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

camh
Centre for Addiction and Mental Health
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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

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Referral source for therapy and focus group participants

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Organizations Hosting Focus Groups

Malvern Library

Women's Place (Malvern Family Resource Centre)

The staff of CAMH and Citizenship and Immigration Canada (CIC) have also provided consistent support from beginning to end. Of course, the funding from CIC made this whole adventure possible. We extend our sincere gratitude to our partner.

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

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

This manual represents one small yet significant effort in the right direction. It features such practices as proactive outreach, cultural safety and timely and relevant cultural modifications to cognitive-behavioural therapy (CBT). The approach calls on health professionals familiar with CBT to go the extra mile for these populations. We recognize that while all individuals from such groups will not require culturally-adapted interventions, many will be better served with such a resource.

A final note, be sure to enjoy your inward journey with the manual. As with traditional CBT, we aim to build your knowledge, skills and self-awareness.

Citizenship and Immigration Canada | Citoyenneté et Immigration Canada

Dear health professionals,

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

1. The facilitator's manual *Cognitive-Behavioural Therapy for People of Latin American Origin*
2. The facilitator's manual *Cognitive-Behavioural Therapy for English-Speaking People of Caribbean Origin*
3. The facilitator's manual *Cognitive-Behavioural Therapy for French- and/or Creole-Speaking People of Caribbean Origin*
4. The training DVD *Exploring a Service Model for Canadians of African Descent*, which includes a historical segment providing context for the problems facing members of the African-Caribbean community and the impact on their identity and mental health; statistics and experiences that demonstrate the ongoing impact of prejudice; some benefits of cognitive-behavioural therapy; and interviews with specialists in the field
5. A *Cultural Adaptation Model for the Preparation of a Culturally Adapted Cognitive-Behavioural Therapy (CA-CBT) Manual for Francophone African Populations*.

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

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

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

Sincerely,

Darlyn Mentor
Director, Settlement Programs
Citizenship and Immigration Canada, Ontario Region

Canada

Contents

Foreword

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

About This Manual

This CA-CBT manual focuses on English-speaking clients of Caribbean heritage in Canada. It is the product of an intensive development process that started with a detailed literature review, focus groups with English-speaking people of Caribbean heritage living in the Greater Toronto Area (GTA) and interviews with mental health workers who provide services to this population. Following this research and community feedback, an initial manual was produced and then pilot tested in the community. The lessons learned from the pilot testing, from follow-up consultations with the English-speaking Caribbean therapists who delivered the CA-CBT interventions and their clients were then used to produce this final manual.

The manual aims to improve the capability of therapists to deliver CBT to individuals with roots in the English-speaking Caribbean. It has been written for therapists with a background in counselling, nursing, psychiatry, psychology, social work and other helping professions. It is also recommended that potential users of the manual have basic therapy skills in interviewing and building a working relationship, a sound knowledge of the fundamentals of CBT, cultural awareness, and an understanding of the cross-cultural dynamic. For maximum effectiveness, therapists should be fully versed in f cognitive-behavioural therapy before attempting to implement the recommendations in this manual. For more information on standard CBT theory, process and interventions, and training opportunities, please refer to the following texts and websites:

- 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

This manual is intended as a resource to help therapists understand and work with the complexities and subtleties that can arise in the delivery of CBT to English-speaking people of Caribbean heritage. While there is no simple formula for providing effective culturally competent therapy, this manual offers general background information about the English-speaking Caribbean population in Canada, and recommendations for therapeutic stances, interventions and tools that may assist therapists in facilitating successful treatment outcomes with clients from this population.

The chapters in this manual outline how CBT can be delivered in a manner that is more relevant to and consistent with the cultural values and life context of the English-speaking Caribbean 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 reviews how organizations, therapists and clients should prepare to implement the recommendations and techniques outlined in this resource.

Chapter II, "Working with Clients in the English-Speaking Caribbean Communities," describes the English-speaking Caribbean population living in Canada and presents the process of CA-CBT with English-speaking Caribbean clients from beginning to end, from first contact to after termination.

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

At the end of this manual, Appendix 1 provides a supplementary reading list and Appendix 2 includes intervention tools that can be used as client handouts.

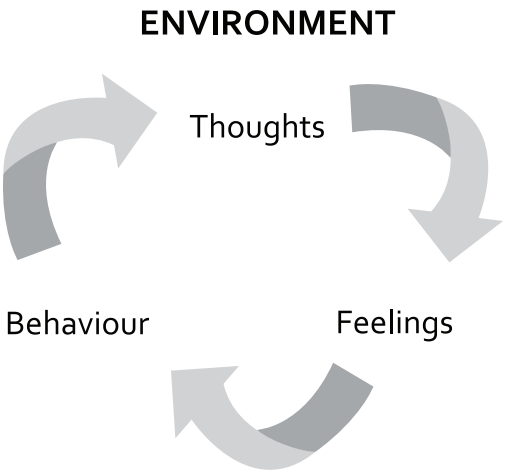
Chapter I: The CA-CBT Framework and Treatment Approach

Cognitive-behavioural therapies have certain elements in common:

- They are based on the notion that unhelpful thoughts contribute to problematic behaviours and negative emotional and physical responses that cause people problems in dealing with everyday life.
- They are designed to help clients 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 happening in the present.
- The problems to be addressed, the goals of intervention and the tasks involved in completing the therapy process are defined collaboratively between the client and the therapist, and possibly with the assistance of significant others in the client's life.

There are some additional emphases in CA-CBT. Emotional and physical states are considered together, using the word "feelings," as many cultural minority groups see the two as intertwined (e.g., Sobo, 1996). It is also important to be aware of the influence of environment on feelings, thoughts and behaviours. The environment includes events in the past and present that affect the way people think, contribute to positive and negative emotional and physiological states, and influence the way people behave. The environment also refers to the social milieu in which people interact with others each day and their experiences when dealing with institutions such as workplaces, schools, hospitals and government agencies. These interactions and experiences all affect feelings, thoughts and behaviours.

Figure 1. Cognitive-Behavioural Explanation of Symptoms



Although many cognitive-behavioural manuals have been developed for the treatment of specific mental illnesses such as social anxiety, depression, posttraumatic stress disorder and psychosis, this CA-CBT manual differs from these in that treatment is not primarily guided by diagnoses. Instead, work is directed to finding ways to "unlearn" thoughts and behavioural patterns that are causing problems and replace them with thoughts and behaviours that will promote health and well-being.

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

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

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

1. What category of intervention is required to address this client's presenting problems?
2. What specific intervention is a good fit for this client's personality, abilities and preferences?
3. What content from the assessment and conceptualization should be drawn upon for these interventions, so that the therapeutic interventions are transferable to real life situations?

The therapist should be able to offer the client recommendations in these areas, but ultimately, these are questions that will be answered in collaboration with the client. The protocol may be shorter or longer depending on clients' needs.

Preparation for CA-CBT

The Organization

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

Cultural Competence and Safety

Cultural competence is a term often used to refer to a set of knowledge, skills and attitudes that help a clinician or a service offer equitable treatment to their diverse populations. The Mental Health Commission of Canada has promoted the concept of cultural safety as a new cultural competency. This concept calls attention to the social and historical status of certain groups within a society and the implications that status has for how they perceive their interactions with individual mental health care providers and institutions (Polaschek, 1998). The aim is to draw attention to the fact that clinical encounters occur in a social and historical context. 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 refers to the experience of some ethnic minorities, recognizing how colonial and neocolonial practices have affected contemporary interactions between groups and the social status of ethnic minority groups in a multicultural context (Anderson et al., 2003). The term also recognizes how a long history of economic, educational and political inequity contributes to present-day health and social disadvantages among ethnic and racial minority populations. Though the concept of cultural safety was originally developed for indigenous populations, its extension to marginalized groups is useful (Baker, 2007). In CA-CBT, the notion of cultural safety draws attention to power dynamics that arise from ethnic and racial minority status, the dominance of Eurocentrism in health care organizations, the under-representation of racial/ethnic minority groups as providers of health care, and the historical and contemporary power relationships that exist because many immigrant

groups originate from countries that have been colonized by European nations. It thus speaks directly to the issue of power.

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

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

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

For more information and resources about what organizations can do to enhance service delivery to English-speaking Caribbean and other underserved communities, please refer to:

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

The Therapist

Given that the social history of English-speaking Caribbean populations is marked by oppressive power dynamics (e.g., colonization, slavery, racism), English-speaking Caribbean clients may have a healthy suspicion of their therapist. For example, some English-speaking Caribbean clients may be particularly attuned to indicators of perceived racial bias, or have an awareness of racial privilege that may foretell racist or "colour-blind" attitudes among therapists of dissimilar racial origins. Other English-speaking Caribbean clients may feel mistrustful of same-race therapists who are perceived to overplay or deny their ethnoracial heritage (Comas-Diaz & Jacobson, 1991).

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, they 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 reflected in the findings of studies examining the influence of therapist-client race matching on treatment outcomes, which 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 (Maramba & Hall, 2002; Sue et al., 1991).

The therapeutic relationship is an essential ingredient for a positive treatment experience and has been identified by clients, irrespective of their racial and ethnic background, as the most beneficial element of treatment (Hwang, 2006; Norcross & Lambert, 2005). Accordingly, in order for clients from English-speaking Caribbean communities to achieve therapeutic benefits, it is likely more important for them to be matched with a therapist who can demonstrate sensitivity to their sociocultural realities and personal circumstances, and engage in respectful but informal ways of relating, than to be matched with a therapist of the same racial or ethnic background.

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

- 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

Setting up a Supervisory Relationship

Therapist supervision is strongly recommended when engaging in CA-CBT. Especially for less experienced therapists, a supervisor can provide support and ensure that CBT methods are being applied competently, and monitor the therapist's provision of culturally safe care. Supervisors are ideally more experienced with using CA-CBT methods. However, peer supervision, in which therapists discuss their 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, given the resources available.

The Client

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

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

- extending 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
- extending office hours outside conventional work hours (i.e., evenings, weekends) to accommodate work and child care commitments
- providing child care services or child care expense reimbursement to facilitate access by clients with young children
- seeking partnership with community agencies, as community settings may be preferable to attending appointments at a hospital or mental health centre
- engaging places of worship, primary care settings and community centres in mental health promotion campaigns aimed at improving knowledge about mental health 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 counseling; 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).
- Clients from ethnic minorities have been found to be more likely to utilize mental health service centers with greater presence of ethnic minority staff (Wu & Windle, 1980). Perhaps ethnic minority staff should be actively recruited to improve the attractiveness of mental health facilities for ethnic minority clientele. Efforts should be made to employ these staff in diverse capacities to avoid perceptions of tokenism.

Chapter II: Working with Clients in English-speaking Caribbean Communities

Introduction

English-speaking Caribbean Communities in Canada

The following are some general facts about English-speaking Caribbean communities in Canada:

- English-speaking Caribbean communities in Canada include people with ancestral origins from different countries in the Caribbean, also referred to as the West Indies. Approximately 42% of English-speaking people of Caribbean heritage living in Canada identify their cultural background as Jamaican. Other backgrounds commonly found in English-speaking Caribbean communities in Canada are Guyanese* (10%), Trinidadian/Tobagonian (10%) and Barbadian (5%). Some may choose to refer to their cultural background in more general terms such as West Indian (12%) (Statistics Canada, 2007).
- Immigration from the Caribbean region to Canada is relatively recent. Only 2% of Caribbean immigrants living in Canada arrived before 1961, with the largest increases in immigration happening since the late 1970s/early 1980s (Statistics Canada, 2007).
- The Canadian population of Caribbean origin is largely concentrated in Ontario and Quebec, with the majority of people living in the urban centres of Toronto and Montreal (Statistics Canada, 2007).
- Most English-speaking people of Caribbean heritage identify themselves as religious and belong to a Christian faith group (Statistics Canada, 2007). For a number of them, their faith and church attendance are significant parts of their emotional and social lives (Waldron, 2003).
- English-speaking Caribbean families are heterogeneous in structure, consisting of diverse living arrangements and child-rearing practices (Calliste, 2003). Canadians of Caribbean origin are more likely than any other Canadian ethnic group to be living in single-parent families (Statistics Canada, 2007).
- It is not uncommon for families to migrate in stages. Usually mothers come first to establish themselves financially, physically and psychologically, and then send for children who have been left behind with extended family. The period of separation and subsequent reunification can be very stressful for parents and children (Barwick et al., 1996; Lashley, 2000; Pottinger et al., 2008; Smith et al., 2004).

* While Guyana is geographically part of South America, it is culturally part of the anglophone Caribbean.

English-speaking Caribbean community members consulted in the development of this manual reported that:

- high 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, nervous problems, feeling bad, feeling pressured, feeling low-spirited and feeling 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.

Those consulted in the development of this manual identified immigration and settlement-related issues as a significant stressor affecting the community, specifically:

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

For further reading on English-speaking Caribbean populations in Canada and internationally, please review:

- Model, S. (2008). *West Indian Immigrants: A Black Success Story?* New York: Russell Sage Foundation.

Engagement of English-speaking Caribbean Populations

Psychotherapy studies examining treatment outcomes among clients of African descent identify higher rates of early termination 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. This may last up to two to three sessions, until the client is satisfied that his or her 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 move to actively engage clients from the very beginning of therapy (Gibbs, 1985).

CA-CBT interventions differ from conventional CBT in that an extended period for engagement of English-speaking Caribbean clients is recommended. The engagement process is extended so that clients from English-speaking Caribbean 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 to establishing the collaborative working alliance so important to the success of CBT treatments. The engagement process begins with the first contact that clients may have with the therapist or treatment centre, and continues through the first and second sessions.

First Telephone Call

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 clients via telephone before the first session. This way, clients will have a better idea of the person they will be meeting, which may increase their comfort level when attending the first session.

The first telephone call may be an important first step for developing the working alliance and should be treated as more than an administrative task: it is the beginning of the treatment process. Tasks for the first phone call include confirming the first appointment and providing clear directions about where the meeting will take place and what will occur. 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 clients that they will be asked to fill out some paperwork when they come to the session, similar to when they fill out forms for the first appointment with a doctor or dentist. The client can be asked to arrive early to complete the forms, or this time can be incorporated into the total time reserved for the first session.

CA-CBT: Building a Working Alliance

A strong working relationship is vital to CA-CBT because the therapist may be working with 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. The client's perceptions of being respected and supported in a warm, positive relationship will make a tremendous difference in whether he or she remains in treatment, and will be able to withstand the challenges that will arise when difficult emotions and experiences are evoked in the therapy.

There is a marked history of mistrust between the English-speaking Caribbean communities and health and social services. 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. According to the English-speaking Caribbean clientele who were consulted in the development of this manual, English-speaking Caribbean clients may be wary of situations in which they could involuntarily be put under the scrutiny of these government agencies. Therefore, it is important to talk with clients about confidentiality—and to recognize that clients may be reluctant to open up at first, until they are sure they can trust the therapist.

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

Session 1: Greeting and Assessment

In the Waiting Room

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

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

In the Office

Members of the English-speaking Caribbean 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 (i.e., 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 he or she is being heard and respected; therefore, make efforts to maintain eye contact and remain verbally and non-verbally responsive to what is being said. In later sessions, note-taking should be reserved for after the session so the client feels like he or she has the unbroken attention of the therapist.

The Working Alliance

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

According to the members of the community consulted in the development of this manual, English-speaking Caribbean clientele may be wary of a therapist who presents himself or herself as an authority figure. Therefore, it may be particularly important for the therapist to emphasize the collaborative

nature of their work together and encourage clients to express their opinions, even if they disagree with the therapist. English-speaking Caribbean clientele may also prefer therapeutic interactions that are more casual and intimate than "professional." Exhibiting a sense of humor may contribute to building the alliance, but be cautious in deciding when it should be used—follow the client's lead.

Self-disclosure by the therapist can also help to build a working alliance (Knox & Hill, 2003). In early sessions, this may mean sharing some information about cultural background to help the client understand where he or she may have commonalities with the therapist. In later sessions, the therapist may disclose personal experiences that are relevant to the client's situation, but this must be done carefully. Self-disclosures can help a client feel like he or she is 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 English-speaking Caribbean 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 he or she is being unfavourably compared to the therapist (Constantine & Kwan, 2003).

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 clients 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 that clients are fully informed about the process and agree with the goals and tasks involved.

Assessment

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

In CA-CBT, assessment is used to gather:

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

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

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

The CA-CBT assessment combines elements of a typical clinical interview with an ethnocultural interview aimed at exploring whether the clients' 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 clients' problems and consider how to integrate this information into the conceptualization of the clients' problems and their interventions. Areas to gather information include the following:

Identity

- name, age, gender
- racial and ethnic background, languages spoken, acculturation
- religious and spiritual practices
- work, education
- nationality, immigration history and status (if applicable)

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, etc. 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 13). Any surprises? Most bothersome symptoms?
  - Any thoughts about death or suicide?

Personal Context

- current living situation
- previous living situations / where person grew up or spent most of life
- relationship status, children
- 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
- 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 he or she should be doing, etc.
- hopes for outcomes from treatment

Non-Verbal Observations

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

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

- McGill University Cultural Consultation Service Guidelines for Cultural Assessment and Cultural Formulation (www.mcgill.ca/ccs/handbook/assessment/cfa/)
- 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* (pp. 67). San Francisco, CA: Jossey-Bass.

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, but could also include speaking to a family member or friend who may be able to provide additional information. Speaking to other people in the client's life can help to evaluate the extent to which the client is experiencing difficulties or how his or her 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 the depression.

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 very valuable to an assessment, but will also provide information about the client's social network and who, if anyone, he or she trusts to include in the treatment process.

Given the high level of stigma in English-speaking Caribbean communities, it would not be unusual if the client declines to involve any family members or friends in his or her 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 to problem-solve or help the client to develop certain skills. However, assure the client that it is completely acceptable to decline permission for others to participate.

At the end of the assessment interview, the therapist summarizes what has been discussed. This can be done by writing down a "problem list." This list will be useful for sharing with clients at various stages in the treatment. In addition, creating a summary gives clients an impression of whether they have been heard and understood, and provides the opportunity for them to clarify, add, set priorities or delete items. It can also be a first step toward clients seeing problems as tangible and manageable.

The therapist should end the session letting the client know that the notes will be reviewed and discussed at the next session. The client should be told 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.

This client may have had to go to great trouble to find time to attend this session, and may 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. Clients should be thanked for their time and told that the therapist is 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 English-speaking Caribbean communities (Schreiber et al., 1998). Clients 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 be more effective in dealing with daily situations.

In our focus groups we encountered clients in English-speaking Caribbean communities who were concerned about how coming to therapy affects their feeling like a "strong Black man" or a "strong Black woman." These images have sustained Black communities through many difficulties but 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 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 First Experience with "Homework"

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

Some clients in English-speaking Caribbean communities may not respond positively to the idea of being assigned homework if that is how it is presented. 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. We found more success when homework was presented to clients as a type of exercise or journalling that they do between sessions. The therapist should explain that doing these exercises will increase the effectiveness of the therapy work.

Although the first session is too early to identify the specific skills clients must develop, it is not too early to send the message that they can be doing things between sessions to promote health. At the next session, therapists should ask clients what it was like to do the recommended therapeutic exercise. This will provide further information about their capacity to complete homework assignments, and may identify barriers and resources that will affect success with homework in the future. For clients in the English-speaking Caribbean communities, it can be particularly valuable to try out a homework 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. 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 some 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, the assessment and conceptualization processes are spread over at least two sessions, as opposed to the one session more common to other cognitive-behavioural models. The therapist may be able to do this in a single session if the 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 will already have a lot of information from the client and others, and 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 there has been some information provided by other sources. Extending the preliminary phase over two sessions is an opportunity to gather more assessment information while giving the therapist and the client more time to build a positive rapport and working alliance.

Session 2: 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 identifies 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 involve:

- creating a problem list that summarizes all major symptoms and problems in functioning
- proposing an underlying mechanism (e.g., core belief, assumption) that may underlie these problems
    - What do all these problems have in common?
    - What belief would a person have who is behaving this way?
    - What are the things that promote this behaviour and what consequences does this behaviour have in the client's life?

- figuring out how the underlying belief might produce the problems listed
- reviewing what led up to the current problems
    - How is the problem connected to a core belief?
    - How is the problem connected to the client's social circumstances?
    - How is the problem connected to environmental conditions for the client?
- reviewing potential origins for the core belief in past experiential, familial, social or environmental situations
- considering potential psychological, social and environmental processes that may present barriers in treatment.

Clients can present with a long list of problems and experiences that may make it daunting to identify one core belief linked to them all. It is usually the case, however, that the presenting problems can be clustered together so that it is possible to identify a set of mechanisms that accounts for several of them. At this point, the therapist is trying to establish a starting point for treatment—this may be modified later based on 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 clients 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 homework assignment. Clients should be encouraged to decide which areas they would like to target during the treatment session. This problem list, or a less structured one developed with the therapist, should be revisited periodically throughout treatment to evaluate progress and revise goals. An example of a structured problem list can be found in Appendix 2, Handout 2: Problem List.

At its most basic level, the conceptualization describes the relationships between automatic thoughts, feelings and the actions that people take. It can help to explain to clients 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 clients 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?

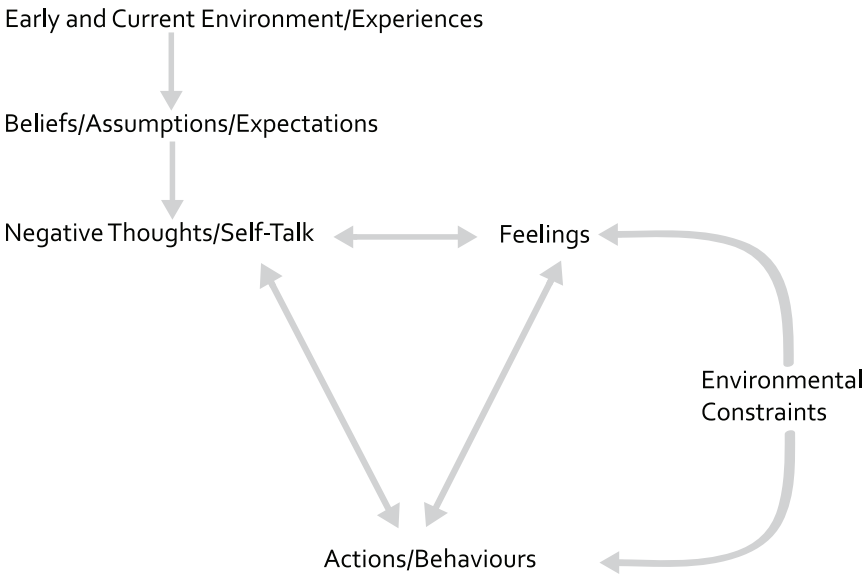
- What do other people notice when you are stressed?
- What aspects of your life are affected by stress? What aspects aren't affected?

Review this with the client at the next session, helping the client to make connections between positive and negative cycles in his or her life. This exercise can also be done in the session by having the 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 that clients have for taking action and expressing feelings in a way that promotes health.

Figure 2. CA-CBT Conceptualization



Identifying cognitions that may benefit from restructuring and behavioural experiments can promote new skill development. Both cognitive restructuring and positive skill development will promote positive changes in emotional and physical symptoms. Treatment should also be geared to helping clients with the concrete difficulties they are experiencing in their daily lives, as the environment plays a strong role in driving clients' 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 his or her 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 increase the sustainability of the interventions put in place to deal with the client's problems. Clients may approach treatment expecting to be told they are sick, abnormal or deficient in some way. A CA-CBT conceptualization must deal with this directly. Emphasizing the strengths and resources that clients have can be therapeutic in itself, because people often lose sight of the resources they have in times of stress and distress or after countless experiences of feeling disempowered. Clients need 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:

- 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 homework assignment if there was one. The therapist will then move to setting the agenda, but for this session, the main agenda item is to give the client feedback from the assessment and case conceptualization.

The conceptualization is not finalized until it is shared with the client. The therapist will present his or her hypothesis to the client so that the treatment plan can be discussed collaboratively. Collaboration is key to this process. Collaboration strengthens the therapeutic alliance by ensuring that the work being done is based on shared understanding of, and agreement about, the goals and tasks of treatment. It also increases the likelihood of success, 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. reviewing client strengths
2. reviewing the client's problem list
3. sharing and discussing the conceptualization
4. reviewing treatment options.

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

- Ensure that you point out clients' 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; clients can add or eliminate items as needed.
- Give specific examples of the links between thoughts, feelings and behaviours, using clients' language and stories. Again, diagrams may help to explain the connections more clearly.
- Check that the conceptualization fits with clients' views of the problems and make modifications based on the clients' 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 clients for dealing with their problems.

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

Clients in English-speaking Caribbean communities may have a strong negative reaction to recommendations that medications may be useful as an alternative or adjunct to therapy. Some people in these communities perceive medication as being suitable only for those who have a severe mental illness or are too lazy to work on their problems; or believe that medications are likely to cause more harm than benefit. With this in mind, the therapist can expect that there will be resistance to the idea of considering medication and of seeking a medication consultation, but discussing it as an option can be an opportunity to dispel misconceptions about what taking medication might mean for the person.

Aligning CBT Goals with Cultural Values

Part of the informed consent process involves discussing with clients how culturally adapted CBT has been designed to be culturally appropriate and consistent with their cultural values. They need to understand how interventions are tailored to people in their ethnocultural community, with the expectation that this adaptation will enhance the therapy's effectiveness. For clients in English-speaking Caribbean communities, 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 clients 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 he or she thinks resonates with members of English-speaking Caribbean communities. Therefore, a good way to engage clients can be to emphasize how they will learn to take control of their emotions and life situations by strengthening their ability to mobilize positive thoughts and decrease unhelpful thinking. Interventions designed to increase social connections are also culturally consistent because they build on cultural values of connectedness and interdependence. Reminding clients that these are reasonable goals and supports, which they would provide for other people, can be a way of engaging them in such strategies.

At its most basic, the goal of CBT is symptom reduction. CA-CBT is also focused on reducing people's symptoms, but as a path toward achieving culturally supported goals, such as personal contentment and more positive relationships. Therapists need to make the connection between symptom reduction and these goals so clients do 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 the client to connect with the CBT material.

A 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 eight–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 the 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, 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 that this will have 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 excerpt, 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 issues:

- *Environmental experiences contributing to depression*: Work schedule, job stress and interpersonal tension with supervisor, conflict with husband and daughter
- *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 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.

A preliminary treatment plan for Liz may look something like this:

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 3 to 9: Teaching the Core Skills

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

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

The therapist should tell clients about this procedure for the sessions as part of preparing them for the first active treatment session. Remind clients 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. There will be a more formal checking-in about progress made on homework and skill development later in the session; at this point, checking in is designed to facilitate rapport and engage the client in the process. The therapist should have recently reviewed the client's file to ensure that he or she can check in with attention to specific realities in the client's life; for example, inquiring about the well-being of significant people in the client's life, or asking about a recent event the therapist knows is important to the client. Clients from English-speaking Caribbean communities may also want to check in with the therapist to make the interchange feel less one-sided; think ahead about what kind of information you feel comfortable sharing and what can be shared without distracting from a focus on the client and the problems that brought him or her to session.

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

An important aspect of check-in, particularly in the first active treatment session, is to check how clients feel about the feedback they have received about their problems. Clients 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 clients' 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 clients' beliefs about the potential for change has an impact on treatment outcome. Checking in about how clients believe the process is working for them is an important opportunity to correct any

misconceptions they may be having, foster hope and encourage positive actions and attitudes they are bringing to the process.

Reviewing "Homework"

Next, the therapist checks in with the client about his or her experience completing the exercises or practice activities recommended the week before. Successes and problems with the exercise are discussed in detail—including barriers that may have arisen to prevent the 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 to establish the skill-building that will be addressed in the session.

Setting the Agenda

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

Psychoeducation

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

At this stage, psychoeducation can be used 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 him or her know that many people share the same kind of difficulties under the same type of experiences. This discussion will help to further inform the client, but can also help to build engagement and rapport by demonstrating that the therapist is listening closely to the information the client has provided.

This is also an opportunity to review the treatment plan with the client, orienting him or her to what will be the general process over the next 10 sessions. The therapist can review the goals of treatment and what types of tasks will be used to achieve those goals. It is a good time to talk about the length of the treatment program, ensuring the client knows that there is flexibility to allow for earlier termination or to add a few extra sessions. If a 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 a total of 12 sessions. For clients who are less able to access their thoughts and feelings, are lower functioning, have more acculturative stress (e.g., underemployment; housing, financial, family separation, immigration issues) or have less education, it may require 16 to 20 sessions to provide them with adequate time to learn the material, to address unexpected comorbidities that may be impacting the treatment, or complete the interventions.

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

It is not too early to start talking about termination, alerting the client to the plan to use the last few sessions for preparing the client to maintain the gains made in treatment.

Skill Development

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 he or she would like to use to build skills for dealing with it more effectively. The conceptualization and treatment plan should prepare the therapist to have a repertoire of potential interventions to use based on what content the client brings to a session.

Assigning "Homework"

The session can be used to practise skills that will be the basis for homework or to work with clients 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 clients are feeling overwhelmed, the therapist could let them use the session for doing this kind of work and then develop a homework exercise that is less demanding on their time and energy.

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

Closing the Session

Therapists should close sessions by reviewing the work that has been done in the session, tying it to the overall goals of the treatment. Both the 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 10 to 12: Termination

Because CBT interventions are time-limited, there is a great deal of emphasis on preparing clients to learn skills that they can practise on their own. In sessions 3 to 9, the therapist should have been regularly reminding clients 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 assistance of the therapist. For the therapist, the time limit should be a reminder to continually evaluate each session in terms of its utility in progressing toward the treatment goals.

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, they can be discussed with clients 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 he or she has 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. It may be important for the therapist to evaluate, with someone else, if his or her 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 clients after termination. In CA-CBT, it could be culturally inconsistent to suggest that there should be no future contact between client and therapist because there has been a therapeutic relationship. 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 clients after termination, but should not discourage clients 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 that the client is continuing to depend on the relationship because he or she lacks confidence about being able to be on his or her own. Accordingly, an important task of termination is to help the client establish that confidence and help the client to determine the difference between normal difficulties he or she might face after termination and situations in which it may be advisable to seek further help.

Preparing Clients to Be Their Own Therapist

Part of preparing clients for termination is building their confidence for picking and using strategies to deal with everyday stressors. This process is started by always collaborating with clients in decisions about what skills are to be learned and how and where they should be applied. As the treatment progresses, clients should be assuming more leadership in this process, building on their growing familiarity with the techniques and knowledge about themselves and their environments from their experience doing the homework exercises. The problem list and/or the conceptualization developed at the beginning of the treatment can be used to guide later sessions, with the therapist asking clients 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 clients are coping successfully with situations that were previously distressing. Together, the therapist and the 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 his or her 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 clients' growth by helping them think through options and evaluate alternatives. If a plan needs some improvement, guide clients to appropriate changes by asking questions that will get them to work through the possibilities, their pros and cons, etc.

The therapist can orient clients 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 clients would address them is another concrete way to demonstrate to clients that they have made progress in being able to face difficult situations. Clients may also provide situations during check-in that can be used as examples of growing competence.

In all of these ways, the therapist should be communicating the confidence that he or she has in clients' ability to move forward positively. Clients will benefit from receiving positive reinforcement from the therapist, but it is even more important for the therapist to call clients' 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.

Reviewing Progress

It's easy for clients to lose sight of the progress they have made during the sessions so the therapist must help them to see how far they have come. This can be done informally by discussing the issues that first brought the 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 clients to recognize the work they have done.

Setting Future Goals

Clients may be inclined to see the termination of treatment as the end of the work they are doing on themselves; to counter this, setting future goals will help to communicate that they are in a lifelong process of improving themselves and their relationships. The termination sessions are a good time to talk about how accomplishments made during treatment can be generalized to other situations. These final sessions can also be used to set goals in new areas, with discussion of how skills they have learned can be adapted to these new situations. In either case, the therapist will be encouraging the 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 that they are available in times of increased pressure or stress.

Setting 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 them to recognize that they have a repertoire of skills and resources available to them that they may

not have had before or used effectively before. Now, they are in a position to help themselves in times of stress and, with regular practice, may even be able to prevent emotional distress and depression. Even so, there may be times that those skills and resources get overwhelmed, so clients also need to know what to do in particularly difficult times.

Discussing What to Do if Symptoms Return

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

Termination is a good time to talk with clients 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. Clients 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 clients about who else in their life can be part of a plan to promote mental health and prevent future relapse. Encouraging clients 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. Clients should also know that they can check in with the therapist as well. The therapist may be able to provide perspective on what is going on with the client and reinforce strategies learned during the treatment, suggest a booster session, or recommend resuming treatment.

Ultimately, clients should be helped to put together a plan for staying well and responding to changes in their mental health. This plan should include health promoting activities, identified social supports and resources and contacts they can access if they experience difficulties.

Terminating Treatment: When Is the Right Time?

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

If a 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; for example, failure to develop a working alliance or poor engagement with the treatment process. Although such a situation can be disappointing for both therapist and 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, clients are not ready to benefit from treatment because their life situation is too chaotic or they have not reached a stage of readiness for change. Terminating therapy and encouraging clients 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 was 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 require setting new goals and implementing new interventions. Extending the treatment four or five more sessions may be sufficient. Alternatively, booster sessions may be sufficient if the client simply needs more time to build confidence in using newly acquired skills.

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

Clients 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 clients becoming less forthcoming toward the end of the treatment, as they mentally prepare to move forward without the therapist's support.

With this in mind, the therapist should encourage discussion of the ambivalence about ending the sessions. This may be another time when it makes sense to revisit the idea of what it means to be "strong" and how that does not include not seeking help when needed, or not ever having any problems again. Reinforce the strength that is demonstrated by taking care of oneself and how this contributes to important goals such as being a strong member of one's family and community.

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

Chapter III: CA-CBT Interventions

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 clients to track their feelings, thoughts, and behaviours—can help raise their awareness. The therapist should review a past situation to show clients how to monitor their feelings, thoughts and behaviours, and then provide them with handouts so they can do their own self-monitoring between sessions.

Identifying Feelings and Thoughts

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

Often people feel poorly because they have trouble identifying their feelings and expressing them. When they hold feelings inside, it makes them feel emotionally and physically unwell. Often the physical sensations—tension, fatigue, headaches, stomach aches—are more noticeable to us than our 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 clients 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 clients notice how their thoughts affect their feelings. It can be a valuable exercise to have clients 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 has been made available in Appendix 2, Handout 5: Noticing & Exploring Self-Talk. Practise this with the client, and then suggest he or she try doing it independently between sessions.

Cognitive Restructuring

Cognitive Distortions and Myths

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

- *All-or-nothing thinking*: Thinking about bad events in terms of them "always" being true, or good events "never" happening or a bad situation staying that way "forever" (e.g., "Nothing good ever happens to me")
- *Overgeneralizing*: Taking a single negative event and assuming it is true all the time (e.g., "All 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*: Rejecting positive statements from other people (e.g., responding to a compliment on your work with "It must have just been luck")
- *Jumping to conclusions/catastrophizing*: Seizing on one piece of information to conclude that the worst has happened (e.g., 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.)
- *Fallacy of change*: Believing that you can change others when, in fact, you can only change yourself or thinking that everything will get better for you if someone else changes (e.g., believing that your love or effort can stop someone from doing negative things)

- *Fallacy of fairness*: Feeling resentful because you think you know what is fair but others will not agree with you (e.g., thinking that your partner should do more to help with the housework because he should see and appreciate what you do)
- *Fortune-telling*: Believing that you know ahead of time how something will turn out (e.g., not wanting to go 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)

Therapists need to be careful about labelling these thought patterns as cognitive *distortions* because clients may perceive this as implying that all of their problems are "in their heads." This may be particularly true among clients from English-speaking Caribbean communities 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).

What we call cognitive distortions are unrealistically negative thoughts that have been learned in negative situations. Clients may have learned this way of thinking from someone who judged, criticized or rejected them. Or they may have learned to think this way to cope with multiple negative experiences and situations in which they were taught to blame themselves or become distressed rather than try to change situations beyond their control or influence. Rather than talking with clients 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 clients realize that their thoughts are not based on reality and are contributing to their negative feelings and behaviours. Talking with clients about what kind of situations evoke these thoughts and where they may have come from can help them to understand the thoughts as learned ways of responding that can be replaced with new learning that will promote more positive feelings and behaviours.

Clients may identify with the notion of having been taught ideas that were wrong and corrosive, as this interpretation resonates with the way many people of Caribbean heritage experience the school system in Canada and elsewhere (Dei et al., 1997). The idea that they have been given distorted information and now have an opportunity for replacing that with more realistic and balanced information may be used to engage clients 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 clients apply in everyday situations. Clients benefit 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 clients 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 clients how these negative thoughts are connected to negative feelings (e.g., being afraid, unsure or stressed) and negative behaviours (e.g., getting angry, giving up or blaming others). This can open their eyes to how changing that self-talk can similarly promote changes to more positive feelings and behaviours.

You will repeatedly be helping clients to make connections between their emotions (A = affect), their behaviours (B = behaviours) and their thoughts (C = cognitions). Presenting a simple figure linking these three elements and providing clients 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 clients to understand that negative self-talk is usually automatic—it happens so fast and so smoothly that the person is barely aware of it, but does feel the negative effects. Negative self-talk usually takes the form of:

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

Negative self-talk has to be actively countered by positive self-talk. A first step is to identify when negative self-talk is happening, and then learn to challenge these thoughts with positive, supportive statements. Clients 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 clients to identify a negative thought, evaluate it and then replace it with positive self-talk. Clients 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 himself or herself as a creation of God, or family-oriented values may challenge cognitions that suggest a client's family may not care about him or her.

Positive self-talk should:

- begin with an "I" (this reinforces the client's ability to manage his or her 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.").

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.
Or		
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 post-it 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 homework exercise is to have people practise modifying their thoughts between sessions. Clients are given a piece of paper with two columns. In one column, they record when they have had negative self-talk or unrealistic negative thoughts. In the other column, they write down positive counterstatements. This exercise will help teach them a three-step process for promoting health:

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

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

Behavioural Experiments

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

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

1. Work with the client to describe the situation and what he or she anticipates will happen when trying out this new behaviour. Focus on the thoughts and feelings associated with the situation.
2. Work with the 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 his or her 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.

In Appendix 2, Handout 8: Your Experiment, you will find a worksheet that can be used to help clients 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 clients 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. Clients may think that they have very few options, until they learn through this process to recognize a fuller range of choices.

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

Clients should identify a problem they would like to try solving. Content that is discussed during the check-in or homework review may identify a problem linked to the treatment goals, but clients should choose the example that will be used 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 clients 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 they can be practised almost anywhere and can be used whenever the client feels stressed or tense.

Abdominal Breathing

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

Yoga Breathing

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

Progressive Muscle Relaxation

Progressive muscle relaxation is another exercise that can teach 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. Clients may find it helpful to do this exercise while listening to a recorded guide; ideally, the agency can provide CDs with recorded instructions. Clients with access to computers can also download progressive muscle relaxation audio instructions. There are several available online without cost through iTunes or at websites such as:

- www.lulu.com/content/474829
- www.allaboutdepression.com/relax/
- www.archive.org/details/CandiRaudebaughProgressiveMuscleRelaxationwithKeywords_withmusic_

When teaching this exercise, the therapist should have a script available to take the client through the relaxation sequence. Some readily available online sites include:

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

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

> *You will do each muscle group once, but feel free to repeat an area if it feels especially tense or tight. This exercise will take about 20 to 30 minutes.*
>
> *For each muscle group, hold the tension for five to 10 seconds, then release for 10 to 20 seconds. You should not feel any pain when you are tensing the muscles. As you exhale, imagine the tension in your body flowing away. Picture the muscle becoming smooth and loose after you release the tension.*
>
> 1. *Take three deep abdominal breaths, exhaling slowly each time. Picture tension flowing away from your body as you exhale.*
> 2. *Fists: Clench, holding them for 10 seconds, then releasing for 20 seconds.*
> 3. *Biceps: Tighten by drawing your forearms toward your shoulders, as if you are "making a muscle."*
> 4. *Triceps: Tighten by extending the arms out straight and locking your elbows.*
> 5. *Forehead: Tighten by raising your eyebrows as high as you can.*
> 6. *Eyes: Clench your eyelids tightly shut.*
> 7. *Jaw: Open your mouth as wide as you can, as if you are yawning.*
> 8. *Neck: Pull your head back as if you are going to touch your head to your back.*
> 9. *Shoulders: Raise your shoulders up toward your ears.*
> 10. *Shoulder blades: Bring your shoulder blades together in the back.*
> 11. *Chest: Take a deep breath and hold it.*
> 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 of evoking a sense of peace and distracting yourself from negative or anxious thoughts. Help clients to design a visualization that is unique to them—perhaps a place they remember, or a place where they have always wanted to be. Do not restrict them to places that are realistic; for example, they can imagine themselves floating in a bubble, or suspended underwater. Help them to paint in the details of their visualization with instructions such as:

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

Meditation

Meditation can be useful for both diminishing troubling thoughts and decreasing tension in the body. Developing the discipline to focus in the present, without being pulled into judgment or worry about past or future, is a very powerful tool for diminishing the negative effects of anxiety, depression and other discomforting emotions. Meditation practices have recently received strong endorsement in the mental health field and the practice of *mindfulness meditation* is often recommended as an adjunct to treatment for mental disorders. Clients may wish to join a meditation group facilitated by someone who teaches mindfulness, or may enjoy learning mindfulness at a Buddhist centre that offers free or inexpensive instruction. Mindfulness instruction is also available in books such as Jon Kabat-Zinn's *Full*

Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness (2005), through CDs and in mp3 files, which can be downloaded free of charge at sites such as iTunes.

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

The basic outline of a meditation practice is as follows:

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

Using Prayer as a Meditation Practice

Some 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. Praying can be a palatable adaptation of meditation practice for clients who are religious.

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

A potential integration of prayer and meditation could be:

- thanking God for the time and space to speak with him or her
- praying for himself or herself
- praying for others
- thanking God for the way that prayer will benefit the client and the people around him or her.

Stress Inoculation

Stress inoculation is a technique that the therapist can use to prepare clients 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 to make a list of the negative thoughts and self-talk that emerge when facing a stressful situation.

Prepare positive, tension-reducing self-statements to use:

- before a stressful situation
- during a stressful situation
- after a stressful situation, to help clients recognize and commend themselves for having attempted to cope.

Clients 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 from English-speaking Caribbean communities who are easily intimidated in situations where they feel uncertain of themselves or disrespected by others. Other areas for social skills training may include:

- asking for help
- praising someone
- expressing anger or disappointment
- standing up for self or others
- setting limits on someone else's behaviour
- approaching someone for friendship
- seeking services.

Social skills training typically involves identifying a situation that is causing stress or distress, breaking down the aspects of the situation that are linked to the distress (thoughts, behaviours) and working with the 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):

1. socially appropriate refusals to give in to the requests of others
2. appropriate expressions of opinions and feelings
3. appropriate expressions of one's own requests.

It differs from aggressiveness in that it is not motivated by anger and it does not operate at the expense of other people's feelings or needs. In Canada, assertive behaviour is considered appropriate and necessary for functioning effectively in mainstream environments such as workplaces and government

institutions. Many 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. Unfortunately, this means that they may hold in feelings of frustration or feel powerless in dealing with situations where they are being exploited or treated inappropriately. Feeling powerless and holding in anger and frustration can be a particular concern in situations of discrimination because discrimination-related stress can contribute to mental and physical health problems (Harrell, 2000).

For English-speaking Caribbean clients, assertiveness may be a difficult issue. Historically, Black communities have been forced to withhold expressing their attitudes and feelings for fear of harsh reprisals and sometimes fatal consequences. Black people who do behave assertively are often perceived as aggressive because of racist thinking about Black people being inherently violent and dangerousness. In turn, Black people may have been taught to have a low sense of entitlement, so the idea of asserting personal rights is foreign and intimidating. Asserting themselves can be particularly intimidating if there has been a history of harsh reprisals in the country of origin and they don't know the consequences of self-assertion in this new country.

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 a 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 that 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 English-speaking Caribbean clients may perceive it as risky behaviour and may encounter others who respond very negatively to them asserting themselves.

Self-Care

Physical Exercise

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

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

Encourage clients 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 English-speaking Caribbean communities feel oppressed by the darkness and cold. Encourage clients 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. Those with poor eating habits can be more vulnerable to negative mood states. It is worthwhile to talk to clients 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 clients 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 clients about teas, tonics or herbs that have benefited them in the past and how they might integrate them into an improved diet.

Sleep Hygiene

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

1. Go to bed when you feel sleepy. Do not go to bed based on time, or other people's activities. Wait until you are showing signs of fatigue, (e.g., yawning, heavy eyes) and then head to bed.
2. Only use the bedroom for sleeping. The bedroom should not be used for watching TV, reading books, working, talking with your partner or doing anything that is not associated with sleep. The one exception to this can be sex, which may relax you before sleep. Once you are in the bedroom, turn off the light and try to go to sleep.
3. After 20 minutes, if you are not asleep, get up. It is important to not stay in bed lying awake, because you want to break the association between sleeplessness and the bed. Move to another part of the house where you can quietly relax, perhaps by reading a book or listening to quiet music. Do not eat, drink or watch TV, as these are all stimulating activities. Wait until you feel sleepy and then return to the bedroom.

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

Downtime

Often clients have little break from their stressors and need to learn to feel entitled to a break from work or other demands. With pressure to keep busy and with many demands on our time, it can feel self-indulgent to take time for ourselves. However, this attitude only contributes to our feeling more overwhelmed, undervalued and stressed. One of the most important skills that clients can learn is to take time out from work and other responsibilities to rest and recharge: this can be presented as a health practice. As much as they are able, clients should be encouraged to try to protect downtime each day, perhaps starting with as little as 15 minutes a day, and working up to one hour per day. Depending on personal circumstances, some clients may be able to work on planning downtime for one day a week or one week every three to four months. Whatever the personal circumstance, many 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. Rest activities could involve sitting in the park, listening to music or taking a nap. Recreational activities could, for example, mean playing a game, reading a book, watching a movie or going for a walk. Relationship time could be spending time with a friend, going to a social occasion or otherwise doing something that involves being with another person without a specific goal or responsibility on the agenda. Work with clients 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 leaves them feeling lost in the new environment. In *The Anxiety & Phobia Workbook* (2005), Edmund J. Bourne advocates for exploring issues of meaning and purpose in an effort to help clients find available resources on spirituality or in re-developing a sense of purpose in their lives. In CA-CBT, this can be used to help people reconnect with spiritual or cultural values that will orient them toward resilience, persistence and in endeavoring to work on themselves and their relationships.

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

Questions that can begin such a discussion include:

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

Encouraging Worship

Many English-speaking Caribbean clients will have past or current connections to church that can be mobilized as part of their treatment plan. Attending church may increase social connections and activities and help reconnect clients to deeply held spiritual values. In addition, church is often a place where emotional expression is sanctioned and, therefore, people can share their struggles in an accepting environment. For many people, the church can be a refuge, though they may lose sight of this when 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, etc. as potential components of a health promotion plan.

References

Anderson, J., Perry, J., Blue, C., Brown, A., Henderson, A., Khan, K. B. et al. (2003). "Rewriting" cultural safety within the postcolonial and postnational feminist project: Toward new epistemologies of healing. *Advances in Nursing Science*, *26* (3), 196–214.

Baker, C. (2007). Globalization and the cultural safety of an immigrant Muslim community. *Journal of Advanced Nursing*, *57* (3), 296–305. doi: 0.1111/j.1365-2648.2006.04104.x

Barwick, C., Hampson, H., & Synowski, E. (1996). Successful Adaptation of Newcomer Caribbean Youth in Toronto. Toronto: Clarke Institute of Psychiatry and University of Toronto Department of Psychiatry.

Bourne, E.J. (2005). *The Anxiety & Phobia Workbook* (4th ed.). Oakland, CA: New Harbinger Publications.

Calliste, A. (2003). Black families in Canada: Exploring the interconnections of race, class and gender. In M. Lynn (Ed.), *Voices: Essays on Canadian families* (2nd Ed). Toronto: Nelson Canada.

Comas-Diaz, L. & Jacobsen, F.M. (1991). Ethnocultural transference and countertransference in the therapeutic dyad. *American Journal of Orthopsychiatry, 61* (3), 392–402. doi: 10.1037/h0079267

Constantine, M. & Kwan, K. (2003). Cultural considerations of therapist self-disclosure. *Journal of Clinical Psychology, 59* (5), 581–588. doi: 10.1002/jclp.10160

Dei, G., Mazzuca, J., McIsaac, E. & Zine, J. (1997). *Reconstructing "Dropout": A Critical Ethnography of the Dynamics of Black Students' Disengagement from School*. Toronto: University of Toronto Press.

Dixon-Woods, M., Cavers, D., Agarwal, S., Annandale, E., Arthur, T., Harvey, J. et al. (2006). Conducting a critical interpretative synthesis of the literature on access to healthcare by vulnerable groups. *BMC Medical Research Methodology, 6* (35), 1–13. doi:10.1186/1471-2288-6-35

Gibbs, J.T. (1985). Treatment relationships with Black clients: Interpersonal vs. instrumental strategies. In C. Germain (Ed.), *Advances in Clinical Social Work Practice* (p. 188). Silver Spring, MD: National Association of Social Workers, Inc.

Harrell, S.P. (2000). A multidimensional conceptualization of racism-related stress: Implications for the well-being of people of color. American Journal of Orthopsychiatry, *70* (1), 42–57.

Henry, A. (1993). Missing: Black self-representations in Canadian educational research. *Canadian Journal of Education, 18* (3), 206–222.

Henry, F. (1994). The Caribbean Diaspora in Toronto: Learning to Live with Racism. Toronto: University of Toronto Press.

Hwang, W. (2006). The Psychotherapy Adaptation and Modification Framework (PAMF): Application to Asian Americans. *American Psychologist, 61* (7), 702–715.

Kearns, R. & Dyck, I. (1996). Cultural safety, biculturalism and nursing education in Aotearoa/New Zealand. *Health and Social Care in the Community*, *4* (6), 371–380.

Kleinman, A., Eisenberg, L. & Good, B. (2006). Culture, illness, & care: Clinical lessons from anthropological and cross-cultural research. *Focus, 4*, 140–149.

Knox, S. & Hill, C. (2003). Therapist self-disclosure: Research-based suggestions for practitioners. *Journal of Clinical Psychology, 59* (5), 529–539.

Kohn, L.P., Oden, T., Munoz, R., Robinson, A. & Leavitt, D. (2002). Adapted cognitive behavioral group therapy for depressed low-income African American women. *Community Mental Health Journal, 38,* 497–504.

Lashley, M. (2000). The unrecognized social stressors of migration and reunification in Caribbean families. *Transcultural Psychiatry, 37* (2), 203–217.

Maramba, G.G. & Hall, G.C. (2002). Meta-analyses of ethnic match as a predictor of dropout, utilization, and level of functioning. *Cultural Diversity & Ethnic Minority Psychology, 8* (3), 290–297.

McKenzie, K. (2003). Racism and health: Antiracism is an important health issue. *British Medical Journal, 326*, 65–66.

McLean, C., Campbell, C. & Cornish, F. (2003). African-Caribbean interactions with mental health services in the UK: Experiences and expectations of exclusion as (re)productive of health inequalities. *Social Science & Medicine, 56* (3), 657–669.

National Aboriginal Health Organization (2008). *Cultural competency and safety: A guide for health care administrators, providers and educators*. Available: www.naho.ca/publications/culturalCompetency.pdf

Nguyen, H.T. (2008). Patient-centred care: Cultural safety in indigenous health. *Australian Family Physician*, *37* (12), 990–994.

Norcross, J.C., & Lambert, M.J. (2005). The therapy relationship. In J.C. Norcross, L.E. Beutler, & R.F. Levant (Eds.), *Evidence Based Practices in Mental Health: Debate and Dialogue on the Fundamental Questions* (p. 208). Washington, DC: American Psychological Association.

Papps, E. & Ramsden, I. (1996). Cultural safety in nursing: The New Zealand experience. *International Journal for Quality in Health Care*, *8* (5), 491–497.

Parham, T.A. (2002). Counseling models for African Americans: The what and how of counseling. In T. Parham (Ed.), *Counseling Persons of African Descent: Raising the Bar of Practitioner Competence* (pp. 100–118). Irvine: University of California.

Persons, J.B. (1989). *Cognitive Therapy in Practice: A Case Formulation Approach*. New York: Norton.

Polaschek, N.R. (1998). Cultural safety: A new concept in nursing people of different ethnicities. *Journal of Advanced Nursing*, *27*, 452–457.

Pottinger, A.M., Stair, A.G. & Brown, S.W. (2008). A counselling framework for Caribbean children and families who have experienced migratory separation and reunion. *International Journal for the Advancement of Counselling, 30*, 15—24.

Radloff, L. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 1,* 385–401.

Sanders Thompson, V.L., Bazile, A. & Akbar, M. (2004). African Americans' perceptions of psychotherapy and psychotherapists. *Professional Psychology: Research and Practice, 35* (1), 19–26. doi: 10.1037/0735-7028.35.1.19

Schreiber, R., Stern, P.S. & Wilson, C. (1998). The contexts for managing depression and its stigma among black West Indian Canadian women. *Journal of Advanced Nursing, 27,* 510–517.

Smith, A., Lalonde, R. & Johnson, S. (2004). Serial migration and its implications for the parent-child relationship: A retrospective analysis of the experiences of the children of Caribbean immigrants. *Cultural Diversity & Ethnic Minority Psychology, 10* (2), 107–122.

Sobo, E. (1996). The Jamaican body's role in emotional experience and sense perception. *Culture, Medicine and Psychiatry, 20*, 313–342.

Statistics Canada (2007). *The Caribbean Community in Canada*. Available: www.statcan.gc.ca/pub/89-621-x/89-621-x2007007-eng.pdf

Sue, D.W. (2010). *Microaggressions in Everyday Life: Race, Gender, and Sexual Orientation*. Hoboken, NJ: John Wiley & Sons.

Sue, S. & Lam, A. (2002). Cultural and demographic diversity. In J.C. Norcross (Ed.), *Psychotherapy Relationships That Work* (pp. 401–422). New York: Oxford University Press.

Sue, S., Fujino, D., Hu, L., Takeuchi, D. & Zane, N. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology, 59* (4), 533–540.

Waldron, I.R.G. (2003). Examining beliefs about mental illness among African Canadian women. W*omen's Health & Urban Life: An International and Interdisciplinary Journal, 2* (1), 42–58.

Williams, C. & Garland, A. (2002). Identifying and challenging unhelpful thinking. *Advances in Psychiatric Treatment, 8,* 277–386.

Wood, P.S. & Mallinckrodt, B. (1990). Culturally sensitive assertiveness training for ethnic minority clients. *Professional Psychology: Research and Practice*, *21* (1), 5–11.

World Health Organization (2010). *Culture and Mental Health in Haiti: A Literature Review*. Geneva: Author.

Wu, I. & Windle, C. (1980). Ethnic specificity in the relative minority use and staffing of community mental health centers. *Community Mental Health Journal, 16,* 156–168.

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

Canadian Mental Health Association (1999). All Together Now: How Families are Affected by Depression and Manic Depression. Available: www.phac-aspc.gc.ca/mh-sm/mhp-psm/pdf/together.pdf

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

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.

0	1 2 3 4	5 6	7 8 9	10
Barely Noticed	A Little	Medium	A Lot	Most I've Experienced

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:

0	1	2	3	4	5	6	7	8	9	10
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 homework 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% true?
What is a possible alternate belief? What supports this alternate belief?
How could I test this alternate belief? (action plan)

Handout 6—Thought Record

It is advisable for the therapist to complete this exercise in session with the client, and to 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).

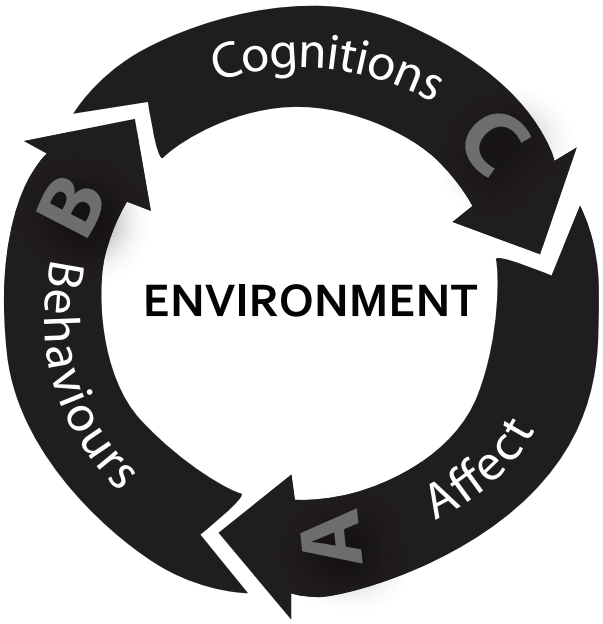
Situation: What's going on? Where are you? When did this happen? Who is with you?	
Thoughts/beliefs	
Evidence to support those beliefs	
Evidence against that thought	
Positive re-statement	
Feelings after the positive re-statement (scale 1–10)	

Thought Record (cont.)

Situation: What was going on at the time?	**Thoughts:** What self-talk or negative thoughts came to mind?	**Positive / More balanced counter-statement**

Handout 7—The A-B-C Cycle

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



Handout 8—Your Experiment

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

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

Handout 9—Scheduling Downtime

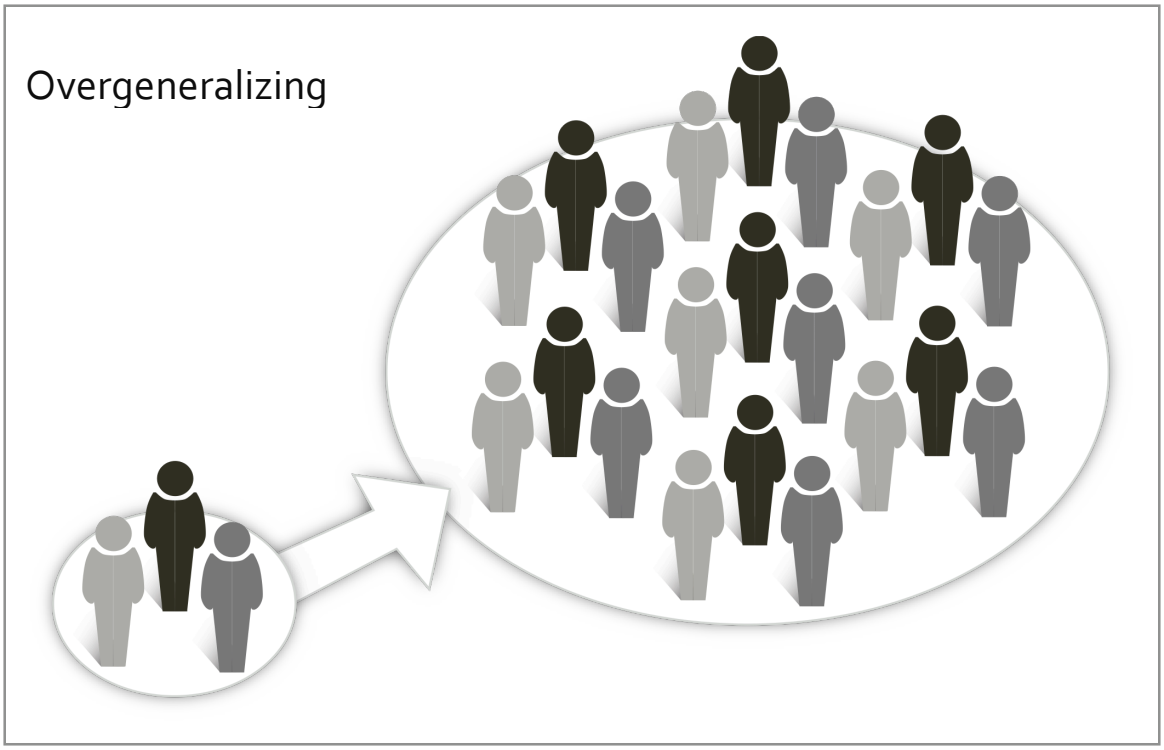
Encourage clients to schedule downtime activity, helping them to work through competing demands that could get in the way.

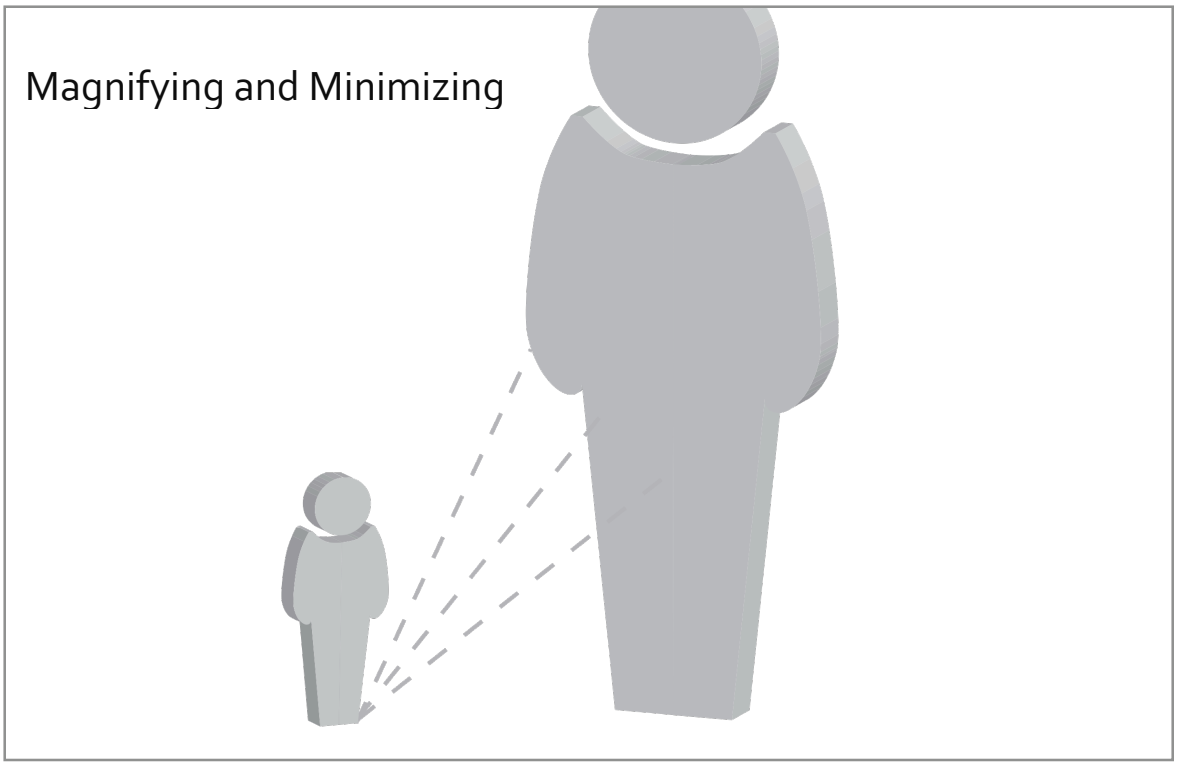
Downtime	…with 15 minutes/day	…with 30 minutes/day	…with 1 hour/day
Rest activity			
Recreational activity			
Relationship activity			

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.

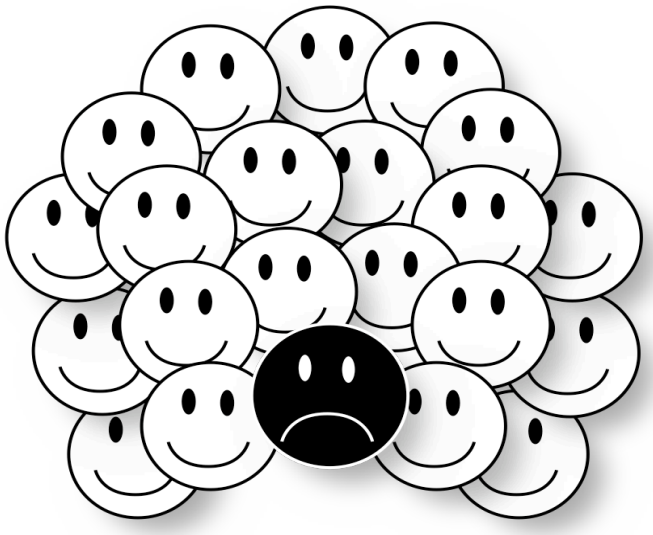
The therapist should help clients come up with examples of ways they apply distortions or myths in their lives; these distortions can be listed during a session, or used as the foundation for an exercise to be conducted between sessions. When the client is aware of these negative patterns of thinking,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


Overgeneralizing


Magnifying and Minimizing

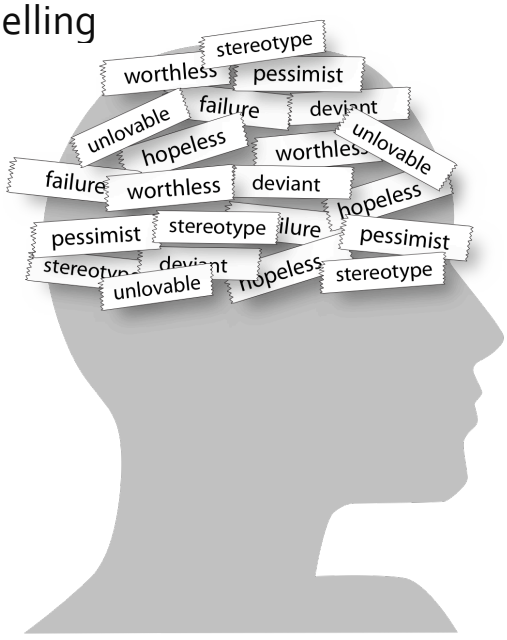
Mental Filter

Disqualifying the Positive



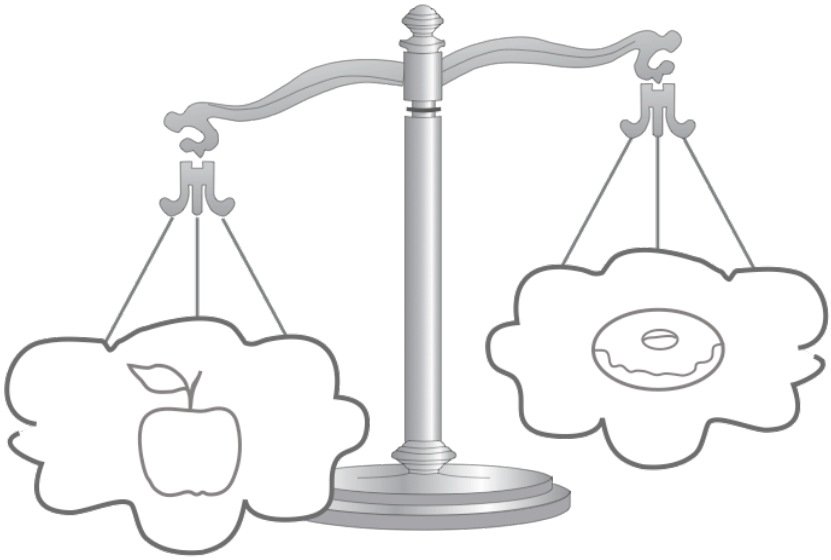
All-or-Nothing Thinking

Labelling or Mislabelling

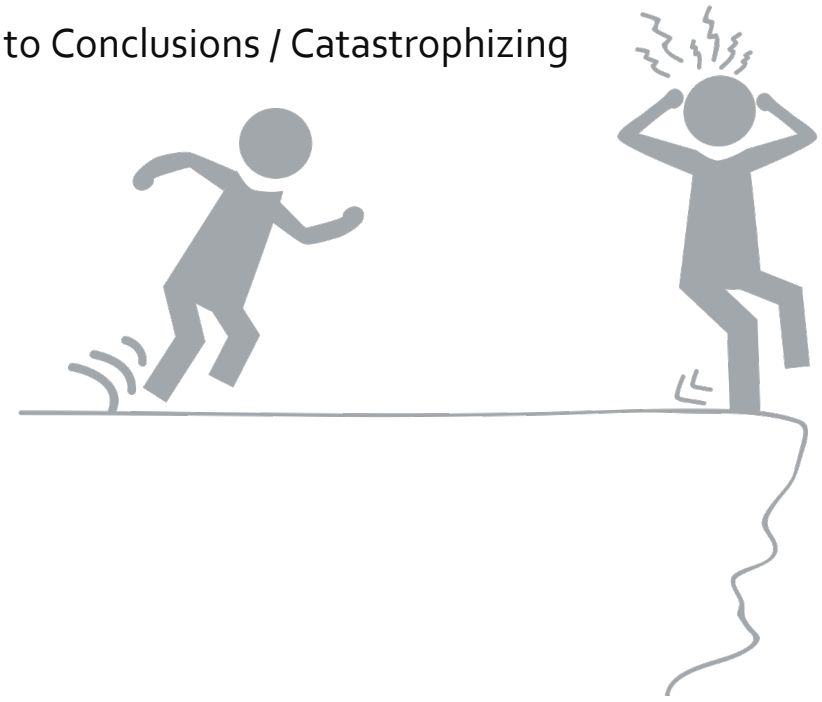


Emotional Reasoning

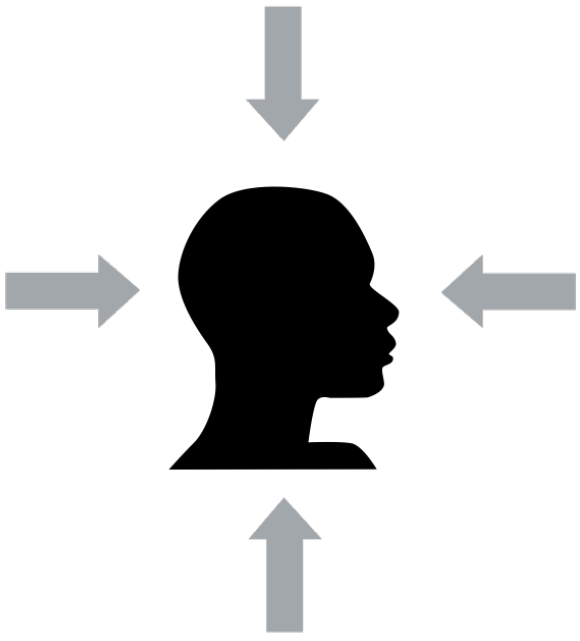
"Should" Statements



Jumping to Conclusions / Catastrophizing



Personalizing



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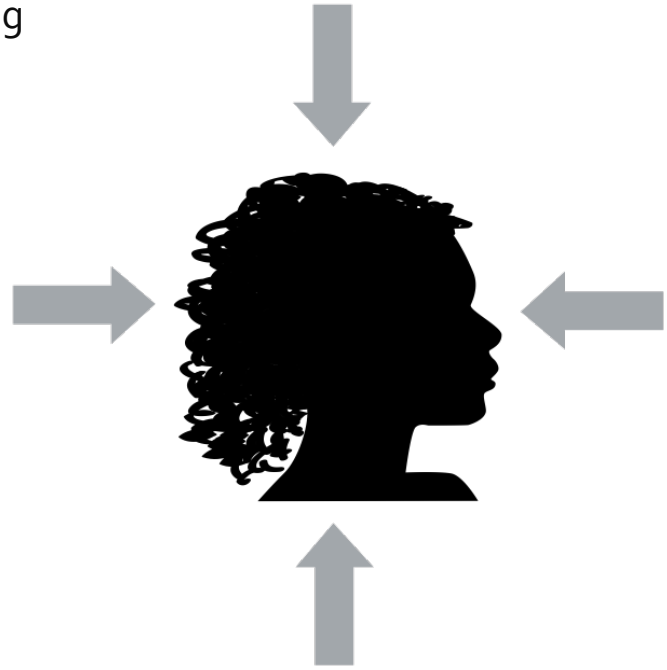

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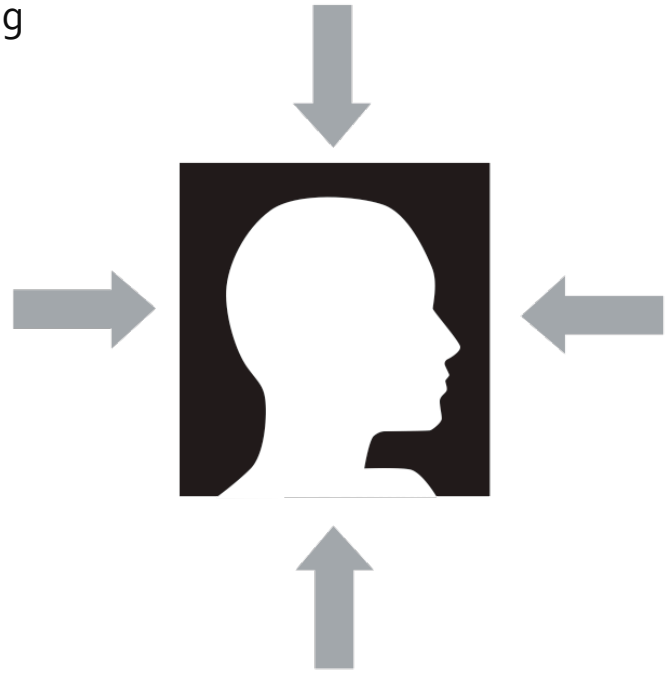

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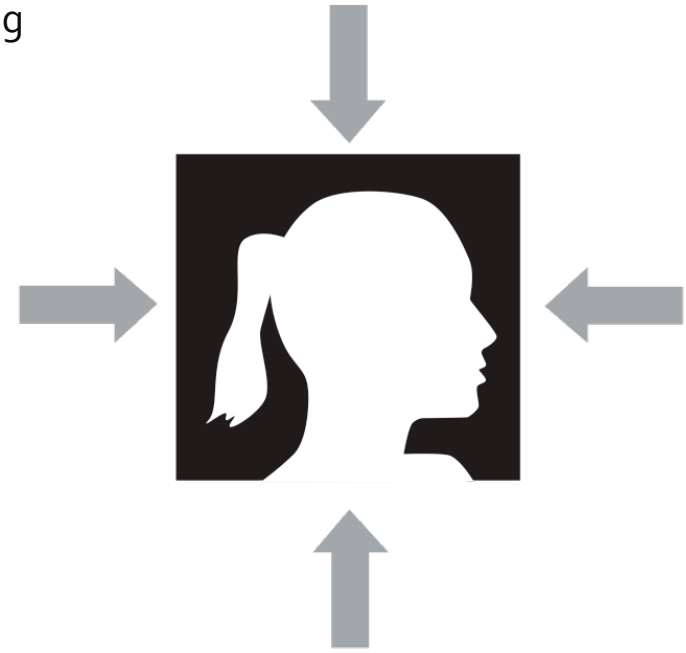

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