Programs include delivery of food boxes and support of urban farming.

Sleep

Individuals from Black communities sleep fewer recommended sleep hours compared to white counterparts (Chaput et al., 2024). A significant amount of shift work among Black clients may be disruptive to healthy sleeping patterns and signal the need to emphasize sleep hygiene. Sleep problems are further 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 the client 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 show signs of fatigue, (e.g., yawning, heavy eyes) and then head to bed.
2. Only use the bedroom for sleeping. Do not use the bedroom to watch TV, read books, work, talk with your partner or do 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 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. Don't sleep during the day. Again, this may be difficult if you're 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 and Self-Care

Black clients may find downtime to be a concept that is unrealistic given demanding work schedules that are often associated with having more than one job. Often clients have little break from their stressors and need to learn to carve out personal time from work or other demands to protect their health. With pressure to work and with many demands on their time, it can feel self-indulgent to take time for themselves. However, this attitude only contributes to feeling more overwhelmed, undervalued and

stressed. One of the most important skills that the client can learn is to take time out from work and other responsibilities to rest and recharge; the therapist can present this as a health protective practice. As much as they are able, encourage the client 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 clients may be able to work on planning downtime for one hour a day or one day every month. Whatever the personal circumstance, many clients 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. For example:

- Rest activities could involve sitting in the park, listening to music or taking a nap.
- Recreational activities could include 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.

Practising yoga may help in reducing anxiety and depression (Nanthakumar, 2020). Studies indicate that although yoga could possibly be an option to reduce stress and promote mental well-being among Black people, there is a need to make yoga culturally appropriate by adopting messaging/communication that reflects the cultural values and beliefs of the Black community (Tenfelde et al., 2018).

Work with the client to generate ideas for what they can do with the time they protect for themselves. For most clients, 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 departure from homes may engender a sense of loss in the new environment. In The Anxiety & Phobia Workbook (2005), Edmund J. Bourne advocates techniques for exploring issues of meaning and purpose to help clients find available resources to renew or recover a sense of purpose in their lives. In CA-CBT, the therapist can use this to help clients reconnect with spiritual or cultural values that will orient them toward resilience, persistence and in endeavouring to work on themselves and their relationships (Vieten & Lukoff, 2022).

By connecting with these values, the therapist can help the client evaluate what they are perceiving and doing that is either consistent or inconsistent with deeply held views. They can also support the identification of ideas and behaviours that are barriers to purposeful living. From such a discussion, it may be possible to identify skills that can be developed, behavioural practices and mental exercises that may be relevant to their goals.

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?

Nurturing spirituality, Encouraging worship

Many Black clients will have past or current connections to churches, mosques, temples or other places of worship that can be mobilized as part of their treatment plan. Attending places of worship may increase social connections and activities and help reconnect the client to deeply held spiritual values. Prayers and participating in religious rituals can foster connections with the community. In addition, places of worship are often a place where emotional expression is sanctioned, and therefore people can share their struggles in an accepting environment. For many people, the place of worship can be a refuge, though they may lose sight of this if they become depressed and start to isolate themselves or feel unworthy of connecting with other people. If the client is religious, discuss attending church services, prayer groups, or other activities as potential components of a health promotion plan.

For clients without religious affiliation, support groups may be an alternative accessible through community health care, community-based groups and/or mainstream organizations. Spirituality and spiritual connections may also be nurtured through nature walks, communal gatherings, meditative practices and other reflective practices.

Organizations that provide communitybased mental health support and resources for Black people in Canada include:

- TAIBU Community Health Centre (https://www.taibuchc.ca/en/) – offers Black-identifying clients from throughout the Greater Toronto Area access to primary care, health promotion and disease prevention programs in a culturally affirming environment.
- Women's Health in Women's Hands Community Health Centre (https://www.whiwh.com/) – specializes in the health and wellness needs of racialized women and prioritizes those from African, Caribbean, Latin American and South Asian communities.

Conclusions

Referral to other practitioners: It is important to note and reinforce that the therapist can refer the client to other practitioners they feel can better support Black clients to consistently improve their own quality of care. While broad adoption of this manual is desired, where a therapist cannot provide CA-CBT, they can tap into a network of other therapists. This is not intended as a way for therapists who cannot adapt to avoid providing services to this population. At the very least, a repository of CA-CBT practitioners should be established to enable clients to find therapists with an understanding of CA-CBT, and also to serve as a bank for referrals when needed.

Current repositories include:

- Black Healthcare Professionals Directory (https://bhpn.ca/) – A database of Black physicians in Ontario that can help find culturally sensitive and competent health care providers who understand the unique needs of the Black community.

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Appendix 1: Resources for Psychoeducation

Reading Materials

- Bilsker, D. & Paterson, R. (2005). Self-Care Depression Program, 2nd Ed: Antidepressant Skills Workbook:. Vancouver: Simon Fraser University & BC Mental Health and Addiction Services. Available: www.comh.ca/publications/resources/asw/SCDPAntidepressantSkills.pdf
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- Centre for Addiction and Mental Health (2001). Alone in Canada: 21 Ways to Make it Better. Available: www.camh.net/fr/About_Addiction_Mental_Health/Mental_Health_Information/Alone_in_Canada/ alone_in_canadafr.pdf
- Centre for Addiction and Mental Health (2004). Depression. Available: www.camh.net/About_Addiction_Mental_Health/Drug_and_Addiction_Information/ EN_depression_photonovella.pdf
- Burns, D. (1999). The Feeling Good Handbook. New York: Penguin.
- Leahy, R. (2010). Beat the Blues before They Beat You: How to Overcome Depression. Carlsbad, CA: Hay House.
- Williams, M., Teasdale, J., & Segal, Z. (2007). The Mindful Way through Depression: Freeing Yourself from Chronic Unhappiness. New York: Guilford.

Online Resources

- www.checkupfromtheneckup.ca: A website aimed at raising awareness about mood disorders www.facingus.org: A website aimed at supporting 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: A mental health website that contains psychoeducation resources for clients
- www.rcpsych.ac.uk/mentalhealthinformation.aspx: The website for the Royal College of Psychiatrists contains psychoeducation resources for clients

Appendix 2: Intervention Tools

Handout 1—Understanding the Problem

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

Problems

Environment: Recent changes / Stressful situations / Past events

Thoughts: Things that go through my head

Feelings: Emotions and physical reactions

Behaviours: Things I do, or don't do

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.

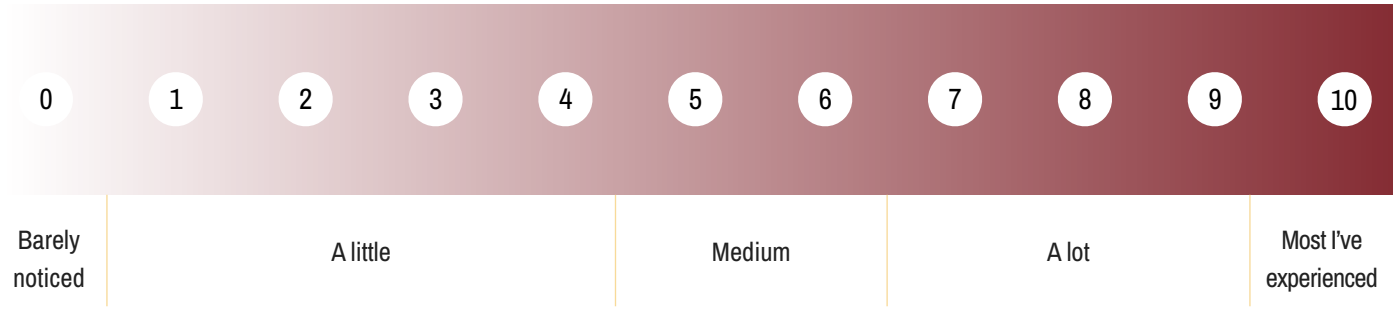
Mental Health											
Nervous	0	1	2	3	4	5	6	7	8	9	10
Sad	0	1	2	3	4	5	6	7	8	9	10
Worried	0	1	2	3	4	5	6	7	8	9	10
Irritable	0	1	2	3	4	5	6	7	8	9	10
Alcohol or other drugs	0	1	2	3	4	5	6	7	8	9	10
Sleeping problems	0	1	2	3	4	5	6	7	8	9	10
Angry	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10

Social Factors											
Family/relationship problems	0	1	2	3	4	5	6	7	8	9	10
Money problems	0	1	2	3	4	5	6	7	8	9	10
Housing problems	0	1	2	3	4	5	6	7	8	9	10
Work/school problems	0	1	2	3	4	5	6	7	8	9	10
Unemployment	0	1	2	3	4	5	6	7	8	9	10
Neighbourhood problems	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10

Medical Problems											
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10

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.



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.

Day	How stressed were you today (0-10)	What caused you to feel that way?
1		
2		
3		
4		
5		
6		

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

Barely noticed	A little	Medium	A lot	Most I've experienced

Handout 5—Noticing & Exploring Self-Talk

This is an exercise to help clients 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 personal project assignment for the client.

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 per cent 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

The therapist should complete this exercise in session with the client, and provide the client 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 (e.g., iCBT, eCBT Mood, Triple Column).

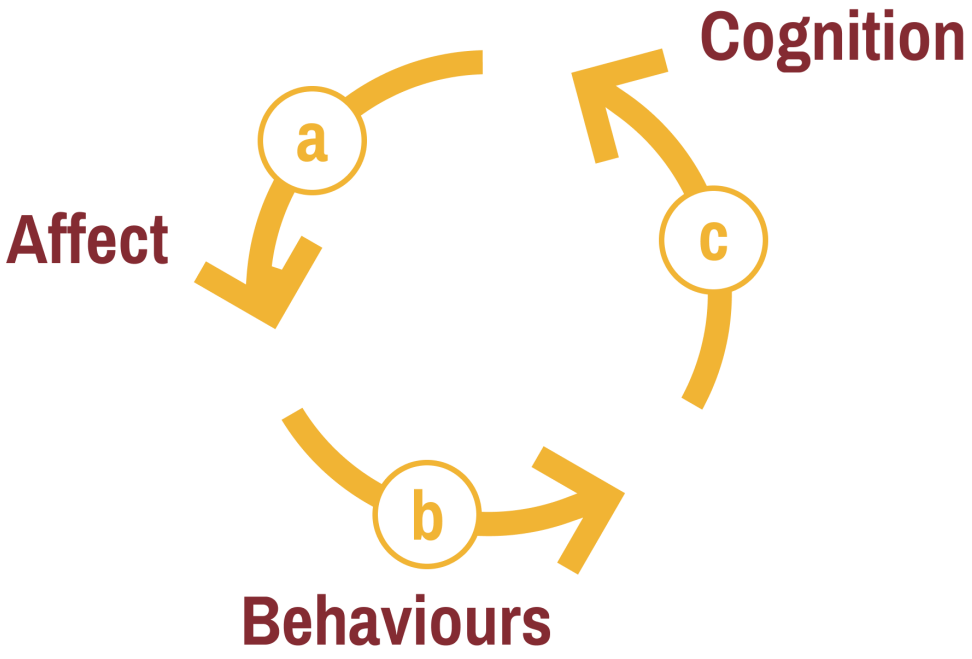
Situation: What was going on at the time?	**Thoughts:** What self-talk or negative thoughts came to mind?	Positive / More balanced counter-statement
1. I fail at everything I try to do. 2. My family doesn't care about me. I'm all alone.	• What is there to suggest this is true (evidence for)? • What are 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.

Thought Record (continued)

Situation • What's going on? • Where are you? • When did this happen? • Who is with you?	
Thoughts/beliefs	
Evidence to support those beliefs	
Evidence against that thought	
Positive re-statement	
Feelings after the positive re-statement (scale 1–10)	

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 to help you discover what happens when you try something new.

Experiment	Possible problems or bad experiences	Strategies to overcome those problems	What happened? Rate your bad feelings (1–10)
New Behaviour			
Step 1			
Step 2			
Step 3			
Step 4			

Handout 9—Scheduling Downtime

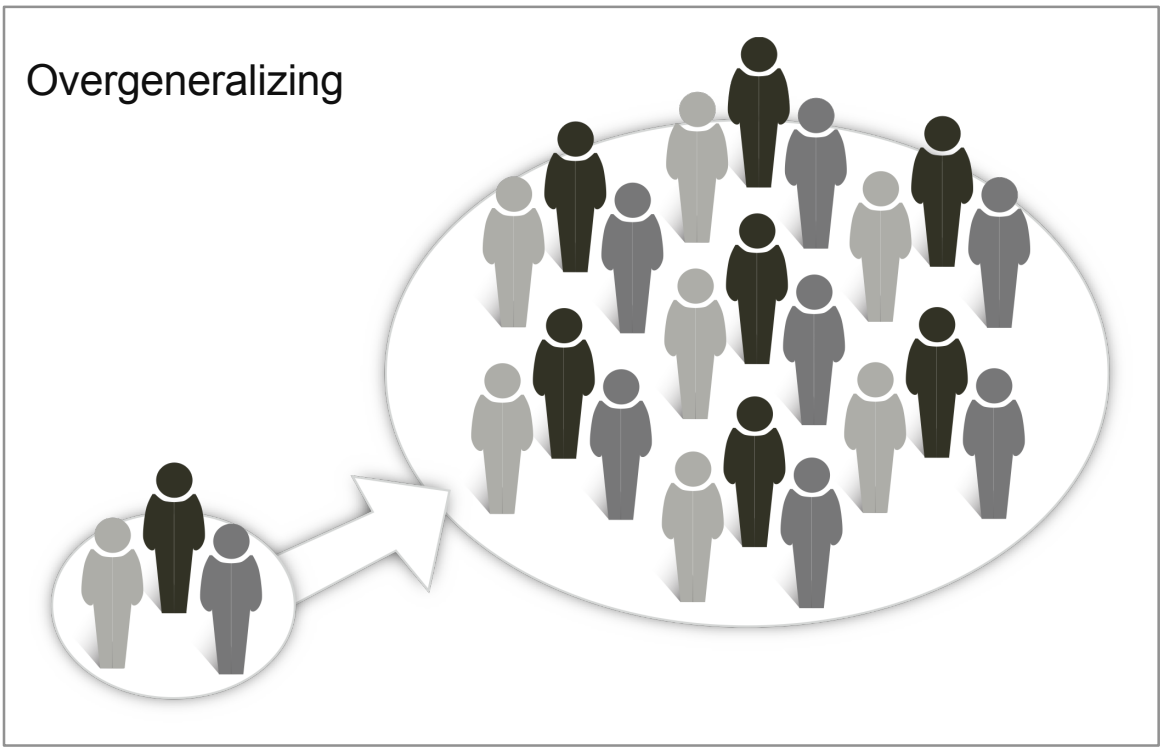
Encourage clients to schedule downtime activity, helping them to work through competing demands that could get in the way.

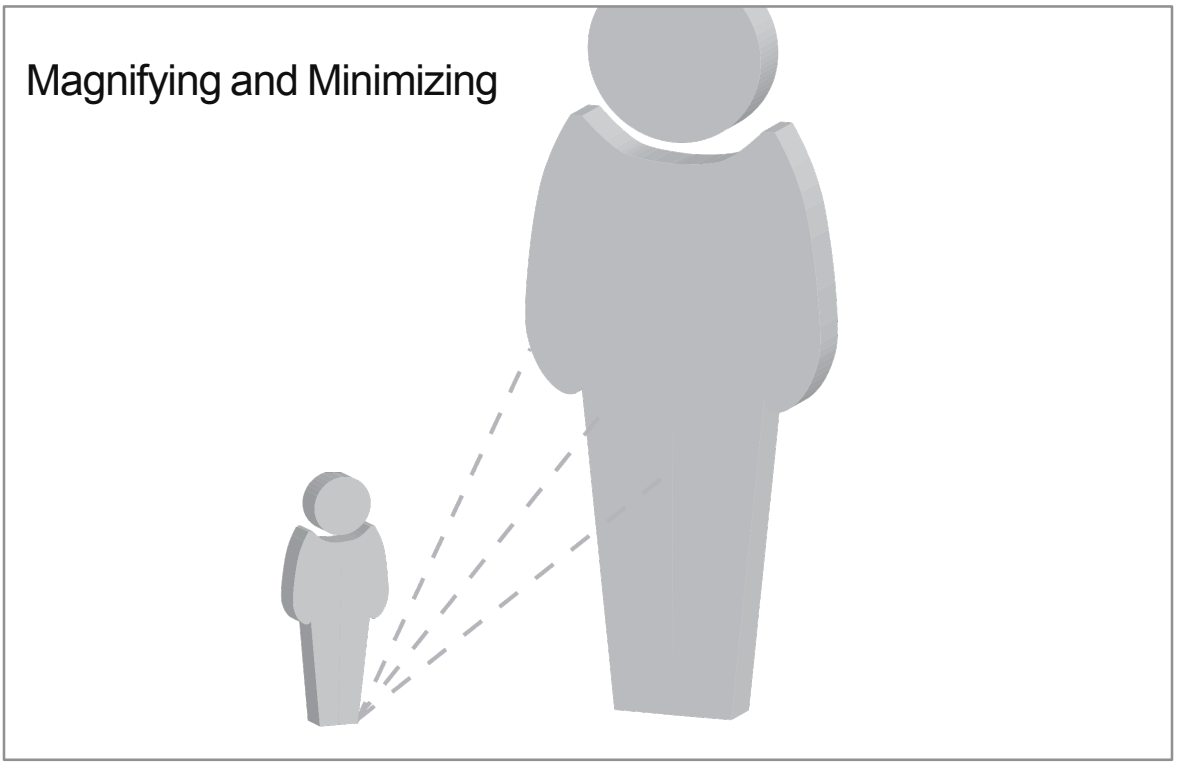
Downtime	...with 15 minutes/day	...with 30 minutes/day	...with 1 hour/day
Rest activity			
Recreational activity			
Relationship activity			

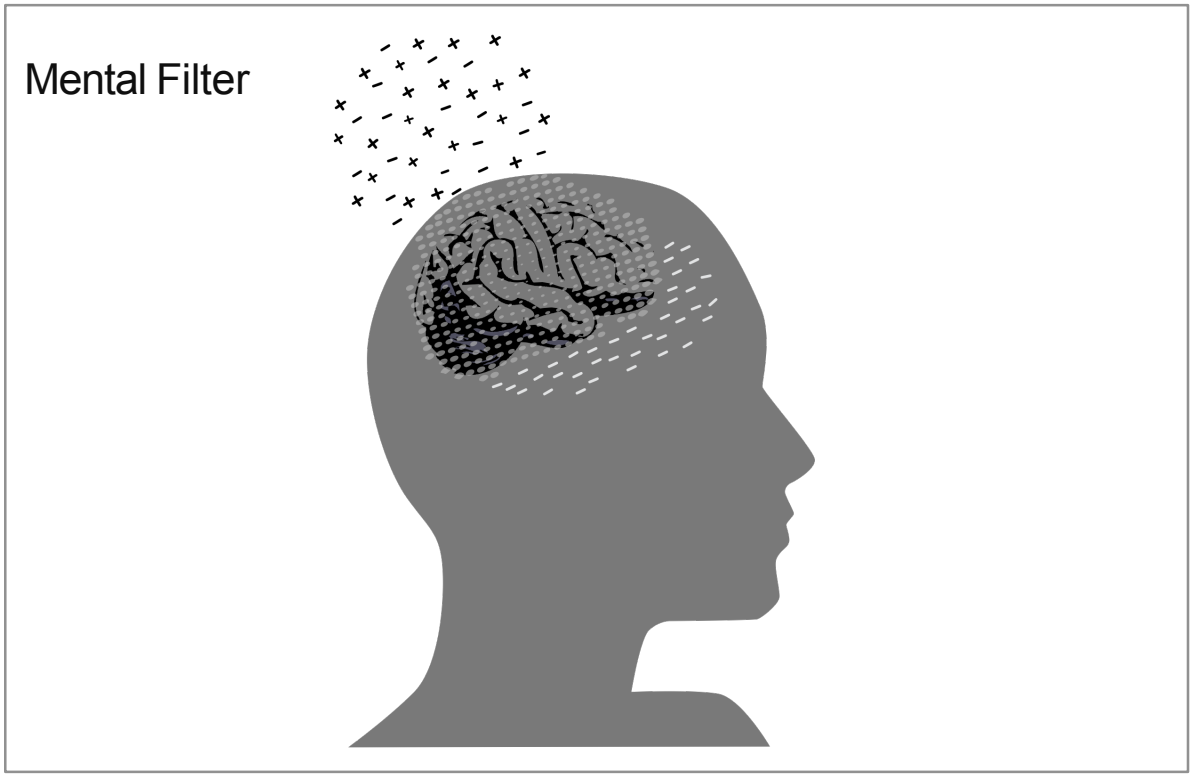
Handout 10—Pictograms

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

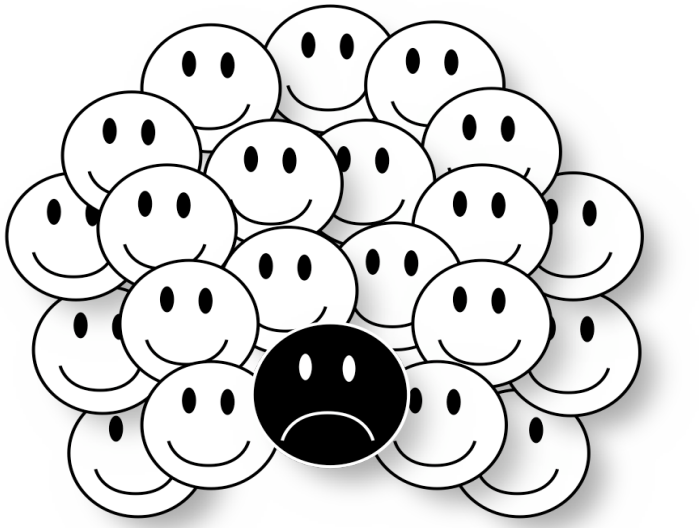
The therapist should help clients come up with examples of ways they apply distortions or myths in their lives; these distortions can be listed during a session or used as the foundation for an exercise to be conducted between sessions. When the client is aware of these negative patterns of thinking, 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 clients between sessions.




Magnifying and Minimizing


Mental Filter

Disqualifying the Positive

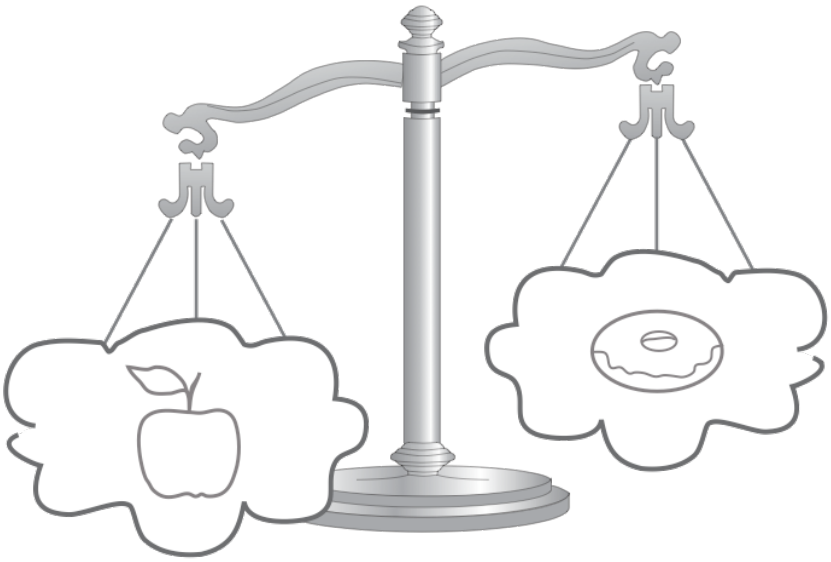


All-or-Nothing Thinking

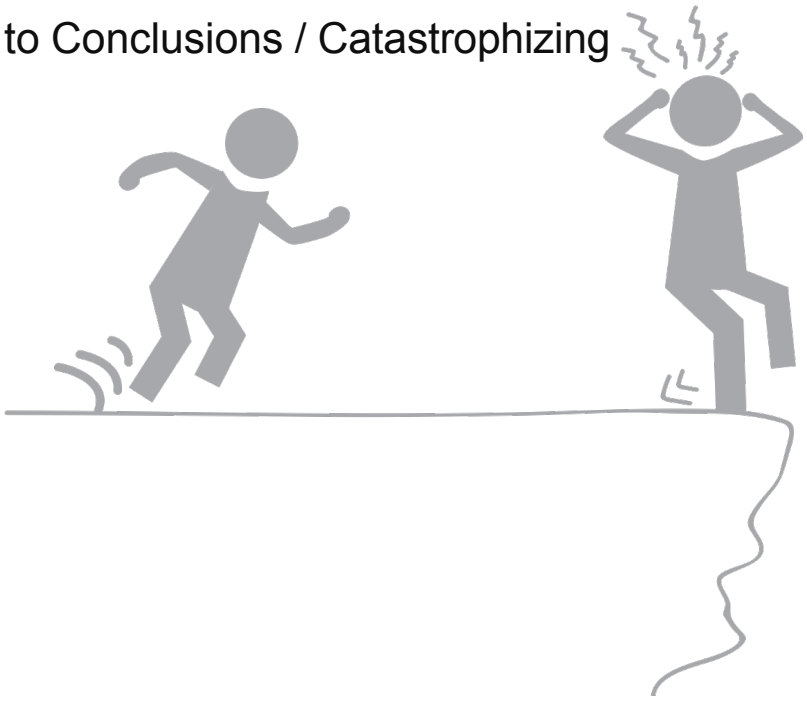
Labelling or Mislabelling

Emotional Reasoning

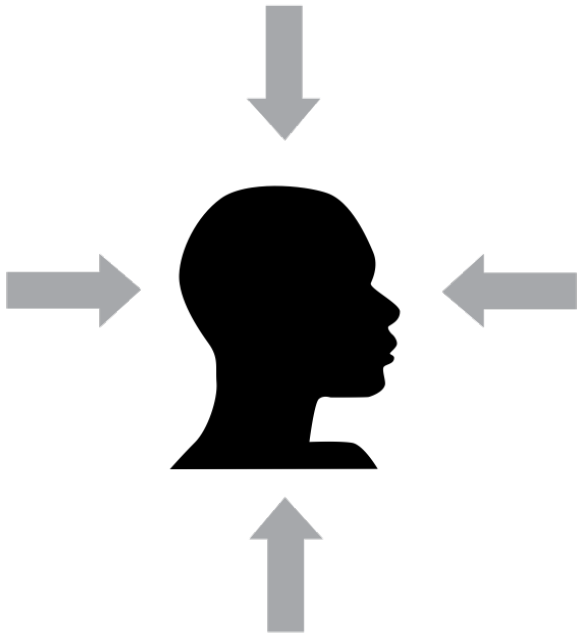
"Should" Statements



Jumping to Conclusions / Catastrophizing



Personalizing



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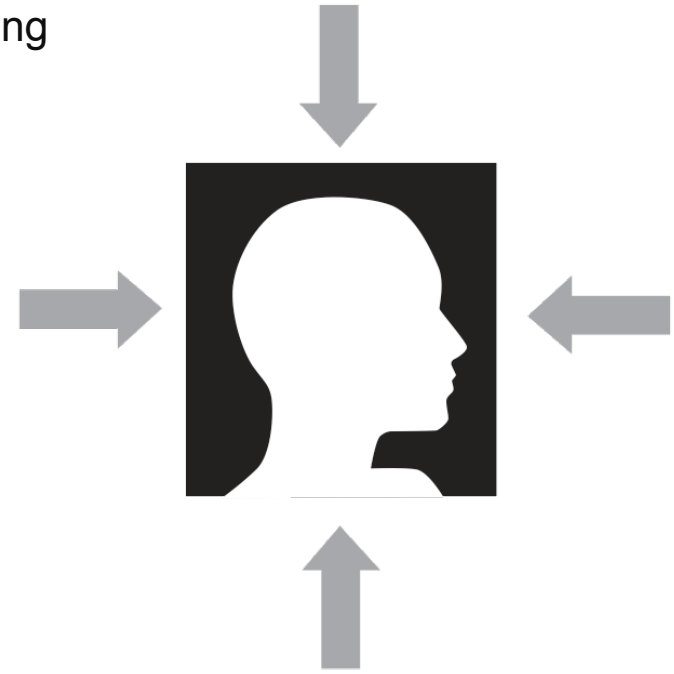
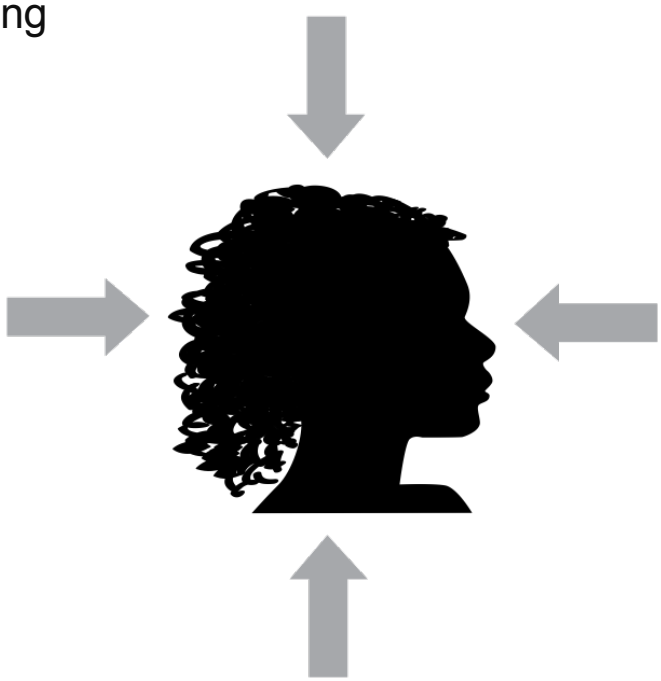


Personalizing



Personalizing