Culturally Adapted Cognitive Behavioural Therapy (CaCBT) for Canadians of **South Asian Origin**

Therapy Manual for Depression and Anxiety

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Title: *Culturally Adapted Cognitive Behavioural Therapy (CaCBT) for Canadians of South Asian Origin*

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Suggested citation: Naeem, F., Virdee, G.K. & Rao, S. (2022). *Culturally Adapted Cognitive Behavioural Therapy (CaCBT) for Canadians of South Asian Origin*. Toronto, ON: Centre for Addiction and Mental Health

Disponible en français sous le titre *La Thérapie Cognitivo-Comportementale Culturellement Adaptée (TCCCA) pour les Canadiens d'Origine Sud-Asiatique*

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Copy-editing and proofreading: Chris Trimmer and Wishah Khan

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12-2022

Foreword

This manual is long overdue in the field of Cognitive Behavioural Therapy and beyond. It highlights the importance of delivering culturally sensitive and culturally adapted care and explore individual's identities which may be embedded in both the South Asian and white Western cultures.

I particularly enjoyed reading the section on religion and spirituality as many people of South Asian heritage do follow religion to some degree, however this is frequently omitted from the care they receive. The authors and study team have included helpful tips throughout the manual providing some useful information to educate therapists about different ethnicities and religions that are often used interchangeably under the term South Asian.

Culture, religion and spirituality can contribute to or alleviate distress and my hope is that this manual will support therapists to deliver therapy using more nuanced approaches and humbly step into the patient's world.

Saiqa Naz
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Acknowledgements

This manual was informed by the research study, *Development and Evaluation of Culturally Adapted CBT to Improve Community Mental Health Services for Canadians of South Asian Origin* that was conducted at the Centre for Addiction and Mental Health (CAMH), in Toronto, Ontario, Canada. We are grateful to all the staff members and partners that were involved throughout the duration of this research project.

We are also grateful to our partner organizations: Moving Forward Family Services (Surrey, British Columbia), Ottawa Newcomer Health Centre (hosted by Somerset West Community Health Centre; Ottawa, Ontario) and Punjabi Community Health Services (GTA, Ontario) for generously giving us their time and for their active contribution. We would also like to thank all other participating organizations who have graciously supported this project.

We would like to thank the following key individuals and organizations for their invaluable support, guidance and timely advice in developing this manual.

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The manual was funded by Health Canada (The Health Care Policy Contribution Program [HCPCP]), as part of a larger research study. The authors and research team thank the study sponsor for their support throughout this project.

We extend our immense gratitude to the research participants who graciously shared their experiences and perspectives surrounding South Asian mental health through interviews and surveys. Their direct contributions have made the development of this work and this research possible.

Financial contribution from

Health Canada Santé Canada

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Glossary

Acculturation is a process of social, psychological, and cultural change that stems from balancing two cultures while adapting to the prevailing culture of the society.

Ayurveda is a form of holistic, natural medicine, originating in India and has been used for more than 5,000 years.

Bhagavad-Gita is a Hindu scripture, and is one of the most important and widely read religious texts of Hinduism.

Bio-Psycho-Social-Spiritual Model is a holistic healthcare approach that incorporates the relationship between biological, psychological, social and spiritual components that are relevant to an individual's beliefs and experiences.

Cognitive Behavioural Therapy (CBT) is an evidence-based, structured form psychotherapy used worldwide for various psychiatric, psychological, and emotional problems.

Cognitive Model describes how one's thoughts and perceptions influences the way they feel and behave. It is a core component of CBT.

Collective Stigma describes the experience where deviations from the cultural norm reflect less on the individual and more on the individual's family and/or community.

Cultural Adaptation is the process of making adjustments in therapy to improve engagement when a provider works with a person with whom they do not share a cultural background.

Note: this definition has been developed by the authors of the manual.

Guru-Chela Relationship describes a therapeutic relationship between the therapist and client, in which the therapist takes the role of an authoritative "guide" or "teacher" and the client is the "student" or "disciple"

Guru Granth Sahib is the central religious scripture of Sikhism, regarded by Sikhs (followers of Sikhism) as the final, sovereign and eternal Guru (spiritual guide)

Hadith are a recorded collection of the sayings and actions of the prophet Muhammad (peace be upon him), which are a major source of guidance for Muslims, after the Quran

Hakim is a name given in South Asia to practitioners of a form of medicine inherited in part from ancient Greece and in part from traditional Chinese medicine

Izzat is a term in various South Asian languages that describes honor, reputation or prestige (of an individual or family/community).

Kirtan is the recitation of hymns, common among Hindu and Sikh religions, as a way of praising or glorifying some form of divinity, and can be expressed in a variety of ways, including oral recitation and with accompanying music.

Note: The practice of kirtan varies by religion; in Sikhism, for example, it is considered to be central.

Nasheed is a traditional Islamic song usually sung in a capella or accompanied with percussion in praise of Prophet Muhammad (peace by upon him).

Quran is the central religious text of Islam, believed by Muslims (followers of Islam) to be a revelation from God

South Asian (SA) an individual with origins from the following countries India, Pakistan, Afghanistan, Bangladesh, Sri Lanka, Nepal, Bhutan, and the Maldives.

Background and Context

This manual was developed with the intention that it will be utilized by mental health professionals who have prior training, knowledge, and experience in cognitive behavioural therapy (CBT). The goal of this manual is to make available to practitioners a guide that will enhance and add to their existing CBT knowledge. Furthermore, this manual has been specifically developed to be used for South Asian clients with depression and anxiety.

Mental Health in the South Asian Community

Canadians of South Asian origin[1] are the largest visible minority group in Canada, with more than 1.9 million individuals, comprising 25.1% of the visible minority population [1]. India, Pakistan, Afghanistan[2], Bangladesh, Sri Lanka, Nepal, Bhutan, and the Maldives are the constituent countries of South Asia. Indo-Caribbean populations are a South Asian diasporic group that also trace their lineage and culture to South Asia [2]. Individuals of mixed heritage may also choose to identify with their South Asian heritage.

The COVID-19 pandemic has exposed the already-existing disparities faced by visible minorities in the countries around the world. South Asian (SA) Canadians are unduly affected by high rates of anxiety and mood disorders, and experience poorer mental health outcomes [3]. Those who immigrate to Canada at age 17 or younger are at a significantly higher risk for depression and anxiety compared to immigrants from elsewhere who entered at the same age [4, 5].

The results from a crowdsourced survey conducted by Statistics Canada in 2020 showed that, when compared to the other large visible-minority groups in Canada (Chinese, Black, Filipino, and Arab, according to the 2016 Census of the Population), the South Asian minority group had poorer mental health outcomes [6]. When asked to self-report their mental health on the same survey, they were more likely to suggest fair/poor mental health along with somewhat/much worse mental health since COVID-19 physical distancing had begun. South Asian participants of this survey were also more likely than all other visible-minority groups to report symptoms of moderate/severe generalized anxiety disorder. This population was also most likely to report COVID-19 related financial insecurity (43.8% of South Asian survey respondents).

1 Note, the population for this project does not only include Canadian citizens, but also immigrants, refugees, and newcomers who do not have Canadian citizenship.
2 For the purposes of this manual, we are including Afghanistan as a constituent country of South Asia to be as inclusive as possible of the ways individuals identify their heritage.

Diversity in South Asian Groups

It is crucial to note that there is a great deal of diversity among South Asian populations. There are a variety of cultural traditions, languages, religions, histories, and many other dimensions that exist. As such, South Asia is one of the most linguistically diverse areas in the world with four language families that comprise more than 650 individual languages [7].

In India, Hindi is widely spoken and in the neighboring Pakistan, Urdu is widely spoken. Some states of India also using Urdu as these two languages are both commonly found to be spoken in the South Asian region [8]. Bengali is the next most spoken language in South Asia and other notable languages include Telugu, Punjabi, Marathi, Tamil, Gujarati, Kannada, Pashto, Malayalam and Konkani. In Canada, the most spoken South Asian language is Punjabi, followed by Urdu, Hindi, Tamil, Gujrati, and Bengali. Other SA languages spoken in Canada include Malayalam, Telugu, Nepali, Pashto, Sinhala, Marathi, and Sindhi [9].

The major religions practiced in the South Asian region are Hinduism and Islam. Other religions that are comprised in the remaining South Asian population are; Buddhists, Jains, Christians, and Sikhism. Hindus, Buddhists, Jains, Sikhs, and Christians are concentrated in India, Nepal, Sri Lanka and Bhutan, while Muslims are concentrated in Bangladesh, Pakistan, Afghanistan, India and the Maldives. South Asians in Canada tend to be significantly more religious than Canadians as a whole, with only 4% claiming to have no religion compared to 17% of the general population [10]. Additionally, 28% of Canadians of South Asian origin identify as Sikh, 28% as Hindu, and 22% as Muslim.

The Task of Providing Mental Health Care for South Asian Groups

One of the main challenges of providing mental health care for South Asian communities is known to be linked to language. In particular, the absence of mental health terminology in the South Asian languages referred to earlier. It is well known that terms for clinical depression, anxiety, and other psychological conditions, mental health expressions, phrases and words are often absent from South Asian languages or not commonly used to describe the experiences of mental illness in this group. This can lead to a lack of awareness and understanding and can perpetuate stigma which may lead individuals to avoid seeking help [11, 12].

This project comes at a crucial time and turning point in mental health for the South Asian population. There is a gap in understanding the mental health experiences from a South Asian point of view, complicated by care provision that does not meet the accurate assessment and needs of such a diverse group. Providers with such diverse groups require guidance that is evidence based, tailored and culturally appropriate for mental health services. This manual is a practical and important step forward in improving mental health outcomes for South Asians across Canada. We hope that it will decrease barriers to providing equitable, meaningful and accessible mental health care to South Asian groups across Canada.

How to Use this Manual

This manual was developed in consultation with individuals with lived experience of anxiety and depression. It was informed by family members and caregivers, community leaders, and mental health professionals who regularly work with South Asian clients.

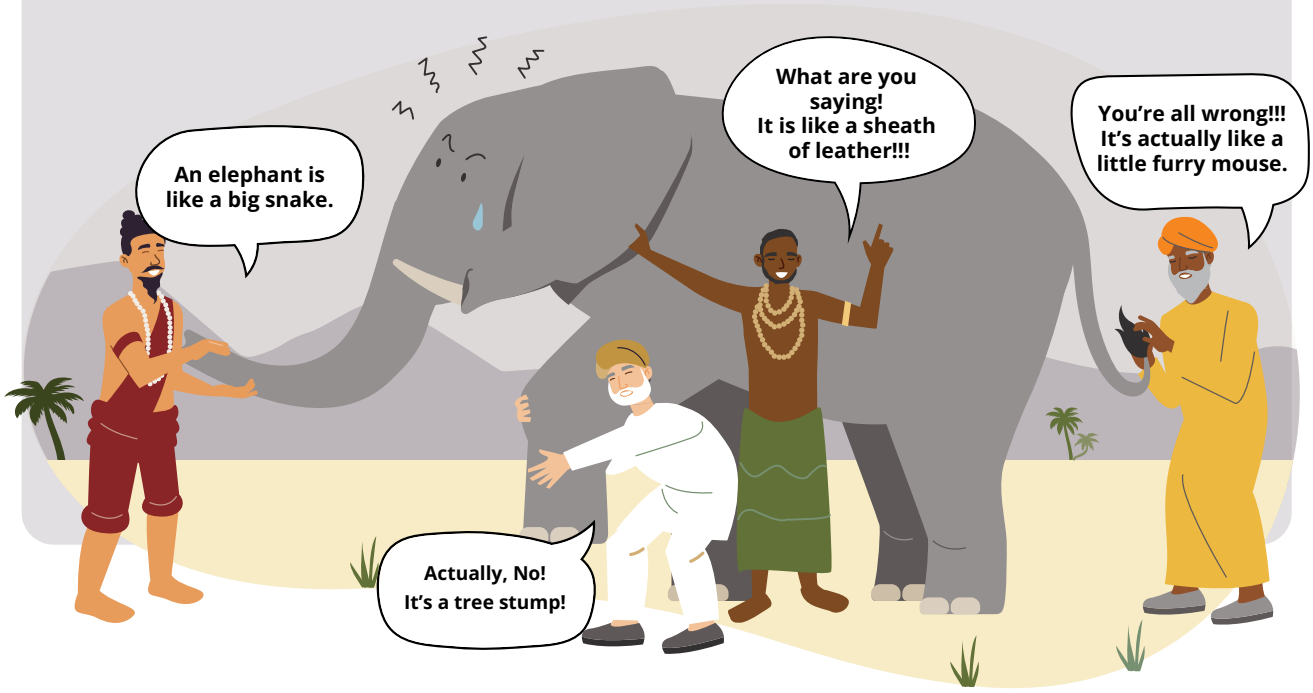
This manual summarizes various topics to help guide users on the theoretical background of cultural adaptation while also providing tips on practical application of techniques. We have incorporated case examples, tips and diagrams to enhance learning, alongside handouts which can be printed and shared with clients to build a collaborative relationship during their treatment. Easy-to-use tip sheets are included to help therapists quickly recall techniques and incorporate adjustments to therapy when working with clients and their families.

We hope that this manual will assist providers and users alike and will improve mental health service outcomes for South Asian communities across Canada.

Authored by: Sarah Ahmed & Dr. Nagina Khan

What is CBT?

There is a famous fable in South Asia about six blind men who go to see an elephant. We often use this fable to introduce the basic concept of CBT to clients. According to the fable, the first man touched the side and said, "This is like a wall." The second man touched a tusk and said, "This is like a spear." The third man, who touched the trunk, said "This is like a big snake." The fourth man touched the animal's leg and said, "This is like a tree stump." The fifth man touched the ear and said, "This is like a sheath of leather." And finally, when the sixth man touched the elephant's tail he shouted "Ah! This is like a little furry mouse!" They argued with each other for a long time about what an elephant looks like. They were all looking at the elephant using a particular perspective. We do this often in our lives as well. We may look at only one aspect of something, ignoring the full picture, and we don't recognize that we can look at the same thing using different angles of views. A CBT therapist helps people to see things from more than one perspective.



Introduction

What is CBT?

Cognitive Behavioural Therapy (CBT) is an evidence-based therapeutic approach used extensively worldwide for various psychiatric, psychological, and emotional problems. The essence of CBT therapy is straightforward—*how we think about things affects how we feel emotionally and what we do*. CBT helps people learn new coping methods, problem-solving techniques, and how to deal with others through conflict resolution and strategies to improve communication. These skills are intended to be helpful throughout a person's lifetime. CBT is primarily a self-help therapy, with a therapist working alongside the client as a guide. CBT is flexible enough to incorporate other disciplines within its framework (e.g., mindfulness techniques are often presented in conjunction with CBT techniques). See Handout 1.

Third Wave Therapies

Third-wave cognitive behavioural therapies, such as mindfulness-based cognitive therapy (MBCT), acceptance and commitment therapy (ACT), emotion-focused therapy (EFT), and dialectical behaviour therapy (DBT), are growing in popularity. However, this rise in popularity may not be reflected amongst South Asian individuals [13]. Many therapists practicing third-wave CBT therapies may assume that since the therapies have connections with Eastern philosophies (e.g., mindfulness and compassion), all South Asians may identify with (and prefer) the principles and techniques of third-wave CBT. This assumption neglects the possibility that these principles and procedures may not be familiar to many South Asians. For instance, Hindu scriptures may emphasize yoga, meditation, and awareness but they do not explain or emphasize mindfulness practices. Most Indians may have studied Buddhism (as part of history lessons), but they may not be phenomenologically familiar with mindfulness approaches or philosophy. South Asians who have primarily grown up in Buddhist-dominant cultures may have different experiences than the therapist expected. For example, the Buddhist practice most familiar to the client may be more ritualistic than meditative.

In addition, several Buddhist schools do not emphasize compassionate-mind training [14]. Overall, different assumptions held by South Asian individuals may not be congruent with third-wave CBT [15].

Similarly, Sikhs and Muslims might not feel comfortable practising rituals that come from Buddhism due to religious rationale. Mindfulness in Islam has added layers of spirituality and God-consciousness that differ from Buddhist practice and have not yet entered secular mainstream psychiatric practice. The values conceptualized in acceptance and commitment therapy (ACT, a popular third-wave CBT school) are very different from those in the East, even in Buddhist cultures [14]. In general, an Eastern perspective of values is that they are not just personal constructs (as suggested in ACT) but also societal, familial, religious, and universal constructs. Further, there may be an element of personal choice in the values that someone ascribes; however, it can be argued that values are not seen as being primarily derived from 'self-focus' or individualistic strivings. In that sense, from an Eastern perspective, values can be conveniently divided into those from family, religion, and the individual. This can also open room for a dialogue between the conflicting parts of the person's life, especially where it involves cultural values versus their own needs. There are many factors to consider when employing cultural adaptations of CBT and the third-wave forms of therapy.

The Process of Therapy

CBT is a relatively short-term therapy. The duration of cognitive therapy usually lasts between 8 to 20 weeks, with individual weekly sessions lasting about 60 minutes [16]. The sessions are highly structured. A typical session consists of 10 minutes of reviewing the previous week's homework, 40 minutes for therapy, and the last 10 minutes for feedback and assigning the following week's homework. A detailed plan is agreed upon at the start of each session. Cognitive therapy uses a collaborative style: the client takes an active role in therapy, completing agreed-upon homework assignments between sessions. The overall aim is to help the individual learn the scientific method to work as a scientist when examining their ideas, thoughts, and beliefs in contrast to their reality. The therapist is encouraged to use a Socratic-questioning approach to explore the client's problems and to help guide the client to solve their problems rather than offering straightforward advice or explanations.

Some South Asians might not be aware of various forms of psychotherapy, including CBT. Therefore, therapists should discuss the characteristics of cognitive therapy with the client at the start of treatment. Providing psychoeducation on depression, anxiety, and CBT is essential for the initial session(s).

The therapist may also wish to focus on problems and symptoms (often relationship problems or physical symptoms) with the most significance to the client. If clients do not feel that the therapist addresses their concerns, they are less likely to return for additional therapy.

Cultural and Psychosocial Interventions

There is sufficient evidence to suggest that cultural differences can influence the process of psychosocial interventions [17, 18, 19]. Several decades ago, it was noted that "...because white males from the West developed most psychotherapy theories, they may conflict with clients' cultural values and beliefs from non-Western European-North American backgrounds" [20, 21]. It has been discussed that Asian and Western European-North American cultures differ in four core value dimensions: individualism–communalism, cognitivism–emotionalism, free will-determinism, and materialism–spiritualism. Researchers have observed that Asians are more likely to be community-oriented, relationship-focused, and can be inclined towards spiritual explanations and a deterministic view of life. Many religions view some aspects of life as predetermined, and this belief may influence the way people think. Hindus and Buddhists, for example, believe in 'karma'. Buddhism also takes a nonlinear view of life. Li et al. [22] have discussed the impact of the teachings of Confucianism (e.g., respect for familial and social hierarchy, filial piety, discouragement of self-centeredness, emphasis on academic achievement, and the importance of interpersonal harmony) and Taoism (e.g., a simple life, being connected with nature and non-interference in the course of natural events) on the mental and emotional health of Chinese individuals. These teachings can profoundly impact the individual's view of mental illness and its management, affecting how the therapist is viewed. An associated concept for the therapist to consider is fatalism, where the individual believes that divine powers govern the world and that an individual cannot control or prevent adversity. For example, some Latin American communities see their mental or emotional problems caused by evil spirits or witchcraft [23].

CBT and Culture

Standard CBT contains as many culture-specific values as any other psychotherapy [24]. CBT involves the exploration of core beliefs and unhelpful patterns of thinking and attempts to modify them. People with depressive illness and anxiety usually have negative beliefs about self, others, and the unhelpful world. Such core beliefs, underlying assumptions, and even automatic thought content might vary with culture [25].

One study from India reported that 82% of psychology students felt that the principles of cognitive therapy conflicted with their values and beliefs [21]. Of these, 46% said that the therapy clashed with their cultural and family values, and 40% described a conflict with their religious beliefs. Another study explored whether the concepts underpinning CBT were consistent with the personal, family, sociocultural, and spiritual values of university students in Pakistan. Although there was little disagreement with CBT's principles concerning personal values, some controversy existed regarding family, social, and, most importantly, religious values [26]. Qualitative interviews with mental health professionals in England [27], Pakistan [28], China [22], the Middle East [29], and Canada [4] revealed the need for cultural adaptation of CBT for persons of non-Western European-North American origin.

What is Cultural Adaptation?

Cultural adaptation of CBT has previously been defined as, 'Making adjustments in how therapy is delivered through the acquisition of awareness, knowledge, and skills related to a given culture, without compromising the theoretical underpinning of CBT' [13]. However, our work has led us to revise this definition to the following: *The cultural adaptation of CBT is the process of making adjustments in therapy to improve engagement when a provider works with a person with whom they do not share a cultural background.*

Some therapists in the USA have developed guidelines for the adaptation of psychosocial interventions based on their work with people from non-Western European-North American backgrounds and their subsequent observation that individuals from non-Western European-North American cultures might have different sets of beliefs, values, and perceptions [30, 31, 32]. However, these earlier guidelines merely described the therapists' personal experiences working with Latinx and Chinese patients. Furthermore, the guidelines did not directly result from research addressing cultural factors and, as far as we know, did not form the basis of adapted therapy that had passed the test of randomized controlled trials (RCTs). The literature on culturally informed guidance for cognitive therapists is generally limited [24].

Evidence for the Effectiveness of Culturally Adapted CBT

Culturally adapted Cognitive Behavioural Therapy (CaCBT) is an evidence-based practice [33, 34]. CaCBT is more effective than standard CBT and has been demonstrated to reduce therapy dropouts compared to traditional CBT [32, 35]. Thus, CaCBT can increase access to mental health services and improve outcomes for immigrant, refugee, and racialized populations [36, 37, 38].

Southampton Adaptation Framework to Culturally Adapt CBT

We developed the Southampton adaptation framework (see Table 1) to culturally adapt CBT [28] using a mixed-methods approach (i.e., qualitative and quantitative data was collected). Our qualitative studies involved the exploration of experiences and opinions of patients, their carers, therapists, mental health professionals working with them, and community leaders. For details of methods and the process of adaptation, please see references [13, 26, 33, 39, 40]. Information obtained from the aforementioned qualitative studies was used to culturally adapt a therapy manual using CBT [41]. This methodology has been used to develop guidelines for cultural adaptation of CBT in South Asia [35], the Middle East [29], North Africa [42], England [43], China [22] and Canada [44].

Table 1 Southampton Adaptation Framework

Major areas	Minor areas
Awareness and preparation	1. Cause and effect model of mental illness used by the population in focus (Bio-Psycho-Socio-Spiritual Model) 2. Language and cultural adaptation of terminology (literal translations do not work) 3. Communication styles, idioms of distress and personal boundaries 4. Family and caregivers' involvement 5. Health system-related issues for future implementation (number of therapists, resources, distance from the treatment facility) 6. Considerations of gender and sex-related issues 7. Pathways to care with a focus on help from traditional healers (faith healers, religious leaders, elders) 8. Coping strategies and cultural strengths—religion, spirituality, cultural practices
Assessment and engagement	1. Common presenting complaints and concerns 2. Self-awareness in therapists about their belief system 3. Assessment of acculturation and immigration status 4. Racism and racial or other trauma 5. Stigma, shame, and guilt 6. Barriers to seeking therapy and engagement with therapy 7. Awareness of illness, its causes and its treatment 8. Beliefs about illness, its causes and its treatment

Major areas	Minor areas
Adjustments in therapy	1. Culturally acceptable patient-therapist relationship (consider attitude towards persons of authority in a given culture) 2. Psychoeducation and access to therapy 3. Cultural variations in dysfunctional beliefs 4. Acceptable therapy settings and style 5. Adjustments or modifications required in therapy settings 6. Use of culturally favourable communication strategies such as stories or images 7. Understanding barriers in therapy, such as how to ensure homework assignments are completed 8. Adjustments in therapy techniques

Suggested Readings

Naeem, F., Ayub, M., Gobbi, M., & Kingdon, D. (2009). Development of Southampton Adaptation Framework for CBT (SAF-CBT): A framework for adaptation of CBT in non-western culture. Journal of Pakistan Psychiatric Society, 6(2), 79–84.

Naeem, F., Phiri, P., Munshi, T., Rathod, S., Ayub, M., Gobbi, M., & Kingdon, D. (2015). Using cognitive behaviour therapy with South Asian Muslims: Findings from the culturally sensitive CBT project. International Review of Psychiatry (Abingdon, England), 27(3), 233–246.

Naeem, F., Phiri, P., Rathod, S., & Ayub, M. (2019). Cultural adaptation of cognitive–behavioural therapy. BJPsych Advances, 25(6), 387–395. https://doi.org/10.1192/bja.2019.15

About this Manual

This is a therapy manual that provides hands-on techniques to implement culturally adapted therapy for South-Asian individuals. Therefore, it does not focus on theoretical aspects of CBT, or cultural adaptation, in detail. However, based on our experience of more than a decade of cultural adaptation of CBT and using the **Triple-A** principle (see Figure 1), we have divided this manual into three parts:

1. **Pre-therapy issues: Awareness and preparation**
2. **Therapy-related issues 1: Assessment and engagement**
3. **Therapy-related issues 2: Adjustments in therapy and session details**

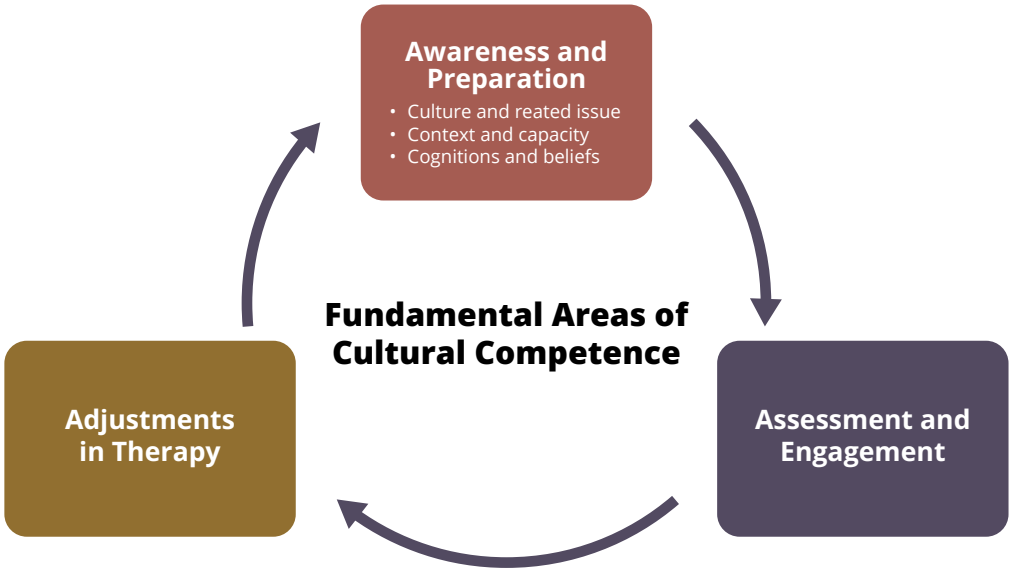
Awareness of relevant cultural issues, in turn, involves:

a. **Culture and related issues** (Culture, Religion and Spirituality, Language and Communication & Family-related Issues)

b. **Context & Capacity** (Individual issues, System of support and treatment, and Pathways to care & help-seeking behaviour) and

c. **Cognitions & Beliefs** (Beliefs about health and illness, Beliefs about treatment and treatment provider and Cognitive errors and dysfunctional beliefs).

Figure 1. Fundamental Areas of Cultural Competence



This manual can be used flexibly to accommodate clients' needs. The CaCBT intervention can be given in a brief CBT format (6–9 sessions) or a standard CBT format (12–20 sessions). You will find useful handouts in the Appendix of this manual. Each session typically lasts 60 minutes with 10 minutes for homework review, 40 minutes for therapy, and 10 minutes for feedback and homework assignment. There will be six core sessions, and the rest of the sessions will be optional. See Table 2.

Table 2 Details of the CaCBT Sessions*

Session	Topic of Focus
1	Assessment, Formulation, Therapy Plan
2	Behavioural Activation
3	Problem-Solving
4	Recognition of Thoughts and Emotions
5	Challenging Thoughts
6	Creating Balanced Thoughts; Termination Work

* *Note: Optional sessions may include Communication and Conflict management. These may be given at any time. Ideally, they should be delivered based on the initial agreement with the client.*

PART 1

Pre-Therapy Issues

Awareness of Cultural Issues and Preparation for Therapy

1.1 Cultural Issues: What to Consider Before Therapy

The therapist's first step in preparation for working with a patient from a different culture should be to conduct research before meeting the patient to explore one's own biases, power, and privilege. For example, the therapist could talk to someone who identifies as being from a South Asian culture, or the therapist can look for culture-specific information in the research. In this manual, we will briefly describe some relevant areas of study. Please keep in mind that South Asian populations vary in cultural traditions, languages, religions, histories, and many other dimensions.

Reflecting on Positionality: Starting with Self-Awareness

Before a therapist can effectively work with clients who may not share their background and/or life experiences, it is advised that the therapist reflect on their own positionality. This deep reflection requires the therapist to consider their own implicit biases, prejudices, and to identify, and acknowledge their privilege through factors like race, class, gender, access to education, income, and citizenship. It requires an acknowledgment that these factors are not equally distributed, and they can powerfully shape the way we think and view the world and our interactions with others. As a result, the power dynamics within the therapist-client relationship also need to be examined. A therapist's implicit biases, judgements, and/or dislike for cultures, accents, religions, and ways of life can become very apparent and impede trust-building within the therapist-client relationship.

This reflective step of the therapist's journey requires deep introspection, seeking out companionship with a wide and diverse group of people, and participating in active cultural learning (e.g., taking courses on world history, understanding colonization, learning new languages, experiencing art from different cultures, etc.). A self-reflective journal can be kept through this learning process, and it can be continued while working with new clients of different backgrounds. Before working with each new client, the therapist can journal and reflect on how they could be viewed as an "insider" (e.g., we both live in Toronto and are university-educated) or as an "outsider" (e.g., we come from different racialized backgrounds, religions, and migration histories) to the group(s) their client identifies with. How can these differences and similarities impact the therapist-client relationship? What assumptions do you make about your client's identity and background? What privileges do you possess that they do not (particularly in experiences of racism) and vice versa? In addition, regularly consulting with other mental health professionals of South Asian background can help to make the therapist aware of their own biases and blind spots and continue the learning process.

1.2 Religion and Spirituality

It is worth exploring the common beliefs held by South Asian individuals regarding the causes of mental illness as these often firmly held beliefs can potentially become barriers to therapy. In many cases, consideration of these factors in formulation and psychoeducation will result in better engagement. See Table 3 for details about widely held beliefs from South Asians about the causes of mental illness.

Table 3 Examples of South Asians' beliefs about causes of mental illness

Psycho-social	Stress or worry, poverty, loss of balance of mind, too much thinking, weak personality
Biological	Heredity, brain chemicals, childbirth, phlegm, increased heat in the liver, masturbation
Spiritual/religious/ cultural	Spirits, magic, amulets (a good luck charm tied to an arm or worn as a necklace), fear of ghosts etc., need to become more spiritual, evil eye, God's Will, Karma
Dual explanations	The treatment combines prescribed medication and seeing a traditional faith healer

Clients from South Asian cultures use a bio-psycho-social-spiritual illness model [34]. This model influences their belief systems, especially those related to health, wellbeing, illness, and help-seeking in times of distress. It has been previously purported that culture and religion influence beliefs about the 'cause-and-effect relationship' [45, 46]. For example, the cause of an accident might be described as the 'evil eye,' 'God's Will,' or 'Karma'. However, God's Will or Karma are complex concepts different from a simple internal or external locus of control. We should also emphasize that God's Will and Karma also provide people with immense strength and help them develop foresight in the face of adversity.

People often use religious coping strategies when dealing with distress [47]. Therefore, a distressed client may already be attending the local mosque, church, mandir, gurdwara or has joined a local spiritual or religious group. Advising or endorsing coping skills that are compatible with the client's cultural, religious, or spiritual background can enhance the therapeutic relationship. It can also improve the overall well-being of the client. For example, advising depressed clients to say their prayers just like they have done in the past (for instance, they may find it difficult now because of their lack of motivation) can help to raise their hope, increase their activity level, interrupt the cycle of negative thinking and improve their spiritual well-being. This is a topic that needs to be explored sensitively.

The Bhagavad-Gita

The Bhagavad-Gita is a very important text within the Indian culture. It is universally respected by all Indians of the Hindu faith, including the current generation and even those who are not very religious. Indians consider this text to be thousands of years old. It was very likely written in second or third BCE, around the time Buddhism was gaining adherents in India. Compared to the other Indian scriptures, the Bhagavad-Gita is easily understandable, less mystical, and contains practical advice. Unlike other religious texts, the Gita is meant for people who have not renounced their society for spiritual pursuits. The setting of the book is in a battlefield with a protagonist, Arjun, who is very conflicted due to an imminent fight with his cousins (who are depicted as unscrupulous and immoral kings). Arjun's charioteer Krishna (who is acknowledged as an incarnation of the Hindu god, Vishnu), provides him with some practical coaching. The key concepts conveyed in the text are that one's actions should be based on righteous action in accordance with the person's roles and responsibilities in life. In this account, doing the right thing trumps other cultural values such as family. However, the emphasis is on universal good and regard for one's vocation (among others). Many Hindus identify with this story.

However, it should be emphasized that culture, religion, and spirituality can also give rise to myths and stigma associated with mental illness (e.g., some Muslims believe that being weak in faith can make a person depressed) [30]. Most importantly, beliefs about the causes of mental illness can heavily influence their choice of treatment and help-seeking pathways [48]. Many Hindus believe

that their suffering from mental illness is due to Karma from the past [49]. Numerous respondents to a large survey in India reported that certain mental disorders were due to loss of semen or vaginal secretion, low sexual desire, excessive masturbation, punishment for their past sins, and polluted air [15]. Sikhism suggests that not worshiping the Lord, Karma, and the loss of a loved one, are a cause of depression. Other causes may include taunts, hypocrisy, loss of wealth, drinking of wine, excessive and unfulfilled sexual desire, anger, and egotism or pride [50]. The therapist needs to be aware of these beliefs and may educate clients about depression and its treatment and ask them to contact a religious scholar or even a community member to clarify some of these concerns. It is also worth exploring a person's social and spiritual support system as well as the resources available in the community.

Case Example #1

Saraswati is a first-generation Hindu SA immigrant who was depressed. She believed that her young son was under the magic spell of her daughter-in-law. Saraswati was not keen on attending therapy. Her son had married 18 months ago and appeared to be devoting most of his attention to his wife. This had made his mother feel upset because she concluded that her son was ignoring her. She began to feel depressed thinking that the change in her son's behaviour was due to a magic spell. Talking to family members who did not share her beliefs was helpful, although magic was a commonly held belief in the community. Her therapist chose a non-confrontational, non-judgmental approach, as the woman was already angry with family members for not believing her. Her therapist then explored and discussed alternative explanations for her son's behaviour. Family members were encouraged to talk to Saraswati between sessions. The therapist also advised the family to highlight alternative explanations rather than direct confrontation. Saraswati was also encouraged to resume her worship. This overall approach was very helpful and on her next visit she was less distressed about magic and showed a willingness to accept therapy for depression (although she continued to believe that magic was a possible cause of her suffering).

However, these beliefs might not be universal. There are many sects and subgroups within each religion. The interplay between local cultural practices should also be kept in mind. For example, a Pakistani Muslim might not share all the beliefs of a Bengali Muslim. Similarly, Hindus vary widely in their religious beliefs. The therapist should take steps to understand the complicated interplay between culture and religion, and how it may intersect personally for the client they are working with.

Moreover, the level of religiosity of clients may vary (e.g., the practices and beliefs of a Muslim who prays five times a day are different from a Muslim who practices their faith only for celebrations or communal gatherings like weddings and funerals) and needs to be sensitively assessed.

The Quran and Hadith

Muslims seek guidance from their holy book the Quran, the sayings of Muhammad[pbuh], (called Ahadith – singular Hadith) and other religious figures. Here are a few examples of quotes that Muslim therapists often use with their Muslim clients:

Surely Allah does not change the condition of a people until they change their own condition (Quran 13:11).

O you who believe! If a liar comes to you with any news, verify it, lest you should harm people in ignorance, and afterwards you become regretful for what you have done (Quran 49:6)

Deliberation is from Allah and haste is from the Satan (Hadith of Muhammad [pbuh])

The believer reserves judgement until the matter is proven (Hasan al-Basri)

It is enough lying for a man to speak of everything that he hears (Hadith of Muhammad[pbuh])

Surely by Allah's remembrance are the hearts set at rest (Quran 13:28)

Be sure we shall test you with something of fear and hunger, some loss in goods or lives or the fruits, but give glad tidings to patient, who, when a calamity befalls them, say: surely, we are Allah's and to him we shall surely return (Quran 155:156)

And He (Allah) dislikes gossip for you, asking too many questions, and wasting money (Hadith of Muhammad[pbuh])

Worry is caused by thoughts, not circumstances (Caliph Ali)

For us, our deeds, and for you your deeds (Quran 28:55)

And we alternate such days between the people (Quran 3:140),

So indeed, hardship is followed by ease. Indeed, hardship is followed by ease (Quran 94:5-6).

Make use of treatment, for God has not created an illness without appointing a remedy for it, with the exception of one illness, namely old age (Hadith of Muhammadpbuh)

A man asked: "O Messenger of Allah! Shall I tie it and rely (upon Allah), or leave it loose and rely(upon Allah)?" He said: "Tie it and rely (upon Allah)." (Hadith of Muhammad pbuh)

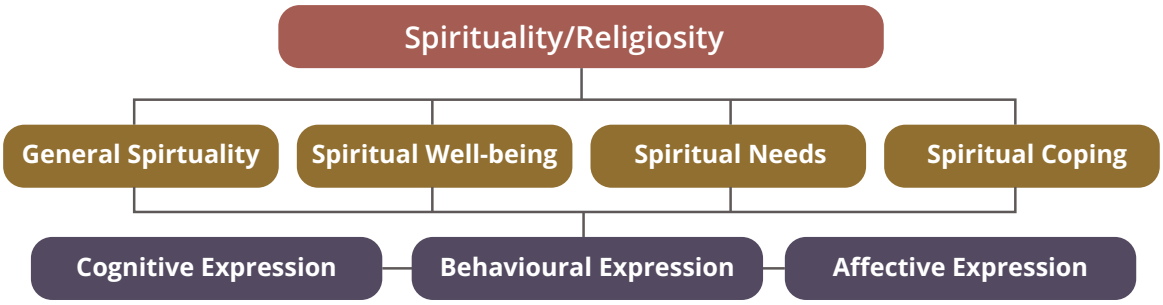
* Note: pbuh refers to an abbreviation for "Peace be upon him," a prayer stated after a Muslim mentions the name of Prophet Muhammad

Case Example #2

Bushra is a SA Muslim woman who worked as a schoolteacher. She presented with symptoms of anxiety and mild depression. She was living with her older sister for 6 months. She had left her husband because he was controlling, emotionally abusive towards her, and verbally abusive towards their children. After nine years of marriage, Bushra decided to leave their marital home after her husband's latest outburst. She said she had left him in the past on two occasions, but family had intervened and she had to go back. However, positive changes in her husband's behaviour following these past events were always short term. So she was determined to never go back to him. Bushra's husband, on the other hand, was still contacting her, and this was a source of constant conflict and anxiety for her. The therapist initially focused on helping her with anxiety, low mood, and decision making. By the fourth session, she had decided to consider giving her husband a last chance if he fulfilled certain conditions, which included, joining her in therapy to address the domestic abuse. Soon after joint therapy started, it became obvious that Bushra's husband felt it was his right and privilege to deal with his wife and family in this way (enacting cruelty upon them), and explained it as being allowed in Islam. The therapist talked to a local religious leader, who informed him that this is a misperception of the religious text and there is plenty of evidence to suggest that the reverse is the case. During the next session Bushra's husband was given the homework assignment of writing the evidence for and against "treating his wife and children with cruelty" from Quran and Hadith (sayings of Prophet Muhammad). The results were remarkable when the couple returned next time. He had a long list of verses and hadith which contradicted his assumption. The couple stayed in therapy for another four weeks and worked on conflict management and social and communication skills. The couple reconciled and re-commenced living together. They returned together for follow up after 6 months and brought a huge basket of sweets as a symbol of gratitude (which the therapist accepted, with thanks).

Exploring religiosity or spirituality is a sensitive matter. Spiritual states might change over time along a hypothesized spectrum of wellness—ranging from spiritual well-being to spiritual distress. A spiritual state might worsen because of external stressors such as illness or bereavement, or be improved by spiritual intervention. Please start by asking open-ended questions such as "Are you a spiritual or religious person?", "Can you please tell me about your beliefs?", and "How are your religion or spiritual values affecting your problems?". *Religiosity and spirituality* are often difficult to define and people might define these terms differently. It is also of note that the terms religiosity and spirituality are often used interchangeably. We find the model of spirituality proposed by Monod et al. useful [51]. Based on a literature search of instruments to measure religiosity and spirituality, they identified the following domains as the most relevant: (i) General spirituality, (ii) Spiritual wellbeing, (iii) Spiritual needs, and (iv) Spiritual coping. Each domain is further divided into cognitive, behavioural, and affective expressions. See Fig. 2 for a visual representation. *Cognitive expressions* measure attitudes and beliefs toward spirituality (e.g., "Do you believe meditation or prayer has value?"). *Behavioural expressions* include public or private spirituality practices (e.g., "How often do you go to your place of worship?"). *Affective expressions* of spirituality capture feelings associated with spirituality (e.g., "Do you feel peaceful?"). See Figure 2.

Figure 2. Various Aspects of Religion and Spirituality



Please note that South Asian clients have a multitude of ways of engaging in help-seeking behaviours. So, you may observe behaviour like taking psychotropic medication and seeing a spiritual healer at the same time. As mentioned, South Asian clients often use a bio-psycho-social-spiritual model of illness. Since religion and spirituality are significant to SA individuals, it may be crucial for therapists to acknowledge that their clients will attend therapy but also use their traditional help-seeking pathways. This information will be gathered at the assessment phase from the client, family, past clinical notes, and/or consultation with their general practitioner (GP). When unsure about a particular belief, please confer with a family member or a person of the same background. Working with local religious or spiritual healers might help therapists deal with issues related to religion or spirituality. There is currently a shortage of literature on faith and CBT. Therefore, we have included a list of articles that can help you understand perspectives on religion and mental health in this group.

Sikhism and the Guru Granth Sahib

The Guru Granth Sahib is a religious text compiled and composed by the Sikh Gurus. This collection of text is used as a basis for guidance on how to live, conduct oneself, handle conflicts, and to survive the human existence with Vahiguru (the name with which the Divine is most often referred to in the Sikh tradition) at heart. "It is used in all Sikh worships and major functions like weddings and naming of babies. Throughout the text of Guru Granth Sahib, various beliefs which shape the Sikh religion are mentioned with primary importance given to the Lord at all points. As per Sikh beliefs, everything that happens in one's life is as per the will (hukam) of God. Every being has to go through these forms as reincarnations (p. 27, p. 50), which include that of worms, insects, elephants, fishes, deer, birds, snakes, rocks, mountains, etc. (p. 176). Human life has been mentioned as the last incarnation (p. 631–16) that one gets only after good karma. All incarnations are said to have pain and suffering at their core, except the human life, which is said to be the best of all, giving one the opportunity to meet the Lord. It is only in human life that one can get peace by reciting the name (Naam) of Lord."

Kalra et al., 2013 (pg. S196, para. 2-3). ***See Suggested Readings.***

Suggested Readings

Bhatia, S. C., Madabushi, J., Kolli, V., Bhatia, S. K., & Madaan, V. (2013). The Bhagavad Gita and contemporary psychotherapies. Indian Journal of Psychiatry, 55 (Suppl 2), S315-321. https://doi.org/10.4103/0019-5545.105557

Husain, A., & Hodge, D. (2016). Islamically modified cognitive behavioral therapy: Enhancing outcomes by increasing the cultural congruence of cognitive behavioral therapy self-statements. International Social Work, 59(3), 393–405. https://doi.org/10.1177/0020872816629193

Kalra, G., Bhui, K., & Bhugra, D. (2013). Does Guru Granth Sahib describe depression? Indian Journal of Psychiatry, 55 (Suppl 2), S195-200. https://doi.org/10.4103/0019-5545.105531

Sabry, W. M., & Vohra, A. (2013). Role of Islam in the management of Psychiatric disorders. Indian Journal of Psychiatry, 55 (Suppl 2), S205-214. https://doi.org/10.4103/0019-5545.105534

Sharma, N. (2014). The Bhagwat Gita as a Complimentary Tool to Cognitive Behavioral Therapy. International Journal of Applied Psychology, 4(2), 45–49.

Valetta, V. (2020). Mental Health in the Guru Granth Sahib: Disparities between Theology and Society. 5(2), 18.

1.3 Language and Communication

It should be emphasized that most literate individuals living in South Asia can speak English. However, consideration of language-related issues remains vital for two reasons. First, due to the difficulty of translating psychological concepts to English, especially for individuals identifying as first-generation SA immigrants living in Canada and, second, because of the relative unfamiliarity with the communication skills central to traditional CBT.

One such example is the concept of *assertiveness*, which is mainly a North American concept (many European languages do not have an equivalent term). In North America, this concept is based on the individual's rights, in South Asian cultures, the implicit emphasis of *assertiveness* is on responsibilities and duties. Traditional South Asian cultures value subtlety and indirectness in communication. More direct or confrontational styles may be viewed as disrespectful and lacking in etiquette. People commonly believe that disagreeing with an elder is a sin. The therapist should be extra vigilant to understand these cultural differences when teaching assertiveness.

Additionally, where necessary and if the client is comfortable, interpreter services should be engaged. One resource that may help work with Bengali-speaking clients is the social media resource, The Bengali Mental Health Movement (https://campsite.bio/bmhm) which has easy-to-understand online posts with mental health terminology in English, Bengali, and transliterated Bengali to help normalize mental health language and increase mental health literacy.

See Suggested Readings for additional information on this topic.

Tip! The Name-it Technique

There will be occasions when you will not be able to find a suitable translation for a mental health-related term. In this case, you may wish to ask the person to name an alternative word for the concept. If the client cannot think of a term, engage a family member or a community member.

Use of culturally-sensitive assertiveness techniques such as the *apology technique*, in which an individual begins a sentence with the following statements: "With a big apology, I would like to seek your permission to disagree....", or "If you allow me to express myself...", or "With all due respect, I would like to say that my opinion is.....", might be useful. While disagreeing, a person from a SA culture often appears humble by lowering their gaze (lowering of the gaze is a sign of respect for elders). Similarly, it is common for clients to use a triangulated approach to communication with elders (for example, talking to the father through the mother as a sign of respect). When nothing else works, we advise clients to find a senior relative or a senior family friend to convey the message or to write a personal message to the other person. For more details on culturally sensitive assertiveness training and relationships, see Handouts 13 and 14.

In essence, it is advisable to provide techniques to clients, who have aversion to confrontation, to try. However, a thorough assessment of risk and benefits should be conducted in collaboration with the client before this is done.

Case Example #3

Anwar is a 32 yr. old second-generation Canadian-born SA Muslim man who, at the time, was living with his parents and younger brother. He has an engineering degree but had been working outside the engineering field for two years as a project manager at a firm in his small hometown. He presented with constant headaches, anxiety, low mood, and disturbed sleep. During the assessment sessions it emerged that he was not happy with his job. He had no friends in his hometown and wanted to return to the city where he had attended university so he could explore better opportunities to work as an engineer and improve his social life. His father wanted everyone to live together under one roof and did not want him to leave. The therapist helped the client deal with the symptoms of anxiety, and further explored the client's conflicting views about going to the big city. Assertiveness training failed since Anwar was not ready to try any techniques. He felt guilty because his father had told him that leaving the family home was against not only their religion, but also his family and cultural values, and would bring shame to his parents. The therapist worked on Anwar's feelings of shame and guilt related to cultural and family values, before referring the young man to a local faith healer (the therapist had gained Anwar's consent prior to this). Meeting with the faith healer was helpful in clarifying his misgivings: he was told that a person is allowed to express his opinion and disagree with his parents, so long as he is not rude to them. He was also told that he had duties as well as rights as a son. This gave him the courage to talk to his father. He was able to discuss the issue with his father and in the end they both agreed that it would be better for Anwar to move out.

1.4 Shame and Guilt

Shame and guilt can be used to control unacceptable behaviours (e.g., use of alcohol or drugs, intimate relationships outside of marriage, etc.) but also prevent help-seeking. It is important to note that South Asian communities and families experience what is termed 'collective stigma', where deviations from the cultural norm reflect less on the individual and more on the family [52].

For example, a client who reports that they are struggling with anxiety due to family pressure to get married by a certain age, or have a high-paying job in a specific field, may be experiencing collective stigma around a cultural norm. Other clients may report concerns from their family members about their chances of getting married if they are experiencing a mental health issue. This relates to the stigma around mental health and the emphasis on the biological/genetic causes of mental illness.

Exploring this might help improve follow-up in therapy and help the individual and their family work through relational issues.

1.5 Family-Related Issues

SA clients may live within an extended or joint family, which is not only an acceptable common practice but is also positively regarded within SA communities. Even when not living under the same roof, close ties are maintained within families. For the therapist, it is advisable to explore a client's ties with their family. Therapists should assess family involvement in the client's life and consider both the pros and cons of their involvement. Family involvement may become a detriment in instances where the client's problems are a result of family stress, when family members want to know everything the client talks about in therapy (versus what the client wants them to know), when there is fear that they may be criticized for the client's illness, and when dealing with issues of shame, guilt, and stigma of mental illness in the family and its communal impact (including for prospects for marriage). Psychoeducation for the family members (e.g., providing materials, education, and other resources) is a vital part of therapy. Therapists should be aware that SA family members may not support the client participating in therapy by devaluing it, invalidating the client's experience, telling them to 'get over it', or actively sabotaging the client's efforts at getting well (e.g., discouraging them from taking medication, completing homework assignments or attending therapy). As the therapist, you can also collaborate with your client on the best means to conduct therapy, where they can receive the privacy they need to have a session. This may require flexibility in scheduling by the therapist.

1.6 Context and Capacity (Health System Related Issues)

The clients' knowledge of the healthcare system, available treatments, and likely outcomes are key factors influencing service utilization and engagement. Some women from SA backgrounds are less likely to attend therapy as they might feel they need permission from family members, and depend on others, to be brought to the clinic [53]. When working with female clients, it would help to engage the accompanying family member during the assessment and provide psychoeducation for them where appropriate. In Canada, the availability of therapists and the distance from the place of treatment might be a barrier for all clients. Due to stigma, some clients might not feel comfortable attending an office or facility that advertises psychological services. The lack of availability of culturally sensitive therapists can be a further systemic barrier. Questions such as "Do you live in an extended family situation?", "Do you have your grandparents living with you?", or "Do you support your parents even though they don't live with you?" can be helpful. The therapist can also ask the family to identify a person as the main carer, with whom the therapist can work together (if they so desire).

A major part of 'traditional' CBT involves reading informational material or completing various homework assignments. The client's willingness, or ability, to proceed with these requirements needs to be sensitively assessed so that alternative methods can be used (e.g., audio recordings on mobile phones and audio diaries, beads, counters, or symbols for writing diaries). Beads and counters are commonly used by South Asian populations for repeating religious verses or words and, therefore, can be used easily, for example, to count thoughts.

Understanding South Asian pathways to care and help-seeking behaviours can be helpful. Some SA clients may seek help from multiple avenues, including traditional/religious/spiritual healers. The pathways to care and help-seeking behaviours are related to social systems, cultural and religious beliefs, and health systems. We have observed that those with somatic symptoms of mental health problems are more likely to attend medical practitioners or traditional healers (e.g., *hakims*—practitioners who use traditional medicines derived from ancient Greek or Chinese traditions, homeopaths, or practitioners of Ayurvedic medicine), while those with only psychological manifestations will present themselves to faith healers or religious leaders [34].

1.7 Cognitions & Beliefs

Beliefs regarding mental health and wellbeing, family dynamics, and social obligations vary across cultures. A therapist within a North American context may find some SA beliefs (such as dependence on others, pleasing others, submitting to the demands of those in authority, and sacrificing one's own needs for the sake of family) in contrast to their own personal belief systems and behaviours [20, 54, 55].

Exploring clients' beliefs about illness and its causes and their expectations of the health system is essential. The Asian subcontinent was influenced by many invaders from Central Asia, the Far East, and the West. The effect of old Greek and Chinese medicine can be readily seen. For example, participants in one of our previous studies described phlegm (a Greek concept), heat in the liver (a Chinese concept) and masturbation (an Ayurvedic concept) to be the cause of their mental illness [33, 40]. Medicines that cause dryness of the mouth are considered to cause heat in the body and might be less acceptable (some clients might drink milk as an antidote for dryness that might lead to weight gain). Many South Asians believe in the prevention and treatment of mental and physical illness through food.

In the above studies, participants could not explain what was wrong with them when asked explicitly about their illnesses. Only a small number of participants with psychosis (and none with depression) were aware of psychotherapy. Also, what the client thinks about healing and the healer is very important. Does the client believe that a good therapist should give him/her a diagnosis just by looking at him (e.g., when author FN once asked a client at the start of a conversation, "How I can help you?" the client replied, "You should tell me, you are the doctor.")

Beliefs about the causation of illness can influence decisions about choice of treatment and help-seeking pathways. Asking clients about their expectations about treatment is important. All the participants in our studies said they would benefit from "good investigations and quality medicines." Educating a client on the side effects, indications, and limitations of medicines can increase confidence in a therapist's abilities and engagement. South Asian clients often look for cures, and therefore, a discussion of expected outcomes should take place.

It is crucial for the therapist to consider these questions: "What does the client think I can do for them? What are their limitations? What are their strengths? Do they think a psychiatrist or psychologist can treat their sadness?" The therapist needs to explore the client's beliefs about 'healing', underpinned by the client's perception of etiology, attitudes towards treatment, and health-seeking behaviours. If the therapist is not aware and respectful of the client's beliefs about healing, and their faith in other healing systems, they might risk offending the client.

Suggested Readings

Avasthi, A., Kate, N., & Grover, S. (2013). Indianization of psychiatry utilizing Indian mental concepts. Indian Journal of Psychiatry, 55(Suppl 2), S136-144. https://doi.org/10.4103/0019-5545.105508

Awaad, R., Fisher, A., Ali, S., & Rasgon, N. (2019). Development and Validation of the Muslims' Perceptions and Attitudes to Mental Health (M-PAMH) Scale with a Sample of American Muslim Women. Journal of Muslim Mental Health, 13. https://doi.org/10.3998/jmmh.10381607.0013.205

Kishore, J., Gupta, A., Jiloha, R. C., & Bantman, P. (2011). Myths, beliefs and perceptions about mental disorders and health-seeking behavior in Delhi, India. Indian Journal of Psychiatry, 53(4), 324–329. https://doi.org/10.4103/0019-5545.91906

Rathod, S., & Naeem, F. (2013). Can you do meaningful cognitive–behavioural therapy through an interpreter? In K. Bhui (Ed.), Elements of Culture and Mental Health: Critical Questions for Clinicians (pp. 17–20). Royal College of Psychiatrists.

PART 2

Therapy-Related Issues I

Assessment & Engagement

2.1 Assessment & Formulation

The purpose of assessment is twofold: (i) To establish rapport with the client, and (ii) To gather information for a case formulation. Case formulation, in turn, guides the therapy process. Therefore, it is best to always share the formulation with your clients. Assessment is an ongoing process and continues throughout the therapy. As new insights develop during therapy, you should modify your formulation and share it with the client.

Tip! Rapport Building

A Personal Touch – "Oh, you are from Brampton? My uncle lives there too."

Experience versus Evidence – "I have seen many people with this problem and now they are living a healthy & productive life."

Culturally/Religiously Appropriate Greeting – It may be best to first ask the client the way they preferred to be greeted. 'Namastay', 'Salam', 'Sat sari akal' are culturally/religiously appropriate greetings that can be used if the client is comfortable. If the client is comfortable, ask them to teach you how to say "hello" in their language.

Follow the Client's Lead – Focus on symptoms that are concerning for the client

Initial assessment starts with a review of the referral letter and any available past notes. The inexperienced therapist may jump straight into the assessment. Instead, take a few minutes to attempt to build rapport before starting the structured interview (See Rapport Building Tips). Ask the client about their knowledge of CBT, their understanding of treatment options, and their expectations and predicted therapy outcomes. Next, you can introduce them to the Cognitive Model. It is essential to explain to the client that assessment is an integral part of the therapy process (Note: Please keep in mind that they might not be expecting many questions, as mentioned in the previous chapter).

Confidentiality is a common issue of concern with SA individuals who worry about potential disclosure to others in the community. This is especially important since we suggest the inclusion of family members where possible. In addition, SA families have the same concern about the community finding out about their loved one getting help for mental or emotional health problems. Furthermore, confidentiality is important because the therapist may need to be aware of family secrets, such as the relationship between a mother-in-law and a daughter-in-law, a family member married outside of race, religion, or even domestic violence. Related to this is an assessment of safety (e.g., strict parents may make it difficult for individuals to disclose what is happening within four walls of the home, such as elder abuse or gender-based violence). Similarly, asking about immigration status can be tricky. People are reluctant to seek help if their status is precarious or worry that they could be penalized somehow if someone were to find out. Ensure that you continue the conversation regarding confidentiality throughout therapy, which can encourage the client's confidence in the therapist, as well as reassurance of sessions being a safe space to share their presenting issues.

There are other barriers to consider for South Asian clients in therapy. When discussing factors such as racism, clients may be reluctant to share their experiences, especially if they believe the topic makes their therapist uncomfortable or it is not worth sharing. Through working with clients whose presenting concerns involve racism, it is important for the therapist to inquire about the effects that racism has had on the client's mental health, and the changes it may have caused in their behaviours. Therapists should work with their clients to understand their anxieties and collaborate on creating ways in which a client can feel safer and more empowered, instead of ignoring the issue.

Another barrier is family and community stigma. There are South Asian clients who may be interested in therapy, but do not want to see a therapist from the same culture or ethnicity as themselves. Clients may fear the possibility of confidentiality being broken and their problems being shared within their community. This is where the therapist's visible identity may initially help or hurt the client's comfort with sharing information. The client may also be hesitant to share more than they feel they need to, as they may have grown up with the idea that problems stay at home. Therefore, building a good foundation of rapport can increase the confidence the client will have in the therapeutic process.

Therapists should ensure to review confidentiality beyond the first session. If there is family stigma regarding the client's participation in therapy, it can be beneficial to bring in a family member into a session and address the concerns they may have (if safe to do so). If this is not possible, ensure that the client is attending their sessions in a space that feels comfortable for them (if being done virtually), and further explore cultural upbringing and family history in session to increase knowledge on how to help with family conflict as a therapist.

Therapists should keep in mind the importance of building a mutually respectful, authentic, and empathetic relationship with their client. Remembering that South Asian cultures are relationship-oriented, taking time to foster a warm and positive relationship, especially for those clients who are new to therapy, will help build and maintain the therapeutic alliance.

2.1.1 **Information Gathering**

In an initial assessment, detailed information about the client is gathered in a structured manner about different parts of their life and ongoing problems. The important aspects of the assessment are:

- Presenting problem(s): This includes details about the onset of the problem(s) and predisposing, precipitating, perpetuating, and protective factors.
- Identify the client's goals in treatment. This is so that you can help them achieve these goals through CBT treatment.
- Check for any previous episodes of anxiety or depression.
- Gather information on any significant past or present substance use.
- Check if they have had any past CBT therapy or counselling.
- Check for any long-term physical conditions or present general health issues.
- Check for ongoing stressors or persistent problems.
- Assessment of risk factors to mental health.
- Go through a specific situation (relevant to the client) in-depth using the CBT-based '5 Part Model' to help the therapist understand the underlying factors causing the current issues.
- Explore bio-psycho-social-spiritual factors.
- Ask about the client's family history of depression or mental health problems.
- Gather information about the client's current occupation, level of functioning, social support, social problems, and hobbies and interests.
- Personality assessment is challenging in a single session. However, you can obtain some initial information through an enquiry about their reaction to stress and coping strategies, their usual mood, and how the person relates to others.
- Ask about the family's concerns.
- Exploration of stigma, racism, and feelings of shame and guilt.
- Assess their language and communication needs.
- Explore their beliefs about health, ill-health, treatment providers, etc.

Note: When possible, try to understand the family's perspective on mental health (including causes and treatments and the family's view on medication and therapy). This will ensure more positive outcomes in therapy.

Once the assessment is complete, you should be able to:

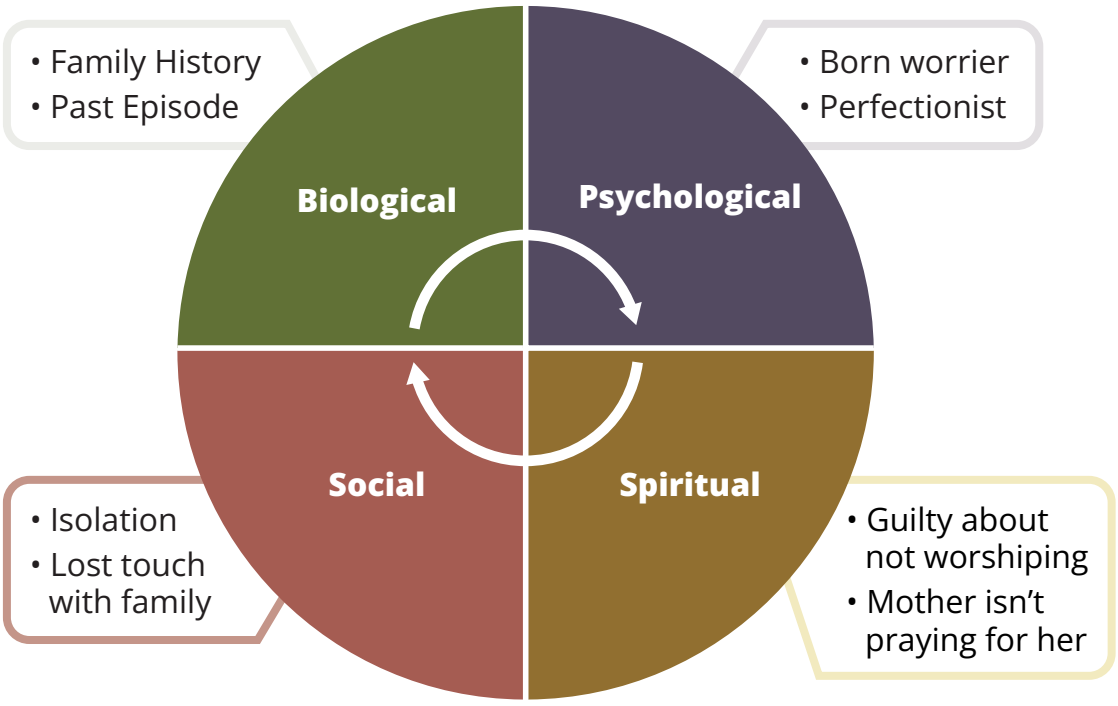
- Share the case formulation
- Make a list of the prominent problems that will guide your therapy plan
- Agree on a therapy plan using the problem list
- Be able to introduce the CBT model using an example or two from the session.

Focusing on the client's presenting complaints is crucial and can improve rapport. For example, if a client focuses on somatic symptoms, it will be worth working on those before proceeding with cognitive restructuring.

2.1.2 **Bio-Psycho-Social-Spiritual Case Formulation**

Case formulation means that therapists build the client's information provided at assessment into a comprehensive model that explains the psychological factors involved in developing and maintaining the client's problem. This 'formulation' is then used to guide and monitor psychological interventions. Thus, case formulation aims to describe why a person has developed a particular problem at this stage and the maintaining and protective factors. There are many different types of formulations in CBT. The formulation also occurs at several levels: symptom, disorder, or problem, and case. See Figure 3.

Figure 3. Bio-Psycho-Social-Spiritual Model



The formulation can link somatic complaints with thoughts, emotions, and behaviours. It can also include relevant spiritual and religious factors. The therapist should not expect the client to change their mind regarding the causes of their symptoms in the first meeting (and the therapist should be ready to talk about this a few times). A careful discussion should be built on neutral ground where the therapist initially does not strongly agree or refute the client's illness ideas. This is a beneficial strategy, for example, when dealing with clients who are convinced that their somatic symptoms are due to a physical condition or a religious or spiritual cause.

Various cognitive behavioural therapy writers have put out several case conceptualization models. The Four Ps model (Predisposing, Precipitating, Perpetuating and Protective factors) [56] is probably the most straightforward case conceptualization model. We usually use this in the first session.

A formulation based on the 5 Areas approach [57] can also be used from the start. When the client understands the CBT model during subsequent sessions, we share the model suggested by Beck [58]. Below is a case example to draw a few examples of formulation using a bio-psycho-social-spiritual model.

Case Example #4

Mary is a high school teacher of SA origin working in the GTA and a Christian. Her husband is a successful businessman. She is a constant worrier. Like most SA families, she always worries about her children's education, even though they are doing well and have good grades. She has perfectionistic tendencies and wants her children to be at the top of their class. For the last 6 months, she has been experiencing heart palpitations, sweaty palms, and pins and needles in her hands and feet. This started when her mom had a heart attack. She is also suffering from constant headaches and she has become irritable over small things. Mary experiences gas (bloating) in her stomach. She is tired all the time and cries over small things. She believes that she is suffering from a heart problem. She has gone to see a cardiologist along with her neighbor. The cardiologist said that Mary has no problems with her heart and is experiencing symptoms of anxiety and depression. Mary also feels guilty because she does not say her prayers regularly, is not seeing her parents who live nearby, and she feels that her mother does not pray for her because she is angry with her. She has experienced an episode of depression in the past and was worried she would become chronically depressed like her mother. She has isolated herself as she doesn't feel like meeting anyone. See Figure 3 and the table below for Mary's case formulation.

4-Factor Model	Bio Psycho Socio Spiritual Formulation			
	Biological	**Psychological**	**Social**	**Spiritual**
Predisposing	◗ *Past episode* ◗ *Family History*	◗ *Worrier* ◗ *Perfectionist*		
Precipitating	◗ *Mother's heart attack*			
Perpetuating	◗ *Family History* ◗ *Past episode*	◗ *Reduced activity*	◗ *Isolation* ◗ *Cutting family ties*	◗ *Decrease in regularity of worshipping* ◗ *Mother not praying for her*
Protective	◗ *Past recovery from depression*		◗ *Stable marriage*	◗ *Having faith*

2.1.3 **Use of Assessment Tools**

Structured assessment tools can be used to assess the client and are routinely used in psychotherapeutic practice to measure psychopathology. We have highlighted the importance of beliefs about illness and its treatment, and this can be assessed with the help of the Short Explanatory Model Interview (SEMI) [48]. This interview explores the client's cultural background, nature of presenting problem, help-seeking behaviour, interaction with physician/healer and beliefs related to mental illness. Another commonly used instrument for client assessment includes the Dysfunctional Attitude Scale (DAS) [59], which can assess dysfunctional beliefs.

2.1.4 **Assessment of Acculturation**

Assessment of acculturation is a vital part of the assessment. *Acculturation* is a process of social, psychological, and cultural change that stems from balancing two cultures while adapting to the prevailing culture of the society. In academic terms, acculturation is "a process in which an individual adopts, acquires, and adjusts to a new cultural environment" [60]. It is wrong to assume that everyone from a given culture is the same or has identical characteristics. There must be flexibility in applying culturally adapted therapy. Migrants, although sharing some commonalities with their culture of origin, demonstrate a wide variation in their cultural beliefs.

Racial tensions, experiences related to migration, and political and social systems in the host culture should be considered. There might be a wide variation between the experiences of first- and second-generation immigrants. An assessment of acculturation should help. It might also be helpful to explore trauma, shame, guilt, and stigma with all clients.

When working with older adult clients, ask them about their migration pathway and the trauma and the stress involved. For many people, the migration experience was a long and tortuous road with varying motivations and goals, fraught with both difficulties and successes. Often their experience is significant concerning their mental status. Also, it is beneficial to ask clients about their social system of support and potential loneliness.

Therapists should be ready to ask about the impact of religion on their client's coping skills. While religion can be a source of strength and hope, it can also lead to issues of hopelessness and defeatism, which are often culturally driven ways of framing doubt (e.g., "We can't do anything about it, it's all in God's hands now"). While addressing belief systems and spirituality may offend some, providing examples of religious texts can offer some clients a source of strength and hope.

Finally, therapists should be aware of their assumptions, biases, and prejudices when working with clients from different backgrounds. Many acculturation measures are available [61, 62]. When discussing a family conflict, try to explore acculturation issues as various family members might have different levels of acculturation.

Tip! Questions to Assess Acculturation

Which language do you speak with your family and friends?

In which language do you think or dream?

Can you still read and write in your native language?

Name your three favorite movies.

Do you watch or listen to movies/music/news programs from your country of origin?

Are your friends South Asian or white or — ?

What food do you cook at home?

Do you go to places of worship your community attends regularly?

2.1.5 **The Generation Effect**

First-generation immigrants often adhere to values that belong to when they were growing up in their country of origin. These values may no longer apply now in their country of origin. Often literature and contemporary movies are valuable resources that outline this change, albeit dramatically. However, there is no hard and fast rule in this area. The first author (FN) has noted that some immigrant families in the west might adhere to the cultural values of first-generation immigrants. In contrast, their culture of origin might have changed and might have adopted Western European-North American values. One expression of this is dress code (e.g., some South Asians prefer to dress like others in their country of origin when they move, while many young persons in South Asia wear clothing based on Western European-North American fashion). First-generation South Asians may adopt western norms in clothing and behaviour outside of the home. Inside the home, however, they may continue to wear culturally congruent clothing and routines. On special occasions, such as weddings or festivals, traditional clothes will often be worn.

A special case may be made for second-generation immigrants (i.e., children of the original immigrants). In such cases, there could be friction between cultural norms and expectations of the parents (and those representing the ethnic group) with those of their peers. The second generation of South Asians may also feel some pride in belonging to an ethnic group but some diffidence in not fully knowing the language and culture. This could lead to a sense of identity confusion, alienation, anger, and resentment. The first author (FN) was once asked to assess a 14-year-old girl for mental health issues by the parents since the girl wanted to colour her hair blue. Similarly, another client was a 29-year-old female who was attending University. She had had a relationship breakup, feeling low, but couldn't confide in her parents, who expected her to have a traditional arranged marriage. She was also expected to fulfil the role of an exemplary daughter, and eventually, a housewife. In this example, the therapist may need to explore cultural norms, her well-being, and deal respectfully with parental demands. It may be beneficial to also engage a helpful elder who she can confide in. Such a person would be of her parent's generation (or older) and may mediate or negotiate on her behalf.

To further understand the generation effect, it is important to consider South Asian clients who identify as LGBTQ+. Author SR has worked with South Asian LGBTQ+ clients who have felt misunderstood by their parents with reference to change in their gender or identity. The role of the therapist is to understand the norms but also help the client search for their own definitions. The therapist must be mindful that every client will have different circumstances that can cause a safety issue depending on what other people in their life know about their gender and/or sexuality. It is crucial to not enforce Western expectations and values onto clients, especially around the disclosure of their identify, as safety needs to be a priority.

2.2 Engagement in Therapy

High rates of drop-out from therapy have been reported among clients from non-Western European-North American cultures [39]. The following pointers might help to improve therapeutic engagement (although a careful assessment of acculturation beforehand is still necessary).

- **The first few sessions are critical:** Most South Asian clients expect immediate relief from troubling symptoms, so focusing on symptom management at the start of therapy can improve engagement and boost the client's confidence in the therapist.
- **Pay attention to non-verbal cues:** In most non-Western European-North American cultures, therapists are seen in a position of authority. So, a client might not openly disagree with their therapist. Instead, they might express their disagreement by not turning up for the next appointment. Therapists should therefore pay attention to the client's body language and subtle changes in language, expressions, and behaviours.
- **Use examples from therapy as evidence:** Clients like to know how successful their therapist has been with other clients. Therefore, we recommend discussing similar cases and how the individual's concerns benefitted from therapy. Also, describing current evidence from research can be helpful.
- **A personal connection:** Clients from many non-Western European-North American cultures like a personal connection with their therapist. The use of religious, spiritual, or cultural examples can help. Offering food or gifts to a therapist is normal, and rejecting these might be considered rude. Personal disclosure about non-significant matters, mainly focusing on similarity and closeness, can help. For example, "Oh, I also have three kids," "Yes, my mother lives in that area where you live," or "Ah, my neighbours come from the same village where your parents came from."
- **Family is a valuable resource in therapy:** Although the family can cause conflict and stress (and even be a barrier to access or engagement with therapy), it can be a valuable resource to help and support clients. After an initial discussion on setting rules and boundaries and gathering client consent, tactfully involving the family can improve engagement. The family can significantly assist in the process of information-gathering, the core therapy (by being 'co-therapists'), supporting the client outside of therapy, and bringing the client back for follow-up each week. Valuable lessons in this area can be learned from culturally adapted family therapy [63]. Due to the hierarchical system typically present in SA families, there is usually one decision-maker in each family. The therapist should find out early in therapy who is the family's decision-maker. Approaching the decision-maker can ensure co-operation and future follow-up. It is crucial to keep in mind the 'secrets' within the family. It is essential to maintain the client's privacy, dignity, and confidentiality within this context. See Handout 4.

PART 3

Therapy-Related Issues II

Adjustments in Therapy & Session Details

3.1 General Advice

In this chapter, we have provided various details on specific adjustments to therapy that can be made in CaCBT. Furthermore, we have included considerations that should be kept in mind while working with South Asian clients.

3.1.1 Use of Images and Stories

Experienced therapists from non-Western European-North American cultural backgrounds often use stories to convey their message to clients. Stories can also be compelling when used with images in handouts [55, 64].

Case Example #5

Krishna presented with a persistent headache. He also had symptoms of both anxiety and depression and was referred for CBT. He expressed anger to his new CBT therapist because his doctor was not initially interested in his headache and had not performed a physical examination. Therefore, the first two sessions with his new therapist focused on the assessment of the headache. The therapist eventually arranged for him to be examined by a physician. Krishna found this reassuring, especially since the examination revealed no physical problems. He was then advised to use breathing exercises and muscle relaxation to help with the headache. Krishna asked whether a traditional South Asian head massage might be useful. The therapist agreed it would be a very good idea. When the client returned the next week, Krishna reported some reduction in his symptoms. The therapist started with educating him on anxiety and depression, describing his symptoms, and using his response to the relaxation exercises as evidence that his headache might be due to anxiety, and not a physical illness. Krishna was happy to proceed with therapy.

3.1.2 **Therapy Style**

A more directive therapeutic style might be helpful when beginning therapy with a client. As therapy proceeds, a collaborative approach can be utilized. The non-Western European-North American model of spiritual and emotional healing typically involves a saint or a guru who gives sermons instead of a professional therapist who teaches through 'Socratic dialogue' (as is preferred in individualistic Western European-North American cultures). Clients from non-Western European-North American cultures often feel uncomfortable if the Socratic dialogue is used without sufficient advance notice. They do not expect therapists to ask questions; they expect that therapists should provide guidance or solutions to their problems. Consequently, asking questions using a Socratic dialogue can create severe doubts about the therapist's competence.

3.1.3 **Guru-Chela Relationship**

Neki, an Indian psychiatrist, outlined the paradigm of the Guru-Chela relationship between the therapist and the client [65]. He highlighted the relevance of this relationship in psychotherapy and how clients from some cultures may benefit from such a paradigm. Interestingly, the validity of this notion has never been tested with a data-driven approach, which highlights the need for clinical trials that can assess the effectiveness of this paradigm. Many cultures regard professionals with a high degree of respect, and this is very much true of South Asian cultures where education and expertise are well-respected. Professionals are considered trustworthy and wise rather than just being seen as 'providers'. Therefore, the relationship is not of *customer/provider*, but instead, the therapist is seen as an educated and concerned expert who is considered authoritative. As discussed above, we suggest a gradual move from a directive approach to a more collaborative role in therapy. However, this will require ongoing assessment on the therapist's part as this will likely be a challenge for first-generation immigrants and may require a slower transition of therapy styles.

3.1.4 **Focus of Therapy**

The therapist must address the client's concerns (e.g., physical symptoms) instead of just using therapy mechanically or rigidly. CBT puts great emphasis on structuring sessions around the client's needs. It is the therapist's responsibility to address the client's concerns, engage them, and, only then, move on to therapy issues that the therapist feels should be addressed. The two-stage rule we use can be described as *focus and connect*. In the first stage, the therapist should focus on the client's concerns (e.g., somatic complaints). During the second stage, the therapist connects the client's problem with the therapist's concerns (e.g., depressive illness, anxiety, or suicidal thoughts) and promotes the therapy plan.

3.1.5 **Dealing with Somatic Symptoms**

Advice on dealing with somatic symptoms can be useful and can build the client's confidence in their therapist. It helps to show clients how physical symptoms, thoughts, and emotions are linked. One good example you can use is the experience of heart palpitations in a threatening situation. Similarly, the link between headaches, nausea, diarrhea, and sweating during stress can also be highlighted. Knowledge of SA idioms of distress is also helpful. For example, when under stress, people often use bodily sensations to express their feelings (e.g., in the West, to express emotions through physical sensations, some common idioms are: experiencing 'heartache', being 'sick with disgust' or telling someone they may be 'giving me a headache').

Clients may find breathing exercises beneficial (some SA clients may easily recognize these if familiar with Yoga and Sufism). Clients with headaches can be advised to get an "extended head massage" (i.e., a head massage that also involves massage of the neck and shoulders). Seeking a medical assessment for somatic symptoms will increase the client's confidence in the therapist. This can have a significant effect on most clients. Drinking less water during meals and avoiding greasy or spicy food can help with gastrointestinal symptoms. A classic description of anxiety among clients is "a bowl of gas that starts from my stomach and then slowly goes to my head, making me dizzy." Bengali-speaking clients may complain of "gastric" symptoms—referring to heartburn, bloating, and gas related to food intake—that are often connected to the client's anxiety level and emotional state.

3.1.6 **Homework**

Assigning homework tasks can be a significant problem in Western European-North American cultures due to non-compliance. For clients from many non-Western European-North American cultures, it may be an even bigger problem. Engaging the family can help, as can assigning activities that are less reliant on the written word. For example, the client could be given audiotapes of the session or bibliographic material and encouraged to use beads or counters (which are commonly used in Asia and Africa) rather than pen and paper to counter negative thoughts. It can also be beneficial to clients to practice in session the material you are assigning for homework. For example, you may discuss one of their cognitive distortions and complete a corresponding thought record together. This is where a collaborative approach can be helpful.

3.1.7 **Use of the Cognitive Model**

Literal translations of CBT terminology might not be helpful in this context. For example, in teaching about cognitive errors, it might be better to explain the concept (e.g., black and white thinking) and ask the client what they call this thinking style in their language or culture. This will help them discover an idiom that is more relevant to them. Next, focus on teaching the client to recognize

their thoughts. It might help to define 'thoughts' as the images the person has in their mind or as their self-talk (in our experience, clients find 'self-talk' the most straightforward description to follow). Finally, we advise therapists to encourage the documentation of physical symptoms in thought diaries to help clients see the link between thoughts and physical symptoms [35].

3.1.8 **Therapy Techniques**

Clients from non-Western European-North American cultures often find behavioural methods of CBT (e.g., behavioural activation or behavioural experiments) and problem-solving techniques particularly useful. Problem-solving can be used without changes or adjustments and is especially helpful when the client's depression is associated with social and financial difficulties. Muscle relaxation and breathing exercises are often the most popular techniques among non-Western European-North American clients. Breathing exercises are a part of many religious and spiritual traditions and are commonly practiced in non-Western European-North American cultures.

However, caution is warranted when using such strategies. For instance, distraction and relaxation techniques can become safety behaviours. In addition, in some instances, people may use cultural practices as safety behaviours (e.g., yoga, prayer, healing practices and repetition of mantras). Therapists need to be aware of this and deal with it sensitively. For instance, this may involve understanding the individual's religion or culture and encouraging practical action from the client rather than on-the-spot safety behaviours. In addition, before using guided meditation tracks, the therapist should ask the client if they are comfortable using audio tracks with or without music. For example, more devout Muslims may not listen to music and prefer music-free guided audio tracks instead.

3.1.9 **Structural Factors in Therapy**

In our experience, clients from non-Western European-North American cultures are much more likely than clients from Western European-North American cultures to request specific information about the number of sessions, the structure of therapy, and the focus of the therapy (and some information on what will happen before the commencement of sessions). This is often because individuals are concerned about the cost—even those receiving therapy through the public health-care system have to think about their travel costs and absences from work—and because they may have no prior therapy experience, unlike their Western European-North American counterparts. Involving family members can also be helpful since they often want to know what the therapist will talk to the client about.

3.2 Depression and Anxiety

Symptoms of anxiety often occur alongside symptoms of depression. It has been suggested that up to 70% of depressed clients also suffer from anxiety [66]. Therefore, the therapist should assess for anxiety symptoms and help the client deal with these while keeping their overall focus on depression. Anxiety symptoms can lead to somatic symptoms that can cause a lot of distress. On the other hand, anxiety symptoms might be relatively easy to address with some immediate relief possible. We have therefore included some tips on dealing with anxiety and depression. See Handouts 2 and 3.

3.2.1 Management of Anxiety Symptoms

Treatment of anxiety usually includes:

1. Dealing with physical symptoms
2. Reducing avoidance behaviours
3. Working on cognitive errors and beliefs

In the following sections, some simple techniques are described which can be used to deal with anxiety symptoms. While some of these techniques address thoughts, others help people experiencing physical symptoms related to anxiety.

Breathing Exercises

Anxiety is caused when the sympathetic part of your autonomic nervous system becomes active. This part of the brain prepares us for fight and flight. In this situation, the body needs more oxygen, and therefore breathing becomes rapid and shallow. This, however, can worsen the physical symptoms of anxiety, especially pins and needles in the client's arms and legs. The purpose of breathing exercises should be explained to the client in detail before they are asked to practice them. Providing audio tapes for use at home can improve compliance.

Breathing exercises can help people to reverse their pattern of breathing. Breathing exercises are very commonly practiced in South Asia, and therefore many clients will be familiar with them. If anxiety is a significant part of the presentation, breathing exercises at the start of therapy will offer the client immediate relief. It helps to educate clients on "fight and flight" and offers the rationale for breathing. It is crucial to practice controlled breathing for 5–10 minutes. It is also essential that clients repeat the exercise many times a day.

Tip! Breathing and Muscle Relaxation Exercises

For Hindi and Urdu speakers, breathing and muscle relaxation exercises can be viewed from this link: https://www.youtube.com/channel/UC3h-7eagyNe_KkqtW95rrbw

Deep breathing works most effectively if the client breathes deeply in and out for equal amounts of time. Ask clients to try breathing in during a slow count of 1–2–3 and out to a slow count of 1–2–3. They can also use words of their choice, a bit like chanting. It doesn't matter whether they breathe through the mouth or nose. However, setting a routine might help the client on focusing their concentration. If the client has a religious inclination, you can ask them to use religious chanting once the skill has been established (e.g., for Sikh clients, Satnaam on the in-breath and Waheguru on the out-breath; for Hindu clients, Oam; and for Muslim clients, Allah on the in-breath and Hoo on the out-breath). See Handout 3.

Muscular Relaxation

Anxiety leads to increased tension in the person's muscles. Encourage the client to explore relaxation activities where muscles are progressively relaxed. Audiotapes of these exercises are also available.

Imagery

Relaxation methods using imagery can also be useful to help with anxiety. Therapists find this technique particularly useful with South Asian clients. The client is asked to visualize scenes that are tranquil and actively relaxing. Scenes may be actual places that people know, or they may be scenes they create. The specific scene is not as important as how the image makes the person feel. The more senses one can incorporate into the image, the more relaxing it is likely to be. If they can imagine the smells, sounds, tactile sensations, and visual aspects of the scene, they will find the relaxation method more helpful.

Soothing Music

Soothing music can also help clients. Some SA clients find it helpful if they listen to flutes or sitar. Everyone has a style of music that relaxes them. Please ask clients to find out what helps them. Many South Asian individuals listen to classic songs (raga), spiritual music, chanting (e.g., Kirtan, recitations, or Sufi songs) and musical instruments such as the wooden flute or sitar. As mentioned before, more devout Muslims may not be comfortable listening to music (because of Islamic prohibitions on stringed and wind instruments). However, they may be open to percussion, voice-only, nature sounds, Nasheed (songs praising the Prophet Muhammad[pbuh]) or listening to Quran recitation instead. It is essential to discuss what type(s) of music the client is comfortable listening to.

Distraction

The way we think is an essential factor in the causation of anxiety. For instance, thoughts can affect our physical reactions (e.g., a frightening thought can cause palpitations). Distraction works because our attention is focused on the thoughts or physical sensations that contribute to our anxiety. This can take many forms, like talking to someone, religious activities, keeping busy with reading, watching TV, listening to the radio, focusing on objects in the environment, and physical activities. More techniques for distraction are described in the section on cognitive errors.

Food and Anxiety

South Asians use a multidimensional approach to healing. For example, while taking medication for depression, many clients will attend a religious or faith healer and try their best to choose the food they believe can heal them. In addition, SA clients often ask their physicians about "food they should avoid" (forbearance) when unwell. See Table 4.

Table 4 Food and Mood

Foods which cause anxiety	Diets which help anxiety	Eating habits which cause anxiety
Caffeine, nicotine, alcohol, drugs	Eating more vegetables and fruits	Eating quickly (mindful eating can alleviate this tendency)
Stimulant drugs	Eating more raw vegetables	Very little chewing (15–20 chews per mouthful is ideal)
High salt diet	Avoiding refined and processed foods	Eating too much
High fat diet	Avoiding foods that causes allergies, stomach pain, or other discomfort	Drinking too much fluid during a meal
Chocolate	Drinking plenty of water	Starving one's self (Hypoglycaemia)
Red meat and animals raised on hormones		

Massage and Head Massage

Both massage and head massage (Champi) are very popular in South Asia. We encourage our clients with anxiety to get an "extended head massage" (i.e., a head massage which involves massage of the neck and shoulders). This can have a significant effect on most clients to reduce their stress and anxiety.

Religion and Spirituality

Encouraging clients to return to past religious or spiritual practices can be of immense help. It is therefore vital to ask about religious or social practices clients were involved in before therapy.

Changes in Lifestyle

Some personality traits and habits are more likely than others to cause anxiety. Sometimes just being aware of these can reduce anxiety. Poor stress management skills, perfectionist or dependent traits, the excessive need to please control others, and being too competitive are examples of such characteristics.

3.2.2 **Symptomatic Management of Depression**

These are some of the commonly occurring problems which are associated with depression and their possible solutions. Clients often find it helpful if the therapist can advise on how to manage their symptoms. As clients from a SA background often use a holistic approach, a therapist should be ready to advise clients on these related issues. See Handout 2.

Problems with Eating

Weight loss is a common problem in depression due to reduced appetite. Sometimes, weight gain can also occur because of overeating and reduced activity or simply due to unhealthy eating. Medication for depression can cause dryness of the mouth, leading to the increased use of sweet drinks and juices. This can also give rise to weight gain. Simple advice and support regarding the client's diet and physical activity can help with these problems. Advise clients to monitor their food and intake of sweet drinks. Eating a diet that is rich in proteins, fruit, and vegetables can be helpful. Clients who lose their appetite can be helped further by taking smaller meals at regular intervals. A simple journal can be used to monitor food and fluid intake to ensure optimal healthy eating. Working with a dietitian experienced with this population is advisable. Similarly, providing a thorough medical check-up can help to rule out physical factors that may affect appetite.

Sleep Problems

Disturbed sleep is likely the most common (and probably the most annoying for the client) of all the symptoms of depression. It is crucial to explore the client's ideas about sleep when a client talks about sleep disturbances. A significant proportion of people who present with sleep problems are often found to have unrealistic ideas about sleep. The amount of sleep each person needs can often vary, and the number of hours they need each night can change throughout their life. On average most people need six to seven hours of sleep. Napping in the afternoon is still very common among South Asians and is worth exploring when discussing sleep problems.

Tips to Improve Sleep

Activities before sleep

Our brain needs some time to switch off. Physical over-activity (e.g., exercising) or overeating just before bed can keep people awake. There are wide individual variations in this regard. Some people read in bed or watch television while lying in bed, which helps them go to sleep. But others might find that such things keep them awake. Everyone should try his or her 'cool down' technique and give themselves the time to unwind. For many clients, prayer and other acts of worship like reciting scripture, may be a helpful bedtime routine.

Physical problems

Physical problems, such as discomfort or pain, can cause sleep disturbance.

Sleep routine

Keeping a sleep routine is very important. Going to bed at night and getting up in the morning at regular times can be helpful for many people.

Psychological problems

Sleep problems often resolve once depression gets treated. Simple anxiety management techniques like breathing exercises (as mentioned earlier) can be beneficial.

Tea, coffee, nicotine, and drugs

Drinking tea or coffee before going to bed can make people feel alert. Not drinking tea or coffee after 6 PM can help many people. Similarly, cutting down on cigarettes before going to bed can also be helpful. Many drugs including cannabis and alcohol provide temporary relief but are harmful in the long term. As some clients might find it difficult to discuss these issues due to stigma, the therapist should provide a safe space to discuss these issues.

Day Naps

Day naps are common for people living in warm climates, especially after lunch. Naps can lead to disturbed sleep. It has been suggested that sleeping late in the morning hours might be linked to depression.

Healthy Sleep Environment

A healthy sleep environment consists of the following: a comfortable bed, a comfortable temperature of the room (neither too hot or too cold), a noise-free environment, and a room without excessive light.

Local practices

A variety of local practices (e.g., herbs such as chamomile or lavender, warm milk, etc.) are used to aid sleep. It is worth exploring these options.

Excessive Tiredness

This is common in depression and can interfere with the day-to-day activities of the client. Simple reassurance—that once the depression improves they will feel more energetic—can be helpful. Clients can be advised to participate in activities that are pleasurable and not strenuous. Or, they can be advised to start with activities that need less energy and increase their activities gradually. Activity schedules can be helpful since some clients will be doing a lot but might believe they are not doing much at all. Light exercise can also play a vital role. Encouraging physical activity amongst South Asian women may be challenging as it is often out of the cultural norm. Helping clients incorporate yoga (for Hindu and Sikh clients) or light walking and stretching into their day may be helpful.

Relationship Problems

As mentioned previously, relationships are vital for SA clients. For example, studies with Bangladeshi immigrants in Toronto revealed that cultural clash and breakdown within the parent-child relationship after arrival in Canada is a significant source of stress and depression [67, 68]. While relationship difficulties might lead to depression, depression can cause problems in relationships, especially if the client complains that their family members are not very understanding of their condition (and therefore not supportive). A meeting with the family members can help in this regard. As well, educating the family might help them understand the client's problems. However, the problem might be relationship difficulties such as communication problems, social skills, lack of assertiveness, conflict management, and partner abuse. See Handouts 13 & 14.

Reduced Sex Drive

One of the features of depression is an inability to enjoy pleasurable activities. Some psychiatric drugs can also cause reduced sex drive. This can cause a problem in the client's romantic relationship. However, this is often a topic people do not feel comfortable talking about. A simple explanation and reassurance can often help. In general, people can also have very wrong ideas about sexuality, increasing feelings of depressed mood, shame or guilt. The topic of sexual health is particularly taboo amongst South Asian women and can be a difficult topic to broach. Moreover, many South Asians believe masturbation and loss of semen cause mental illness. Therefore, careful discussion, education, and advice are advised.

Case Example #6

Janani is a 23-year-old Sri Lankan person. In their first therapy session, they reported a long history of depressive episodes (starting in early adolescence), self-harm by cutting, substance use issues, and multiple intimate partners. They described themselves as being a high achiever and often felt pressured to do well at school, saying that, "There is no other choice". Janani comes from a strict family which meant they couldn't go out alone, and socializing with friends outside of the school environment was a stressful process to negotiate with their parents (so much so that they would often not bother or simply lie). They had specific duties in the home, which included cooking, cleaning, and caring for younger siblings and grandparents. The older Janani got, the harder it became to manage the stress of living what they described as "two lives"—the spaces they accessed outside of the home were very different, they were exposed to different cultures, ways of thinking, and freedoms that were prohibited in their home and community of origin. They also said that it's likely their mother suffered from depression but had never sought support for it. The depressive episodes consisted of feeling worthless, guilt for abandoning their family values, persistent sadness, and irritability in the home environment (despite needing to be passive). More recently, Janani started to notice what being passive meant in other environments and relationships. It had become difficult to assert their needs and opinions, and this contributed to increased feelings of worthlessness. In therapy, Janani and their therapist focused on cognitive restructuring and flexibility, assertiveness training, and, most importantly, navigating multiple and complex identities. Family was not involved in treatment as Janani wanted an independent space to explore their thoughts and feelings about their family and integrating family into the work left them feeling unsafe. Over time Janani reported improvements with their mood and motivation levels, and the identity work was ongoing as they transitioned through different life stages.

Constipation

Infrequent bowel movements are a common problem of depression. Low food and water intake add further to this problem. It can be an unpleasant experience but can be dealt with easily. Some antidepressants can also cause constipation. Our experience and discussion with medical colleagues taught us that South Asians often stop eating or use home remedies that increase constipation. Please ask your client how they are trying to treat their constipation. It is essential to explain to the client the likely causes of constipation. Usually, this is helped by drinking plenty of water, eating many vegetables and fruits, and increasing physical activity. Simple local remedies like Ispaghula Husk (psyllium fibre) or drinking a glass of warm milk at bedtime can be helpful.

Alcohol and Drugs

Some people may use alcohol or drugs to cope with a depressed mood. This can worsen their mental health symptoms. Alcohol and drugs are widespread among individuals from SA cultures (contrary to the popular belief that it is not). However, due to the stigma attached to drinking, many clients also feel guilt or shame, worsening their depressed mood. It is crucial to advise such clients to use healthier coping strategies.

Similarly, people who smoke can also smoke excessively when depressed. This is another unhealthy strategy. Smoking has been associated with the risk of becoming depressed. This issue is similar to using alcohol and drugs. However, it is difficult to abstain from smoking due to its social acceptability and social desirability in some cultures. In addition, substance use and sleep disturbances impact the ability to engage in spiritual practices, which exacerbates symptoms, negative self-evaluations, and recovery.

Anger

SA clients with depression and anxiety often present with anger. In SA culture, constant politeness is a requirement, so expressing anger or excessive irritability can often lead to shame and guilt. It can be helpful to explain to clients the link between anger, irritability, depression, and anxiety and provide them with tips such as distraction, use of thought diaries, and breathing exercises.

Guilt

Guilt is a common symptom of depression. It has been suggested that people from Western European-North American cultures based on Judeo-Christian religions might experience more guilt than other cultures. Clients with depression often feel guilty because of real or imagined mistakes or shortcomings. For SA clients, feelings of guilt may revolve around not looking after their family, especially the elders, or not performing religious rituals. Reminding Muslim clients of God's mercy and forgiveness and *hadith* (sayings of the Prophet Muhammad[pbuh]) such as, "By the One in whose hand is my soul, if you did not sin, Allah would replace you with people who would sin, and they would seek forgiveness from Allah and He would forgive them", may provide solace. Reassurance and explanation of these symptoms can be of paramount importance. Clients need to be informed that once their depression improves, these thoughts will go away.

Even for those who don't feel markedly guilty, self-blame is common in this group. As already mentioned, the SA population is more focused on responsibilities than rights, leading to self-blame. A technique that can be used here is called "reattribution." This is also used when clients accept responsibility for everything that happens in their life and personalize other people's mistakes. Therapists begin by examining the event and analyzing the available information to make an appropriate assignment of responsibility. For Muslim clients, it may helpful to quote verses of the Quran such as, "That no bearer of burdens will bear the burden of another. And that there is not for man

except that [good] for which he strives. And that his effort is going to be seen—Then he will be recompensed for it with the fullest recompense" (Quran 53:38-41). Quotes like this may remind the client that God does not hold them responsible for anyone else's deeds other than their own.

You should try not to issue the client a 'clearance certificate' but instead help them to see how much responsibility they should accept. The core idea is that you should help the client to see that they are not responsible for everything that happens, that there are external factors too, and that most things are influenced by more than one factor. Another effective tool to help the client explore responsibility is the responsibility pie. See Handout 16.

Shame

Shame is a societal value that is kept in high esteem in Asian cultures. For example, speaking to an elder in a loud voice, or even disagreeing with an elder, can signify shamelessness and is viewed negatively by others. Shame and guilt can also affect others in Asian cultures. For example, clients might feel ashamed of not doing what they are expected to do. Similarly, a family member might use shame to make the client do things even when they are depressed. The therapist can explore this concept with the client to see whether the client has feelings of shame, discuss how to cope with these feelings, and how these thoughts are related to feelings of guilt.

Gilbert et al. [69] found that *Izzat* (reflected shame and honour, or the shame and honour that can be brought to others by one's behaviour) plays a vital role in South Asian families. The importance of maintaining family honour and identifying with it (Izzat) was linked to personal shame. It was also given as a reason for why people can be trapped in complicated relationships. Moreover, fear of reflected shame and loss of Izzat were regarded as key reasons South Asian women might not use mental health services. A central fear of South Asian women is the potential failure of mental health professionals to maintain confidentiality.

South Asian communities operate within a highly patriarchal system, and therefore women and those from minority groups are more likely to experience the harmful effects of Izzat. For South Asian women, it is well documented that they are considered to carry the Izzat of the family and therefore engaging in shameful behaviours perpetuates familial shame and stigma.

South Asian cultures may have more expression of shame as opposed to guilt (more common in Abrahamic religions such as Islam, Christianity and Judaism). Even when guilt is encountered, this may be in reference to violating a societal or familial norm. The Western-educated therapist may see this entirely as cognitive distortions but may need to understand the context of these emotions in a community affiliative cultural context/value.

3.3 Behavioural Activation

From our experience, we have recognized that behavioural techniques are almost culture-free. We, therefore, encourage therapists to use behavioural techniques before they try cognitive techniques. In addition, it might be worth exploring the resources which a client doesn't have, including money, legal status, social connections (including isolation at home, especially for the elderly), necessities (e.g., not being able to leave the house due to a lack of driving skills or access to transportation, especially for the elderly and women) so the therapist can use these real-life examples to talk about problems and how to overcome them.

3.3.1 **Self-Monitoring of Activities**

Self-monitoring involves recording activities and associated moods for at least one week. In this way, we can get concrete evidence about clients' levels of activity. It is common for clients to say that they are not doing anything, with some clients only realizing how much they are doing after they look at the record. The record also gives the therapist an idea of the client's levels of activities. This can then serve as a baseline record that can be used for future comparisons. The therapist can ask the client to record the level of mastery and pleasure associated with each activity. The records can be used to test beliefs related to the client's inability to do things. These records can also highlight any unhelpful coping strategies. Finally, the therapist can use the activities to remind the client of the thoughts and emotions that the client experienced. The therapist can then ask the client to increase activities that improve their sense of mastery or pleasure and reduce activities that cause distress. See Handouts 9 & 10.

3.3.2 **Activity Scheduling**

Clients with depression often complain of reduced activities. This can happen for many reasons, including low energy and tiredness, low mood, little sense of enjoyment or achievement, and lack of interest. Whatever the reason, reduced activity leads to a further increase in inactivity. It is therefore important that this vicious cycle of reduced activity is broken. See Handout 9.

Therapists working with the SA population report that clients find activity scheduling very helpful, and they often use this as a first step in therapy. Activities can be connected to the way people feel. Following the observation that depressed people tend to stop doing pleasurable activities, depression treatments often emphasize that the client increase the weekly number of enjoyable activities. As a first step toward treating depression, it is often helpful to increase activities—especially pleasurable activities or those that lead to a sense of accomplishment. When we do activities that are enjoyable or activities that accomplish something, we usually feel better. In consideration of SA values, we encourage people to consider social and spiritual activities. By tracking their activities, clients can discover how they affect their mood. They can see how their past and current activities are associated with their mood. And you will notice that their depression is reduced by planning future activities. See Handout 10.

By scheduling and doing enjoyable activities, clients will be making behavioural changes that can reduce their depression. Additionally, doing highly enjoyable activities should help them more than doing less enjoyable activities. Examples of enjoyable activities include talking to a friend or a family member, listening to music or religious chanting, engaging in religious or spiritual activities, playing on a computer game, taking a walk, going out for lunch, watching a favourite TV show or sporting event, or playing with their child. Notice that pleasurable activities do not need to be expensive. Activities can be either (a) those which give mastery and pleasure, (b) those that have been pleasurable in the past or, (c) new activities that the client and therapist feel are going to be helpful.

When advised to complete an activity schedule, clients should be informed that they should not expect to find the activities as enjoyable or as satisfying as before they became depressed. As mentioned above, weekly activity records can help identify what a client was doing when they felt depressed, anxious, or angry. In addition to identifying behaviour and moods, the weekly activity schedule can be used as a guide to see what changes in behaviour might help them feel better. Helping clients in this area can help to increase their sense of mastery, control, and effectiveness. When a client has difficulty performing an activity, the therapist should discuss it in detail with the client and try to find out the obstacles that caused the hindrance.

Case Example #7

Kuljeet is a 69-year-old Sikh male who immigrated to Canada at the age of 45 yrs. He initially worked in a factory and then progressed to taxi driving. He came from a stable family in the Punjab region of India. He moved to Canada along with his wife and young son. He didn't have any other family in Canada but there were many people from his home village in Punjab who he considered family. Also, over the years, other taxi drivers became a core part of his community. Kuljeet reported always missing his homeland, his family and friends and coped with the feelings of loneliness by 'staying busy' by working overtime, or if at home, turning to alcohol to cope with feeling low, unmotivated, and irritable. There was a lot of external pressure to ensure his family in Canada had all their needs met along with sending money home for his parents and siblings. The alcohol use increased when he retired, and his feelings of loneliness and worthlessness increased concurrently. The more alcohol Kuljeet consumed, the more distant he became from protective factors like spending time with his family and engaging in *seva** and other spiritual practices. His family and grandchildren, motivated him to seek therapy, and over the course of therapy they supported him to begin exercising, eating healthy meals, and engaging in prayer. In psychotherapy sessions, there was a focus on psychoeducation to help increase his understanding of depression and how alcohol had become an unhealthy coping strategy that developed over time. Behavioural activation was a core component of therapy to help Kuljeet with getting active again—he had spent most of his life being busy and since retirement he has been at a loss with how to spend his time. Reengaging with spiritual practices helped him foster *chardi kala***—a mindset that had helped him through life; he would say "the closer I feel to God, the better I feel".

* Seva: Sanskrit word meaning selfless service

** Chardi kala: central concept in Sikhism. Acceptance of Divine will, that gives one courage to face life's struggles

3.3.3 **Graded Tasks**

When complex activities are planned, it might be useful to break them into smaller steps. You should ask the client to start with small and simple steps. This is also called "success therapy" because it is assumed that the chance for future success increases if the client experiences success. In our experience, clients like this exercise and find it very easy, even when given at the start of therapy. However, you may wish to clarify that this is not the only thing the client has to do and you can continue to prepare them for cognitive therapy during this period to avoid premature termination. When clients cannot perform activities agreed upon in a session, they might feel more depressed. One significant advantage of the graded task technique is that it helps to reduce the chances of failure.

3.4 Practical Problem Solving

Everyone faces problems from time to time. People can often solve these problems easily or with the help of their friends and/or family. However, sometimes these problems can be overwhelming, and people find it difficult to cope with them. The relationship between depression and experiencing difficulties or problems is not a straightforward one. Sometimes people can become depressed because they are overwhelmed with too many challenges. But a depressed client might find that even everyday situations are challenging to cope with. Problem-solving can be used without any significant cultural modifications for the SA population.

Problem-solving can help those who have functioned well in the past and those who, due to their emotional problems, now find it difficult to cope with problems, and also those who were never good at solving problems. Problem-solving has its limitations. The technique is best used when:

1. The problem can be defined in specific and concrete terms.
2. The client's goals are realistic (although the client may not see it that way right away).
3. Severe mental or physical illness is absent.

Clients must be taught to systematically deal with problems (e.g., that you cannot deal with all your issues simultaneously), and it helps to prioritize and deal with these problems one by one. See Table 5. Although sometimes it is impossible to control how and when they emerge, with some practice, it is possible to foresee some of the problems and tackle them as they emerge. It is essential to point out that some people try to ignore problems hoping that they will disappear. This is a fatal mistake, and they feel overwhelmed with their problems, which can cause immense stress. Dealing with issues when they arise is the only way to tackle problems without getting stressed. Clients may need a lot of help with problem-solving at the start. Therefore, they will need a lot of therapist input at the beginning. See Handout 11.

Table 5 Common areas in which people experience problems

Common areas
◗ Family Life (relationships, housing, children etc.)
◗ Social Life
◗ Work (problems at work, relationships with colleagues, stress at work, or even loss of work)
◗ Legal Problems
◗ Use of Alcohol or Drugs
◗ Health Problems
◗ Financial Problems

Steps in Problems Solving

1. Define the Problem

The first step is to make a list of possible problems. This can help in prioritizing the problems. The client can then decide which issue is the most important and should be dealt with first.

2. Decide which Problem is to Be Addressed First

It is preferable to choose a problem that appears easy to solve. An alternative approach is to solve the problem which is most important to the client. Our advice is to start with the first approach since that has the immediate effect of raising hope, which might be especially helpful when the client is depressed or has low self-esteem. Although the client should ultimately decide which problem is to be tackled first, a therapist can offer more active guidance during the initial stages of the problem-solving process.

3. Think About Possible Solutions

It is best to encourage clients to think of as many solutions as possible to their problem, a process akin to brainstorming. Encourage them to include solutions that you or the client think are possibly silly since this approach may bring forth ideas that the client may find helpful. It may be beneficial for the client to disassociate themselves from the problem for a short period. If the client finds it difficult to generate solutions initially, the therapist can help them to find solutions.

4. Look at the Cost and Benefit of Each Solution

Once a list of solutions has been formulated, it is necessary to go through them one by one, to look at the advantages and disadvantages of each. To do this, ask them to draw a line on a piece of paper and write down the advantages and disadvantages of a solution on each side. You can then decide which solution is the best. This is called the two-column technique.

5. Choose the Most Appropriate Solution

The above strategies should help the client to find a solution to the problem. However, it is important to remember that the solution should be (a) realistic, (b) helpful in making a positive change, and (c) specific.

6. Break Down this Solution into as Many Steps as Possible

Now is the time to look at how to execute the solution. To do this, every part must be considered carefully. Breaking down the solution into small doable steps can be helpful. Ask the client to write down as many small steps as possible, even if they look foolish. They might realize that you need more information or might have to go back and rethink another solution. Cognitive rehearsal—i.e., going through the whole process in imagination—can usually be helpful at this stage. This can also help the client to imagine possible barriers.

7. Execute the Plan

Finally, it is time to act on a plan using the steps which have been devised.

8. Review the Outcome

Once the client has acted on their plan, it is good to review any challenges or mistakes. Then, clients can learn from them and refine their decision-making skills for the next time.

Case Example #8

Problem solving with Vithushan

Vithushan was a 22 year old Bachelor of Arts student experiencing various issues in his life. Both Vithushan and his therapist agreed that Vithushan will feel lot better if they discuss his problems and see if anything can be done about them. These are the stages which they adopted.

List of problems

- No job
- Low self esteem
- Cannot speak in public
- Problem with studies
- No money for next semester's tuition
- Shyness

Once a list of problems had been made, the therapist and Vithusan went through each problem to see which problem should give immediate relief, which is most important to Vithushan and can be solved quickly. Since Vithushan had to submit his tuition payment within two weeks, it was a concrete & practical problem and he could lose his schoolyear if he was unable to submit the fees.

List of solutions

- Talk to father
- Talk to local businessmen
- Connect with a local community
- Talk to friends
- Borrow money from someone
- organization with student support programs
- Steal Money
- Talk to the university administration

Choosing a solution – Talking to University Administration

Advantages

- *Government announced new grants recently and university may help me to apply*
- *I will be able to concentrate on studies if I don't worry about fees*

Disadvantages

- *Will have to talk to university administration who is known for being strict*
- *People will make fun of me if they find out about my financial situation*

Steps in applying solutions

- *Getting ready*
- *Request a meeting with university admin*
- *Finding more about admin department*
- *Deciding on what I have to wear during the meeting*
- *Writing down what I have to say in meeting*
- *Getting there on time*
- *Role play and rehearsal*
- *Ask a friend who can accompany me for support*

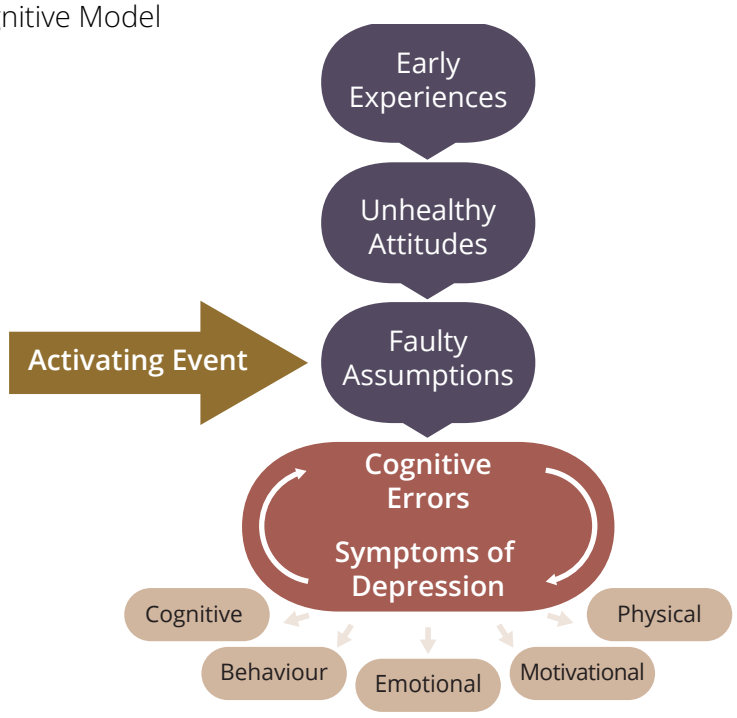
Although the university administration was not able to help Vithushan as the deadline for grant applications had passed, he was surprised that the advisor was very helpful and sympathetic. Vithushan next decided to try a local community organization. He was asked to see a local businessman who had helped students in the past, who then provided with the financial support needed. Vithushan was able to submit his tuition fees on time.

3.5 The Cognitive Model

The cognitive model emphasizes that *it is important how we perceive an event and not the event itself*. Our perception of an event can lead to negative thoughts and thus lead to distress and negative emotions. The model further asserts that negative automatic thoughts or cognitive errors (unhelpful ways of thinking) are the thoughts that are present when a person reacts negatively to some situations. For example, a person has been asked to meet with his boss. While they walk towards their office, the person might think, "My boss will fire me," although there is no reason to believe this. These thoughts are believed to be due to core beliefs and internal rules this person holds. A helpful metaphor says that the core beliefs are like roots, while the thoughts are like plant branches. We will discuss the cognitive model of depression here briefly. See Figure 4.

The model suggests that we lead our lives by internal rules (our belief system). These rules are the outcome of our experiences throughout our lives, starting from childhood. These beliefs influence our thoughts, which subsequently lead to certain behaviours. Some of these rules and assumptions are negative and, once activated, can increase negative automatic thoughts. In turn, these thoughts lead to symptoms of depression that can be behavioural, emotional, cognitive, or physical. We all have these negative automatic thoughts from time to time. However, clients with emotional problems have them more often than usual. Once these thoughts are activated, a vicious cycle sets in. For example, a depressed mood, which can lead to less activity, then leads to more time for thinking, and eventually further mood deterioration.

Figure 4 The Cognitive Model



3.5.1 **Components of the Cognitive Model**

Emotions

South Asians commonly use the word "mood" (it may be helpful to keep in mind the past British occupation and cultural influence—the so-called British Raj) to describe their emotions or feelings. Here, we are using "mood" and "emotion" interchangeably to reflect the language used by South Asians. As such, we have noticed that clients often find it challenging to recognize emotions. This reflects in traditional mindfulness systems, Ayurveda and Sufism, which do not acknowledge the duality of the brain and the body. Therefore, it is an essential part of the therapy to teach your clients about emotions and their meaning. Keeping a mood diary can help with recognizing the mood. This is similar to a thought diary.

Tip! Questions to Help with Recognizing Emotions

These questions can help clients in recognizing their emotions by labelling them and in differentiating one emotion from another. Ask the client how he/she might feel when in these situations.

- You had an accident.
- Someone shouted at you for no reason.
- You lost your job.
- You are in your bed and you hear a noise on the roof.
- You have been caught while stealing from a shop.
- Your friend has told you off for no reason.
- You have just been offered a job.

A "mood" is how we feel at a certain time. There are many different types of moods. Some of them are easily recognizable, while others are not. Some people find it difficult to separate one type of mood from another. In general, clients with depression find it difficult to enjoy pleasant situations while displaying an exaggerated response to an unpleasant one. Some clients might also refuse to accept that they are feeling sad. It may be natural for clients to judge moods/emotions as "good" (e.g., happy, grateful, client) or "bad/sinful" (e.g., angry, depressed, resentful, unforgiving). However, most clients can become aware of their depressed mood after being educated on depression and its symptoms. Sometimes clients talk about the loss of (or reduction of) emotions and emotional experience. It is also essential to discuss the difference between feelings and thoughts with the client.

An understanding and accepting approach can be beneficial since many clients might have learned to suppress their emotions. Teaching about emotions can start with brainstorming and describing common emotions. See Handout 12.

You can ask the client questions related to situations in which they are likely to experience certain emotions. If the client has difficulty recognizing these emotions, ask them to focus their attention on their head, chest, heart, stomach, or other body parts. Clients can also be asked to measure their emotions using a visual analogue scale.

The Cognitions (Thoughts)

Depressed clients tend to look at everything negatively. It has been postulated that there is a strong link between negative thoughts and moods. Therefore, an essential part of treatment is teaching the client to recognize their emotions and cognitions and how they are related to the physical symptoms, behaviour and life events they are experiencing. Cognitive errors (unhelpful ways of thinking) play an essential role in causing depression. Once a client is adequately trained, they should be able to identify their cognitions.

This teaching can be done in small steps. In the first step, they can be taught what cognitive errors are (using examples from their assessment) and relate them to a recent event when the client felt depressed, anxious, or angry (or even an example from someone else). Next, the clients can be asked to record negative cognitions at home using a diary.

Lastly, you can help the client see the link between thoughts, emotions, and behaviour using examples from their diaries. You can then try to change cognitions. The process of change starts when the clients start recognizing their thoughts. Information leaflets on thoughts and emotions can be given to the client in a written or audio format.

Cognitive Errors

We advise therapists to monitor their thoughts and to observe other people around them before working with clients. This gives them a chance to observe and learn about their thinking styles and give them examples that they can use in therapy. It is also important not to use literal translations of the CBT terminology. For instance, clients generally don't like the term "negative thinking", so we use the term "unhelpful ways of thinking". The adjacent box has real-life examples that can give clients and therapists a vocabulary grounded in everyday vernacular.

We need to emphasize that these thoughts are not specific to depression, and they can occur in other disorders and even in non-depressed persons. However, in non-depressed people, negative automatic thoughts are not as extreme or as frequent.

Changing Thoughts (Cognitive Restructuring)

Thoughts can be changed in three simple steps:

1. Recognizing thoughts and their accompanying emotions, physical symptoms, and behaviours
2. Challenging thoughts
3. Creating a balanced thought

Tip! Unhelpful Ways of Thinking

Jumping to conclusions
Making an assumption with very little evidence (or none) to support it. For example, you see your husband or wife talking to someone on the phone and you think they are having an affair.

Selective abstraction
Focusing on a detail taken out of context, ignoring more salient features of the situation, and conceptualizing the whole experience based on this chosen fragment. For example, a client might feel they are useless at work, even though their boss tells them about how many positive things they are doing and that, overall, that they are doing well, although they still need to improve their computer skills. A client may selectively ruminate on the one point of criticism and not the many points of praise.

Over-generalization
Thinking that 'if it is true for one thing it should be true for all things.' A common example might be, "Because I failed in one test, I am a total failure" or "I am always late" or "I will never find someone I can trust."

Magnification or minimization
Reducing the importance of positive information or expanding the importance of negative information (i.e., making mountains out of mole hills, or mole hills out of mountains). For example, you forget a name and blame yourself the whole day for being forgetful.

Personalization
Assuming responsibility for everything that goes wrong even when there is no evidence for it (e.g., **your colleague resigns from his job, and you think "this is because I did not support him"**).

All or nothing thinking
Everything is seen as one extreme or another (i.e., seeing things in black or white terms, with no shades of grey). An example of this type of thinking, "If I don't pass all my exams with an 80% grade, I am a failure", or "If I don't buy expensive clothes for my children, I am a useless father."

Physical Symptoms

South Asian clients often present with somatic complaints. In a typical psychiatry outpatient department, nearly 60% of depressed clients present with bodily complaints [70]. We often use the example of the increase in heartbeat or abdominal cramps in response to stressful situations to highlight the link between stress and bodily symptoms. Focusing on these symptoms can help

to gain immediate rapport even if the symptoms are not relieved. The most common complaint is headache, and clients respond primarily to relaxation exercises, although in rare instances, a small dose of an anxiolytic might be required.

Behaviours

Most of the time, people are not aware of the link between their thoughts and their behaviour. Because we do so many things in our lives automatically, it is not a surprise that we are not aware of our thinking most of the time. For example, when riding a bicycle or driving a car, you do not have to think about what to do next apart from being careful about traffic or what direction you are going. Similarly, we don't realize how our thoughts guide our behaviours. Thoughts precede all our actions. For example, the thought "I am thirsty" comes before you go and get some water to drink. Similarly, the thought "he insulted me" might have come to a person's mind before hitting another person.

People experience different types of moods because of their thoughts. When they are in a situation, they interpret it according to their thinking at that time. This can then make them feel happy or sad. The way we feel, in turn, leads to how we behave.

3.5.2 **Recognition of Thoughts**

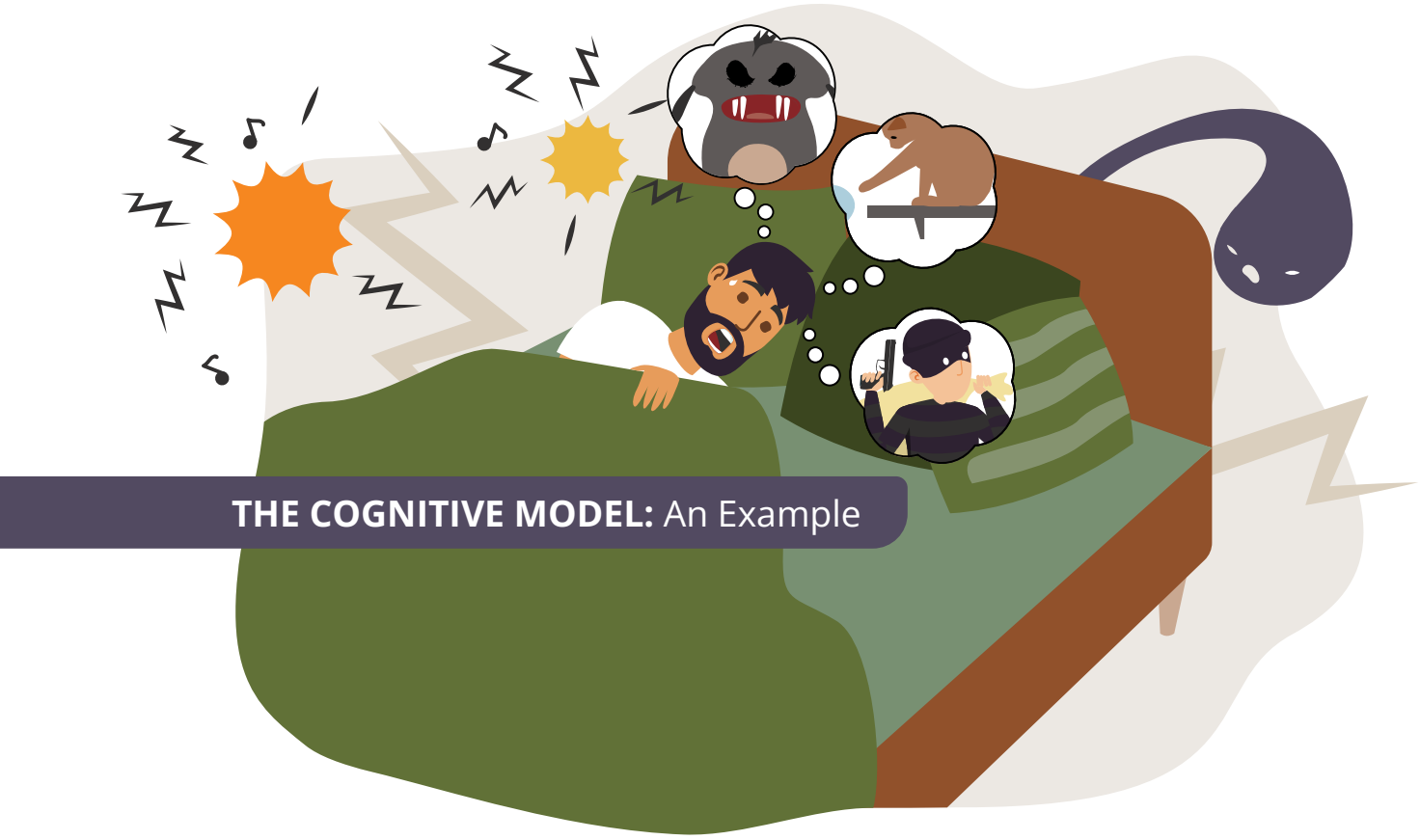
The links between the components of the cognitive model can be explained using examples from the client that you gathered during their assessment. Otherwise, more general examples can be used to describe the link to the client. Here is an example we use with our clients to explain the link between different cognitive model components. We start by giving the person the example and then ask them to identify the possible thoughts and emotions they would experience (and if the client fails to do this, we give them examples to elaborate the link further). Suppose you call your friend for a chat, but they tell you they are busy and will call you back later. Then, you can have the following thoughts and connected moods. See Table 6.

Table 6: The Relationship Between Thoughts and Mood

Thought	Mood
He does not want to talk to me	Despair, sad, irritated
He is never available when I want to talk to him	Sad, Angry
He might be busy, as he said, and will ring when he is free	No distress

Some clients find it helpful to tell themselves that thoughts are words, images, memories or self-talk, which come to their minds in response to specific events. Also, thoughts are not the same as feelings. It is essential to explain these concepts to the clients. Examples are always helpful to clarify things. Statements like "I felt scared, I felt angry, I was confused" or "I am not happy" express

emotions and not thoughts. You can then expand the above example to establish the link between components of the model. For example, what physical sensations would you have in response to each thought? What action would you take in response to each thought?



3.5.3 **Helpful Techniques for Recognizing Thoughts**

Other techniques to show the link between thoughts, emotions and behaviour include:

Induced Imagery

You can ask the client to imagine an unpleasant scene. It should not be an intensely unpleasant scene. The scene should also be from the recent past. Once the client imagines the unpleasant scene, you can ask him the accompanying thoughts. You can then ask the client to imagine a pleasant setting and describe the thoughts.

Talking about Recent Emotional Experiences

After explaining to the client what cognitions are, you can ask them to describe their thoughts, images, self-talk, and memories regarding recent events. For instance, they could describe what they were thinking this morning when waiting for an appointment and what they are thinking now about treatment. Again, it is helpful if they use examples from recent events.

Keeping a Thought Record

Once the client understands cognitive errors and moods, they should keep a record of thoughts and emotions. You will need to go through the examples many times before they become used to catching thoughts. The best way to catch thoughts is to use a diary such as in Handouts 5, 6, 7 & 8 of the Appendix. The most accurate method is to catch the thoughts during the experience of anxiety or depression. Ask them to record as many thoughts as possible when they happen. Since this is not always possible, you can ask the client to write down the events and thoughts every evening. Don't use vague terminology when asking them to record their thoughts. The following prompts must be pre-written in the diary, "What exactly was going through your mind? What were your thoughts, images, memories or what was your internal voice saying to you?" If the client doesn't come up with any thoughts, or only a few, you can go through some of the events during the session that made them depressed or anxious during the last few days.

Finally, you can use beads and counters for clients who are not able to write or don't like to write diaries. We have used counters successfully with some clients. But our experience is very limited in this regard. It has been suggested that audiotapes might also help these clients. Clients can seek help from a member of the family who can read and write. Alternatively, clients can use mobile phone apps based on thought diaries or even record their thoughts on their mobile phones.

3.5.4 Helpful Techniques for Dealing with Thoughts

Once clients have learned about their thoughts and emotions and successfully observed (and documented) them, the stage is set for changing their thoughts. It is essential to explain to the clients that it is tough for us to control our thoughts; however, we can generate alternative thoughts with some practice. Although distraction techniques can be used to deal with ruminations, thought diaries and thought challenging techniques are used to change thoughts. Distraction techniques are helpful initially and require less hard work both by the client and the therapist.

Case Example #9

Kavita, a first-generation SA woman who is married to a busy family physician, was feeling depressed for six months. An assessment revealed that there were no social, marital, or economic problems. Her husband had already told the therapist, "I do not understand why she is unhappy; she has got everything a woman can dream of". Kavita's parents were strict when it came to educating and training their children. She was criticized a lot by her parents. She was the eldest, and like many other SA families, she was required to be a perfect child. A commonly heard phrase in their household was "You are nothing if you are not well-educated and well-mannered." Kavita described herself as always being sensitive and having low self-esteem. Her depression started when her son failed to get admission to a medical school six months ago. She feared that this would bring shame to the family (e.g., Kavita regularly asked her therapist, "His father is so educated, how can he be so bad?" even though her son had missed the admission cut-off by a small percentage). She constantly blamed herself for her son's failure. She described feelings of immense guilt related to these thoughts. During one of her therapy sessions, Kavita criticized her daughter for not securing the top position in her class. Kavita is an educated woman and fully engaged in therapy. She was always punctual and did her homework meticulously. With only a little training she became an expert in catching and changing thoughts. She showed remarkable improvement in three months.

Distraction Techniques

Focusing on an Object

In this technique, a client is asked to describe an object in detail. A flower vase in the consultation room can be a good example. Once the client has learned this technique, they can be asked to repeat the exercise at home

Awareness of the Environment

The client is asked to focus his attention and describe using as many senses as possible in the environment. For example, the therapist can take the client through different objects in the room first using vision, hearing, smell, and touch.

Mental Arithmetic or Imagery

This can include counting sheep jumping over a fence, counting backwards from 1000, or even imagining a nice place or event from the past. The client can also be trained to imagine pleasant places in fantasy. Some SA clients have also reported benefiting from envisioning images of holy places.

Mental and Physical Exercise

Light exercise, especially if it involves some degree of mental absorption, can be helpful. Similarly, mentally absorbing activities like playing cards or chess can help clients.

Culturally or Spiritually Meaningful Exercises

After speaking with the client about the cultural and spiritual practices that are important to them, additional exercises can be recommended, such as praying, reading scripture, dancing (e.g., Bharatanatyam), and singing traditional music (e.g., *raga or ghazal*).

Behavioural Techniques

Behavioural techniques may include activity scheduling and monitoring activities or graded task assignments (in which the client is asked to gradually increase an activity that has provided comfort in the past).

Cognitive Techniques

Re-Attributions Techniques

We have already mentioned the reattribution technique earlier in this manual (please see pg. 55).

Being Aware of Thoughts

Simply being aware of their own thinking errors can help clients. Therefore, a therapist must spend a lot of time on the identification and recording of negative thoughts. This can stop the cycle of negative thinking into which clients can get trapped.

People, in general, see their thoughts as facts. This tendency is more common among depressed or emotionally disturbed clients. The therapist works together with the client just like a scientist to explore a new idea—testing a hypothesis against the available evidence or setting up an experiment to test it.

Challenging Thoughts

This exercise aims to teach the client how to reassess their thinking. First, the therapist talks to the client about each thought and asks for the client's evidence for the thought, using the thought record they previously completed. Again, at the start, clients find it difficult to see the evidence (for or against the thought) themselves. But by now, the therapist should have gained sufficient information from the client to highlight points that do not support the thought.

However, it remains important to move forward and help the client find the evidence for and against the thought themselves. This is a critical skill for the client to acquire. Clients should be encouraged to write the evidence for and against a specific thought in their diary as homework. They should also be encouraged to challenge the thought verbally. The client can also be encouraged to consider evidence from scripture to challenge their thoughts if they are spiritually inclined (e.g., "Are there any

verses from the Veda that support your thoughts?"). The therapist will need to feel comfortable with this process for their thoughts (i.e., going through the whole exercise multiple times on their own) before encouraging the client to do this themselves. The purpose of challenging thoughts is to teach the client to get into the habit of questioning their thought patterns as soon as they feel anxious, depressed, or angry.

Tip! Questions to Help Clients with Challenging Their Thoughts

What am I thinking?

Is this a cognitive error?

Is there any evidence for this thought?

What is the evidence against this thought?

What would another person say about this thought?

Usually, clients have developed a cognitive style whereby they ignore evidence that does not support their thoughts and beliefs. Instead, they magnify the evidence that supports the negative thought or belief, or they may even distort the positive evidence to support their negative thoughts. It is not an easy task when helping clients to challenge their thoughts. Clients may give a lot of examples (or evidence) in favour of their negative thoughts when they start to learn this technique. However, you will realize that most of these items of evidence are their feelings and not thoughts. A helpful approach is to advise the client to imagine that they are a detective and that they should look for the evidence for and against the thought. The client should also be told that the evidence needs to include concrete examples and not just feelings. This can help clients to be objective in their approach.

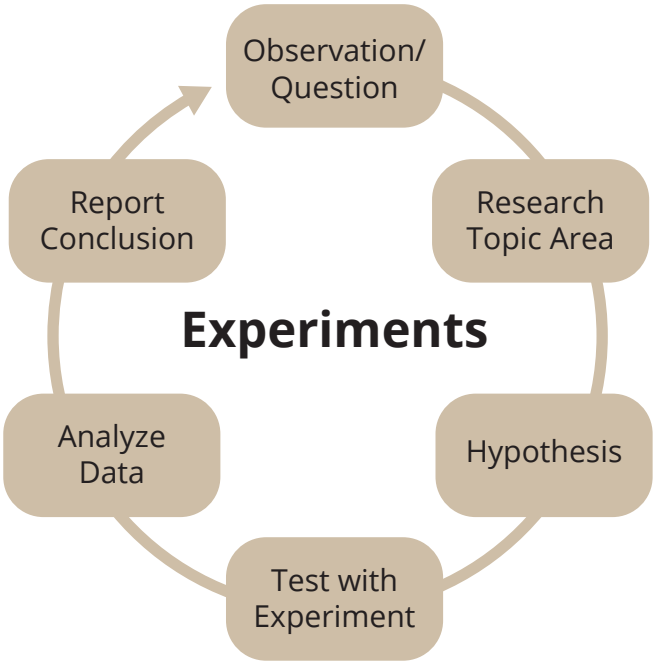
Behavioural Experiments

An experiment is a powerful method of checking the validity of a specific thought or belief. Both the client and the therapist should think of themselves as two scientists who want to explore and see whether they are right or wrong about a supposition. So, they make a specific statement which they can check. They then agree on an experiment and how to go about it. They set conditions. They also discuss the possible outcomes and interpretations. Most of the time, experiments involve other people, and therefore the therapist must be careful in devising and experimenting. It is essential to ask the client to describe the experiment's outcome and discuss it with the therapist instead of his interpretation. Once the therapist and the client have discussed interpretations, they compare them with the client's interpretations. Don't try to test a belief system. The experiment can only test a behaviour or action, not a thought. See Figure 5.

Tip! A Good Behavioural Experiment

- ✓ A clear idea (hypothesis) is selected that is testable.
- ✓ Review the evidence for and against the hypothesis.
- ✓ Break up the experiment into small steps if needed.
- ✓ Ask the client to devise an experiment, write it down along with the possible outcomes and its meanings.
- ✓ Probability of positive outcome by chance should be very small.
- ✓ Results of the test should be clear, precise, and unambiguous.
- ✓ Draw the conclusion.

Figure 5 The Scientific Method



Finding Alternative/Balanced Thoughts

The next step is to think of alternative thoughts or possibilities. Once the client has discovered that there is not much evidence in favour of their thought, they can be trained to think of alternative thoughts. Tell your clients that there's usually more than one way of looking at a situation (i.e., different angles of thoughts). Try to think of several alternative explanations.

The whole idea behind the above exercise is to find a balanced point of view. Once the client can look at the evidence, both for and against, they can have an expanded (or alternative) perspective. Alternative or balanced thinking is often more positive than the initial automatic thought but is not merely substituting a positive thought for a negative thought. As one can see, this new alternative thought is different from being solely a positive thought.

Tip! Questions to Help Clients to Think of Alternative Thoughts

A series of questions can help clients in thinking of alternative possibilities. These include:

- ✓ What would my brother/sister/friend/spiritual or community leader think if they were in a similar situation?
- ✓ What would I have thought if this had happened in the past, or when I was not so depressed/anxious?
- ✓ What would I think if this happened a few months from now or when I am a little better?
- ✓ If my friend was thinking like this, what would I tell them?
- ✓ Try to think of similar situations in the past, and what did you think then?

PART 4

Wrapping Up and Planning for Future Skill Use

The Last Session

The last session gives you a chance to offer feedback (from both the client's and therapist's perspective), review the past sessions (if needed), and prepare the client for working independently. It is essential to highlight to clients that the end of therapy does not mean the end of practicing and learning. Unlike medication, therapy involves regular practice to master techniques. You can also tell the client that you (as the therapist) have taught them all of the fundamentals, and now they should go and practice what they have learned. See Handout 15. Here are the recommended steps that may help when ending the therapeutic process.

1. **Review their overall progress and provide feedback**
   - Briefly summarize therapy content and review with the client their experience in the previous sessions.

2. **Ask for the client's feedback**
   - Take a non-judgmental approach and offer space for the client to express their feedback regarding yourself (the therapist) and their therapeutic experience.

3. **Prepare for the future**
   - By now, you will have an idea of the client's strengths and weaknesses and factors that may cause a relapse. It is best to discuss with the client about possible obstacles to wellness. In addition, this will be an excellent opportunity to engage the family or other supports in the client's life. They can remind clients about helpful strategies and watch for the signs of relapse.

4. **Discuss termination of therapy and resources they can use in the future**
   - Termination work should involve a frank discussion of progress made, areas that need more work, and information on resources for use in the future. From a CBT perspective, growth occurs as individuals become more authentic, responsible, and accountable for how their experiences affect the functioning and well-being or themselves, other people around them, and their communities.
   - Relationships are critical to SA clients. Some clients may look upon the ending of the counselling relationship as something to be worried about or think they are not yet capable of increased functioning. Again, you can use the metaphor of a teacher who prepares a student for the world when discussing the end of therapy.

5. Evaluate treatment gains

- Evaluation of treatment gains should be conducted, preferably, using diverse information sources.

6. Plan for future skill use

- Identify future situations that could be challenging for the client and decide what skills may be needed in these situations. In addition, decide what skills would be best to include as part of the client's healthy lifestyle change.

7. Express gratitude for the opportunity to work with the client

- Convey your gratitude for the professional development that you attribute to your relationship. Some clients might offer gifts of appreciation. If this is not a violation of your organization's code-of-conduct, and is not expensive, we advise accepting them and sharing them with other colleagues.

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APPENDIX
CACBT Handouts and Tipsheets

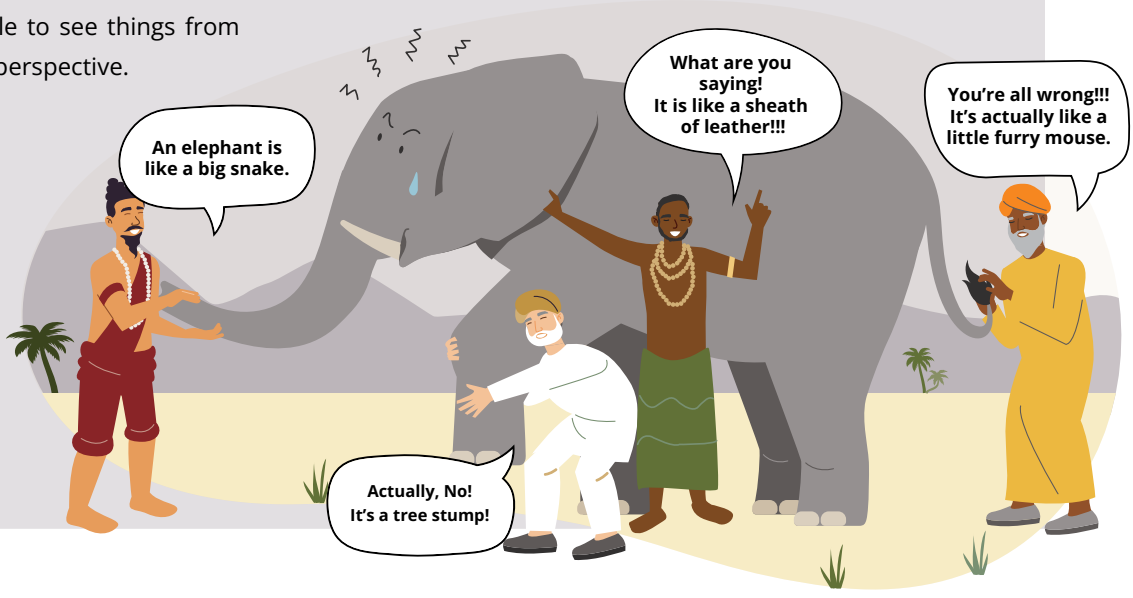
Handout 1

What Is Culturally-Adapted Cognitive Behavioural Therapy (CaCBT)?

Cognitive Behaviour Therapy (CBT) is a type of psychotherapy. CBT is an effective treatment for depression and anxiety. With the help of CBT, nearly six out of ten people recover from depression. As such, it is equally effective as antidepressants. In fact, it has been shown to be superior to antidepressants in preventing the relapse of depression. It can be used on its own (for mild to moderate depression) or combined with medication.

Since CBT is underpinned by Western European-North American values it needs to be modified for clients from non-Western European-North American cultural backgrounds. Culturally Adapted CBT, therefore, aims to modify therapy for the cultural needs of clients from non-Western European-North American backgrounds. The CaCBT intervention is usually given in 6–9 sessions over 9–12 weeks. Each session typically lasts 60 minutes with 10 minutes for review of homework, 40 minutes for therapy, and 10 minutes for feedback and homework assignment. Therapy typically addresses unhelpful ways of thinking, problem-solving, reduced activities, anxiety management and relationship problems.

There is a famous fable in South Asia about six blind men who go to see an elephant. We often use this fable to introduce the basic concept of CBT to clients. According to the fable, the first man touched the side and said, "This is like a wall." The second man touched a tusk and said, "This is like a spear." The third man, who touched the trunk, said "This is like a big snake." The fourth man touched the animal's leg and said, "This is like a tree stump." The fifth man touched the ear and said, "This is like a sheath of leather." And finally, when the sixth man touched the elephant's tail he shouted "Ah! This is like a little furry mouse!" They argued with each other for a long time about what an elephant looks like. They were all looking at the elephant using a particular perspective. We do this often in our lives as well. We may look at only one aspect of something, ignoring the full picture, and we don't recognize that we can look at the same thing using different angles of views. A CBT therapist helps people to see things from more than one perspective.



Handout 2

What is Depression?

Depression is a common mental illness that affects how you feel, think, and act. A depressed mood can be a normal response to a loss (for example, grieving the loss of a loved one). However, it is called a depressive illness if the depressed mood lasts for more than two weeks and the individual feels sadness without reason or the severity of depression starts interfering with their daily routine. 1 in 20 people suffer from a depressive illness in their lifetime.

Symptoms of Depression

Sometimes people can experience physical symptoms such as headaches, gastric problems and other stomach-related pain, chest pain, and muscle tension due to depression. Depressed people may also lose their temper quickly. Other symptoms include feeling tired, memory problems, trouble concentrating, inability to enjoy things and, in severe cases, suicidal thoughts. Depressed persons may also experience sleep and appetite problems.

Causes of Depression

The common causes of depression are:

- **Chemical Imbalance**
- **Personality and Thinking Patterns**
  - Those who worry easily, who have poor coping skills, or who have perfectionist or obsessive personality traits
- **Childhood Circumstances**
  - Negative or traumatic events
- **Difficult Life Circumstances**
- **Physical Disorders and Illnesses**
- **Alcohol or Drug Abuse**

Treatment of Depression

Research shows that, ideally, depression should be treated with a combination of antidepressant medication and psychotherapy. Cognitive behavioural therapy (CBT) is a form of psychotherapy that is commonly used for the treatment of depression.

Handout 3

What Is Anxiety?

Anxiety is the feeling we get when we experience a threat (real or imagined). Anxiety is simply the brain reacting to something stressful and can be recognized as the creation of unhelpful thoughts or through specific symptoms in the body.

It's important to remember that anxiety is a normal reaction to a threat in our environment (for example, if we came face-to-face with an uncaged lion) and symptoms of anxiety can help us prepare for a real life-threatening situation. However, anxiety can get out of hand for some people or can be triggered during situations where it becomes unhelpful to the individual.

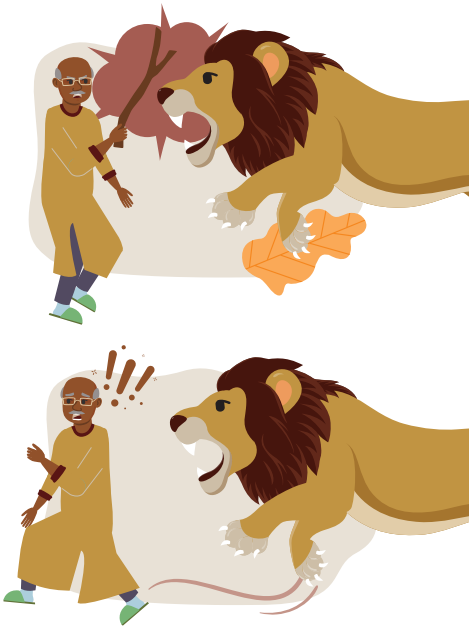
Symptoms of Anxiety:
Symptoms include worrying, overthinking, restlessness, irritability, difficulty concentrating, your 'mind going blank', aches & pains, upset stomach, palpitations, shortness of breath, blurred vision, and tingling sensations.

Causes of Anxiety:

- Unhelpful ways of thinking
- Stressful life events
- Physical arousal

To understand anxiety, we will have to understand the 'fight or flight' response. When we perceive a threat, a message is sent from the brain to get ready to fight or to flight. This part of the brain is called the "fight or flight center." Our body's response consists of the following:

- **Shallow and fast breathing** – so that your body gets plenty of oxygen.
- **High heart rate** – pumps nourishment around the body for energy.
- **Tension in muscles** – gets the major muscle groups ready for action.
- **Shaking** – increased muscle tension can cause shaking.
- **Sweating** – cools the highly charged system.
- **Lump in throat, dry mouth, upset stomach** – blood is diverted away from the digestive system causing these symptoms
- **Sensitivity to light and noise** – so you can spot environmental threats to prepare to fight or run away



How to Calm Your 'Fight or Flight' Response?

The best way to control your 'Fight or Flight' response is to practice controlled breathing. Muscle relaxation exercises can also help reduce muscle tensions and thus reduce pain in the body. You can watch breathing and muscle relaxation exercises (for Urdu and Hindi speaking people) here: https://www.youtube.com/channel/UC3h-7eagyNe_KkqtW95rrbw

Handout 4

For a Friend or Family Member

For a Friend or Family Member

If someone is injured, people can sympathize with him/her because a wound can be seen. When someone is experiencing depression, what is happening in their mind cannot be seen. Depression is an illness like other physical illnesses. It is not a sign of weakness, and it is not because of punishment for sins. When your loved one is experiencing depression, please consider the following facts:

- Someone experiencing depression cannot control their mood.
- Provide care and sympathy—listen to your loved ones carefully and try to empathize with them when they share their feelings.
- Individuals experiencing depression have a difficult time solving problems—even ones that may appear to be simple. Helping them to find solutions to their problems can ease their distress.
- Sitting and talking to your loved ones can help them to feel better.
- Encourage them to engage in activities they used to enjoy. However, remember that forcing them to do so can be harmful.
- Encourage an individual with depression to take their medication and psychotherapy as prescribed and visit their therapist on a regular basis.
- Healthy eating can improve mental health and wellbeing. Encourage your loved one to eat healthy food.
- Some individuals experiencing depression may begin to use alcohol or drugs to cope with their illness. However, this can increase depression.
- If your loved one is expressing suicidal thoughts, contact their mental health provider as soon as possible.
- You can support your loved one by encouraging them to read the material from their therapy sessions and to carry out the assigned homework assignments.

Handout 5

Thinking About Thinking

Thinking About Thinking

Thoughts are a very important part of our life. However, we usually don't think about our thoughts. To change your unhelpful ways of thinking, you can learn to recognize your thoughts and emotions and see how they are related to your behaviour.

Thoughts

Thoughts are ideas, mental images, words, or memories that appear in our minds because of events. Thoughts can also appear in the form of self-talking or inner voices. Our thoughts are automatic, which means we don't have control over them. In patients with depression & anxiety, thinking patterns are different from people who do not experience depression and anxiety. These are called "unhelpful ways of thinking." When a person, who is vulnerable to depression is under stress, these unhelpful ways of thinking become activated. These can then cause a depressed mood.

Thoughts and Physical Symptoms

Our thoughts are also related to physical symptoms, for example the thought that "I am going to have an accident" can cause palpitations or even sweating. Your first step is to simply look at your thoughts and how they are related to your emotions and physical symptoms.

For the next week, we want you to act like a detective who is investigating her/his own thoughts. When something happens, look closely to discover the link between your thoughts and your emotions. The best time to use this diary is when you are feeling distressing emotions. Write as many thoughts as possible. Try to keep your diary with you and write your thoughts as soon as you experience distressing emotions. Try to look at the link between your thoughts, emotions, and any physical sensations. Ask yourself each time you are in distress, "Am I making a thinking error?"

Thought Diary # 1

Event	**Thoughts** (thoughts/mental images/self-talk)	Emotions	Physical symptoms

Handout 6

Unhelpful Ways of Thinking

Unhelpful Ways of Thinking

A specific life event (a change in circumstances, stressor, etc.) can sometimes trigger unhelpful ways of thinking, which in turn cause distressing physical sensations or emotions. These can also lead to changes in behaviours.

What are unhelpful ways of thinking?

- **Jumping to Conclusions**
  Making an assumption with very little (or no) evidence to support it (e.g., you see your husband or wife talking to someone on the phone and you think s/he is having an affair).

- **Selective Abstraction**
  Focusing on a detail taken out of context, ignoring other more salient features of the situation, and you frame the whole experience on the basis of this fragment (e.g., you have the thought, "I am useless at my work" when your boss tells you that you are doing well, but need to improve your computer skills).

- **Overgeneralization**
  If it is true for one thing, it should be true for all things (e.g., "Because I failed one test, I am a total failure", or, if you are late for work one day, you say to yourself, "I am always late").

- **Magnification or minimization**
  Reducing the importance of positive information or expanding on negative information (the common phrase for this is—Making a mountain out of a molehill, or making a molehill out of a mountain!). An example is, you forget a name and blame yourself the whole day for being forgetful.

- **Personalization**
  You assume responsibility for everything that goes wrong, even when there is no evidence for it (e.g., your colleague resigns from his job and you think "This is because I did not support him")

- **All or nothing thinking**
  Everything is seen as one extreme or another, good or bad, black and white, with no shades of grey (e.g., "If I don't pass all my papers with 80% marks, I am a failure", "If I don't buy expensive clothes for my children, I am a useless father")

Ask yourself, 'What are my unhelpful ways of thinking?'

Handout 7

Challenging Unhelpful Thoughts

Challenging Unhelpful Thoughts

Once you have learned to recognize your thoughts and emotions, the stage is set for changing your thoughts. You will do this in two steps. In the first step, you will learn to challenge these thoughts. Please remember that it is difficult to change a thought, however, we can replace one thought with another. To do this, you should first try to weaken the unhelpful thought. This can be achieved by constantly challenging your unhelpful thoughts.

Find the Evidence

The easiest way to challenge your thoughts is to look for evidence for and against your thought. Look at each thought in your diary and examine it. Imagine that you are a judge who must look at the evidence which is either for or against the thought to make a judgement whether this thought is realistic or not. At the end of this handout, you will find a second thought diary which includes two extra columns, in which you can write both the evidence for and against the thought. Some people find it difficult to initially find the evidence against their thoughts. Therefore, it might be helpful if you involve a friend or relative when you start this exercise. Similarly, some people ignore the evidence against their thoughts.

After a little practice, you will become an expert in finding evidence for and against the thought. Of course, this is not an easy task. Some people can use their feelings as evidence for the thought, for example, 'I feel so bad, I believe this is true. I am sure this is the case.' But remember that evidence means *solid evidence* and not feelings or perceptions.

Questions you can ask yourself to challenge your thoughts:

- What am I thinking?
- Is this an unhelpful thought?
- Is there evidence for this thought?
- What is the evidence against this thought?
- What would another person say about this thought?

Thought Diary #2

Event	**Thoughts** (thoughts/mental images/self-talk)	Emotions	Physical symptoms	Evidence for the thought	Evidence against the thought

Handout 8

Creating a Balanced Thought

Creating a Balanced Thought

Once you start examining the evidence for and against the thought, you weaken that thought. Once you find more evidence against the thought than for it, you will realize that it's not a realistic thought. As mentioned earlier, it's difficult to control or change an unhelpful thought. However, once you have learned to challenge the thought and find some evidence against it, you can create a new or balanced thought.

Finding alternative / balanced thoughts

The whole purpose of this exercise is to find an alternative thought. Once you have examined the thought you can create an alternative thought, which is also called a 'balanced thought'. The next step is to think of alternative thoughts or possibilities. But this is not enough; you should try to remember this balanced thought. You can do this by writing it on a piece of paper and looking at it whenever you have an old unhelpful thought, or you can repeat it many times a day like a mantra. Once you have created a balanced thought, you can act on it and see the results for yourself.

These questions will help you in creating an alternative thought

- What would my brother/sister/ friend think if they were in a similar situation?
- What would I have thought if this had happened to me in the past, or when I was not so depressed/ anxious?
- What would I think if this happened a few months from now or when I am a little better?
- If my friend was thinking like this, what would I tell them?
- Try to think of similar situations in the past, and what you thought of at that time.

Thought Diary #3

Event	**Thoughts** (thoughts/mental images self-talk)	**Emotions**	**Physical symptoms**	**Evidence for the thought**	**Evidence against the thought**	**Alternative/ balanced thought**

Handout 9

Activities and Wellbeing

How do our Activities Affect our Mental Health?

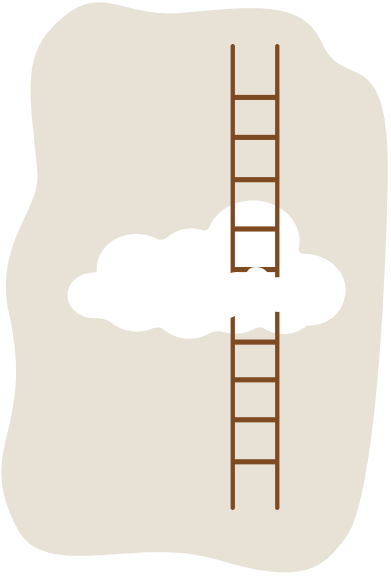
There is a deep link between our behaviour & emotions. Sometimes people with depression reduce their daily activities due to tiredness, low mood, lack of interest, and having little sense of enjoyment or achievement. Conversely, a reduction in daily activities can lead to an increase in depression. It is therefore important that this vicious cycle of reduced activity be broken.

The Balanced Activities

The first step towards wellness is to bring balance to your activities. You might find that increasing the amount of your pleasurable activities, such as watching TV or playing video games, helpful as a first step. By tracking your activities and your mood, you can discover how they affect one another. Additionally, this diary can be used as a guide to see what changes in behaviour might help you feel better. Write your activity diary every day. Gradually add activities. Look at the four types of activities we recommend on the next page.

Go slow

Increase your activities gradually. When complex activities are planned, it might be useful to break them into small steps to keep the overall activity manageable. It would help if you started with small and simple steps—one by one—just like a ladder.



Handout 10

List of Common Activities

Creative Activities	Recreational Activities	Social & Spiritual Activities	Work Related Activities
Writing a poem	Spending time with your pet(s)	Meeting friends & relatives	Dishwashing
Drawing a picture	Visiting a zoo, circus, festivals or fairs	Calling a friend or sending them a text	Ironing cloths
Decorating your room	Going for a walk	Visiting a park with family	Cleaning the house
Playing a musical Instrument	Listening to music	Going shopping or to a restaurant	Looking after children
Sewing or stitching (Fabric arts)	Reading a novel or magazine	Going to mosque/ temple/church	Working in the garden
Writing in a diary	Going to the movies	Going for a religious or cultural ceremony	Going to your work/job
Singing a song	Gardening	Spending time with children	Looking after pets
Arranging flowers	Swimming	Volunteering	Doing an educational course
Dancing	Playing or watching a favourite game	Reading your holy book or using tasbeeh/prayer beads	Going to a school lecture
Interior design (e.g., arranging furniture in a new way)	Watching TV	Giving people around you a compliment	Identifying future goals (school, work or personal goals) & planning them out
Doing your make-up	Visiting your favourite place		Clean your car or bike
	Visiting a park or lake		
	Planning for a vacation		
	Fishing		

Daily Activity Diary

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7am–8am							
8am–9am							
9am–10am							
10am–11am							
11am–12pm							
12pm–1pm							
1pm–2pm							
2pm–3pm							

Daily Activity Diary

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
3pm–4pm							
4pm–5pm							
5pm–6pm							
6pm–7pm							
7pm–8pm							
8pm–9pm							
9pm–10pm							
10pm–11pm							
11pm–12am							

Handout 11

Solving your Problems

Solving Your Problems

You can solve your problems using this technique that involves a few short steps. When you start using this technique, it may be helpful to try it with a friend or a family member first.

1. **Identify your problem(s)** – The first step is to make a list of possible problems. Once you have done this, decide which problem you should tackle first. It is best to choose a problem that appears easy to solve and is important to you.
2. **Think about possible solutions** – Now that you have chosen your first problem, try to think of as many solutions as possible. Even the solutions that you think are ridiculous. This is called brainstorming. You might also try to imagine that it's not your problem and you're trying to find as many solutions as possible for another person.
3. **Look at the cost and benefit of each solution** – Now go through each solution one by one, to look at the cost and benefits of each. To do this, draw a line on a paper and write down the advantages and disadvantages of a solution on each side. You can then decide which solution is the best. It is essential to bear in mind that the solution should be (a) realistic, and (b) helpful in making a positive change.

4. **Break down this solution into as many steps as possible** – Write down as many small steps as possible, even if they look foolish. You might realize that you need more information or might have to go back and rethink another solution. You can also do "mental rehearsal"—i.e., going through the whole process in your imagination.
5. **Execute the plan** – Finally, it is time to act on your plan using the steps which have been devised
6. **Review the outcome** – Once you have acted on the plan, it is a good idea to think of mistakes or hurdles you faced along the way and how you can learn from this process.

Problem Solving Worksheet

List of problems: (Once you have listed all the problems you'd like to address, circle the problem you would like to solve first)

List of possible solutions:

Choose a potential solution:

Advantages: **Disadvantages:**

(Repeat the same process, choosing a potential solution and coming up with advantages and disadvantages, until you can identify the best solution)

Chosen solution:

Steps needed to apply the solution:

Review of the outcome and lessons learnt:

Handout 12

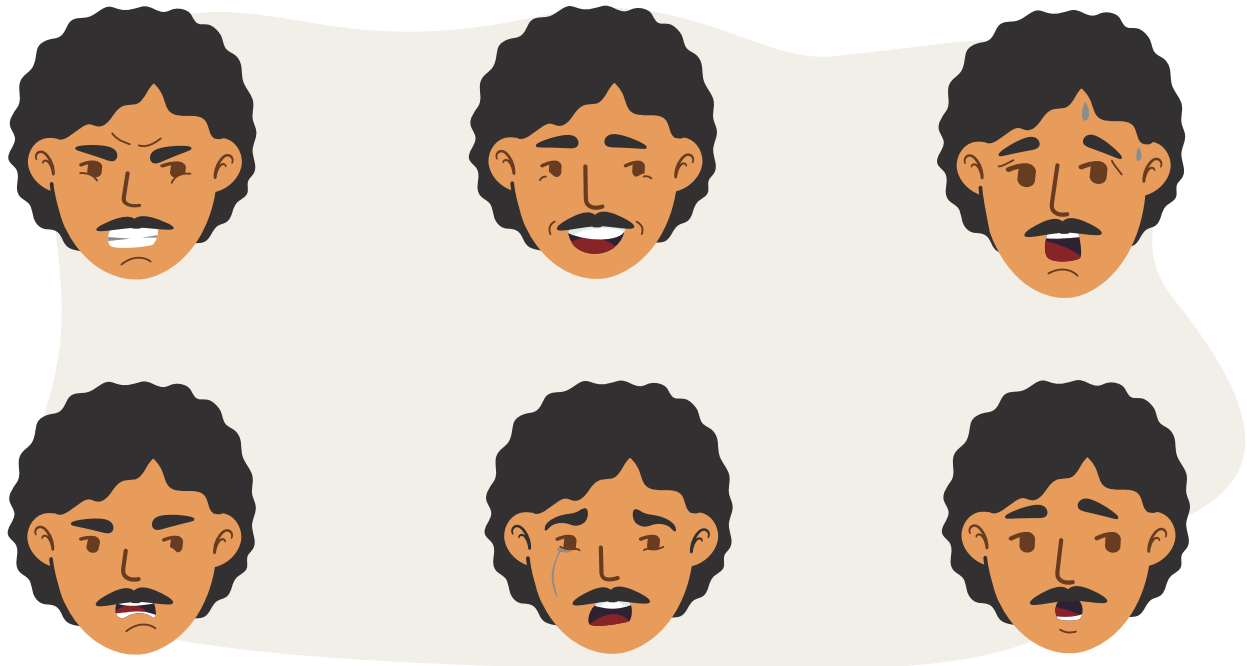
What is Mood?

What is mood?

Mood is how we feel at a particular time. There are many different types of moods. Some of them are easily recognizable, while others are not. Some people find it difficult to separate one type of mood from another.

To understand your emotions, think about how you would feel in the following situations:

Event	Emotion
You were just involved in an accident	
Someone shouted at you for no reason	
You just lost your job	
While in bed, you hear a noise on the roof	
You were caught trying to steal from a store	
Your friend told you off for no reason	
You have been offered a job	



Handout 13

Improving Relationships – 1

Communication

Relationship problems can play a significant role in causing stress and tension. Relationship problems are caused by (a) communication problems, and (b) poor conflict management skills. There are four styles of communication that you need to understand:

Passive

Passive people usually don't express their feelings. They don't tell others what they want. They are unable to express their anger and bottle up their feelings.

Aggressive

Such people are aggressive, abusive, and demanding. They usually don't care about the rights and needs of others. They attack, criticize, and degrade others. They are unhappy, which can affect the mood of others too. They are loud and rude.

Some people are a combination of passive and aggressive (i.e., they can be passive or aggressive depending on the situation).

Manipulative

These people know how to exploit other people's weaknesses and get what they want by making others feel guilty. They play the victim card to abuse others.

Assertive

Assertive people tell others what they want and what they don't want. Assertive people are often less likely to suffer from depression, helplessness, anger, and work-related or relationship problems. They are also healthier, with a low risk of developing pains, ulcers, and high blood pressure.

How to be assertive

Try to keep calm with a pleasant and relaxed appearance. Maintain eye contact, but don't stare. Adopt a relaxed posture. Don't cross your arms on your chest.

Practical Tips:

Don't tell long stories. Be straight and to the point, like "Can you help me with getting a job?" Complete your sentences. So instead of "Where did you put it", say, "Where did you put the keys?" Use the word "I". Listen to the other person's point of view. Don't interrupt others. Discuss one topic at a time. Don't ignore others. Don't interrupt and complete another person's sentence (e.g., "I understand, you want to stop working?") When you don't understand something, ask another person to explain it.

Make a list of situations in which you need to be assertive. Start your practice with low-risk situations. Think about the consequences. Choose the right time and place. Write down your statement on paper. Practice it with your friend or in front of the mirror.

Being assertive does not mean being rude. Listen to others' points of view. Please don't ignore them. Do not interrupt them while they are speaking. Do not look around when someone talks to you. Do not complete their sentences. Do not read their minds. Summarize what the other person is saying after they have finished speaking to make sure you understood. Ask them more questions to understand their point of view.

When you have to say something negative: Use the words "I" and "You." Instead of saying, "People are saying that someone is not doing their job properly," say, "I think you are not taking an interest in your work." Then tell them what exactly is wrong. Try to express your emotions (e.g., "I am upset with what you said").

Saying "No": Saying yes to others solely out of politeness can cause stress in some cultures. Usually, saying "no" politely, but firmly, is enough. However, if it does not work, do this; a) summarise the other person's request, so they know you listened to them, and b) explain the reason for saying "no." Alternatively, you can delay by saying "Let me check my schedule, and I'll get back to you." Or, you can suggest an alternative (e.g., 'We can't meet tonight, I am busy. What about next week?').

Helpful techniques for different situations:

Broken Tape: Repeat your point of view gently. Don't start an argument. For example, if you want to return an item to the shop, say, "I have decided that I don't want it, so I want my money back." After that, whatever the person says, you can repeatedly ask for your money back without getting into a debate.

Fogging: You agree with some of the facts but stick to your decision. For example, your best friend insists that you should cut your hair short, but you don't want to do this. You agree with whatever they say, but don't agree to change your haircut.

Cooling down: If someone gets angry during the conversation, you say, "You are angry now. I can understand your reaction. However, it is better to talk some other time when both of us are relaxed."

Handout 14

Improving Relationships – 2

Improving Relationships 2: Conflict management

Dealing with conflicts head-on can guarantee a healthy life. Successfully resolving conflicts also strengthens relationships. Here are some of the communication styles that cause conflict:

Extreme statements: "It must be done according to how I want it," "He always misbehaves with me", "He never agrees with me", & "You are all the same".

Fortune teller's mistake: Trying to predict the future or believe you know for certain someone's thoughts (e.g., "Whatever I do, he will never listen to me" & "She won't agree with me because she doesn't like me.")

Emotional arguments: "I know he will do this", or "You have a point, but I am not going to change my decision."

Mixing positive with negative: You mix the positive with negative (e.g., saying to your wife "You are beautiful but you don't know how to dress properly").

Personal rules/principals: "Everyone should agree with me", "They should respect me and obey my rules"

Instead, try these technique to manage conflicts better:

Agree to disagree: When you feel that the other person is stubborn, you can always say, "Let's agree to disagree."

Give & take: Conflicts can often be resolved with "give and take." That is, by working together and coming to a compromise, conflicts can be resolved without problems.

There is a story of two goats who came upon a bridge and started arguing about who will cross first. They begin to fight and both fell into the river. A little later, two wise goats, reached the bridge and, realizing it was very narrow & only one goat can cross it at one time, one goat sat down and the other one jumped over him to cross the bridge safely.

Handout 15

Staying Well

Here are some things you can do to stay well:

Do one thing at a time

If you feel that you have lots of things to do, then make a list and prioritize the items.

Be mindful of your limitations

Learn to say, 'I don't know', or 'I cannot do it'.

Be aware of your strengths and weaknesses

Try to find out what makes you stressed.

Share your problems with your family and friends

Share your problems with others. Don't try to face every problem on your own.

Improve your sleeping habits

Sleep affects mood because it is crucial for recovery from fatigue. Lack of sleep affects your health.

Take care of your diet

A balanced diet will keep your mind healthy too. Look after your diet. Try to reduce oily and spicy foods.

Regular exercise

Regular exercise improves your self-confidence & self-esteem and decreases stress, tension, anxiety, & depression.

Balanced activities

Spend some time every week in activities that give you enjoyment and pleasure. This can be anything, like reading a book or magazine, go for a walk, and spend time with good friends.

Keep in touch with others

Spend time with positive, trustworthy, & loving people—it will decrease your level of stress, improve your mood, & help you to feel better. Healthy relationships are one single factor that will help you throughout your life.

Keep your thoughts positive

Our thoughts make us, and people who are having positive thoughts (or balanced thoughts) live a happy life.

What are you going to do to stay well?

Handout 16

Responsibility Pie

Adapted from (https://get.gg/)

Oftentimes, we blame ourselves for some fearful future event that may or may not happen. However, we also give ourselves more than our fair share of that blame and responsibility.

This "Responsibility Pie" is one way of challenging that unhelpful thinking.

Write down how responsible you would feel if the feared situation happened, using a percentage scale with 0% being not at all responsible, and 100% being totally responsible.

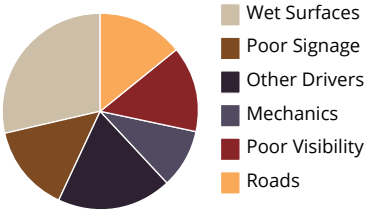
%

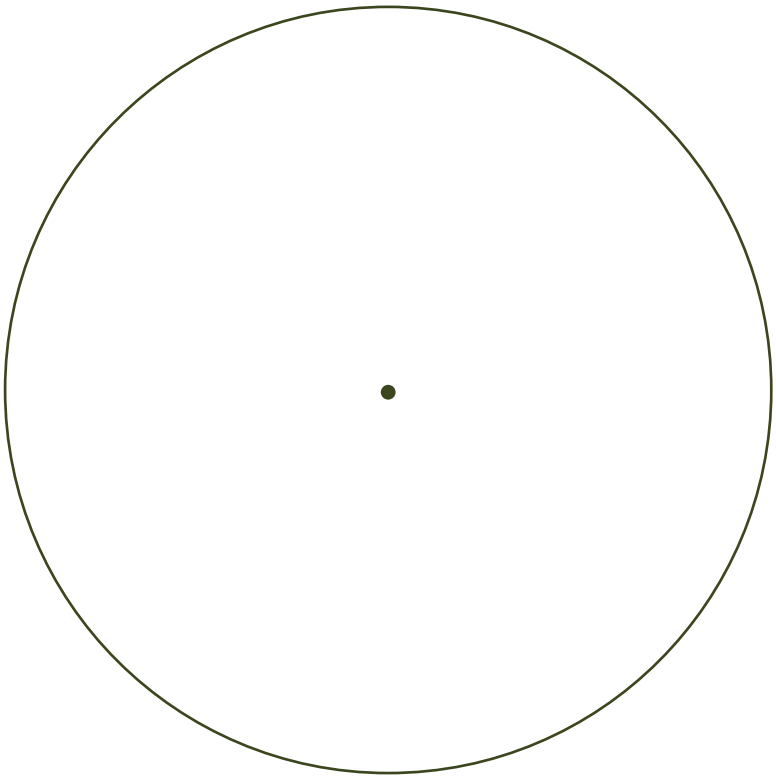
Now think about and write down all the other factors that may have contributed to this event, and share some responsibility

Now draw lines out to the circle from the centre and mark off sections for each factor, according to how responsible that factor would be.

The part you are left with (if any) is how responsible you REALLY may be. The Responsibility Pie can also be used when we blame ourselves completely for a bad event that DID actually happen.

Example: I crashed my car





Quick CaCBT Tips for Practical Application

The first step in preparing to work with a patient from a different culture should be to complete research before meeting the patient (p.17). For instance:

- Talk to someone who identifies as being from a South-Asian* culture
- Look for culture-specific information in research

** Please note that the South Asian community is diverse, and each client will be different. Being open to learning about the culture from the client will ensure you do not make any cultural assumptions that do not apply to your specific client.*

Furthermore, it is not for the therapist to determine whether or not the client is South Asian. If the client identifies as being South Asian, then the client's self-identification is enough. Their self-identification can be used as a cue for the therapist to apply CA-CBT.

Self-Reflective Journaling (p.18)

Through journaling, the therapist can reflect and consider their:

- Cultural biases
- Prejudices
- Privileges
- Power dynamics

Rapport building (p.34)

Ways to build rapport with clients at the start of the therapeutic relationship may include:

- A Personal Touch: "Oh, you are from Brampton? My uncle lives there too."
- Experience versus Evidence: "I have seen many people from your background with this problem and now they are living a healthy life."
- A focus on symptoms that are concerning for the client.

Exploring the client's spirituality and its potential relationship to the problem (p.19)

Ask questions such as:

1. Are you a spiritual or religious person?
2. Can you please tell me about your beliefs?
3. How are your religion or spiritual values affecting your problem?
4. How does religion/spirituality come up in your life?

Aligning coping skills with the client's spiritual beliefs and cultural practices (p.19):

- Encourage clients to use spiritual and religious tools that have helped them in the past such as reciting prayers and reading texts that are important to them. Do not introduce spiritual and religious tools if the client does not bring up the importance of religion/spirituality in their life or for their mental health treatment.

The Name-it technique (p.26)

There will be occasions when you will not be able to find a suitable translation for a mental health-related term. In this case, you can provide a description of the concept in simple language and ask the client to name the concept, based on their understanding. If the client cannot think of a term, engage a family member or a community member, if possible.

Techniques to recommend to clients when they wish to communicate their concerns with someone else:

1. The apology technique (p.27): Can be suggested to clients as a tool to replace more assertive and direct ways of approaching others.

   Start a sentence by using the following:

   a. "I'm sorry, but if you allow me to disagree..."
   b. "If you allow me to express myself..."
   c. "I respect what you have to say, and if it is okay, I would like to say my opinion is..."

2. Triangulated approach to communicating with elders: Talking to one member of the family through another member of the family (example: talking to the father through the mother).

Counting beads (p.46)

- Beads and counters are commonly used by South Asian individuals for repeating religious verses or words. Hence, they can be easily used to count thoughts.

Questions for the therapist to reflect upon when considering client's understanding of the cause of their situation (p.31):

- What does the client think I can do for them?
- What are their limitations?
- What are their strengths?
- Do they think a psychiatrist or psychologist can treat their sadness?
- What does the client think is helpful/hurtful OR healthy/not-healthy OR problematic/not problematic about the presenting issue?

Questions to assess acculturation (p.40)

1. What language do you speak with your family and friends?
2. In which language do you think or dream?
3. Can you still read and write in your native language?
4. Name your three favorite movies.
5. Do you watch or listen to movies/music/news programs from your country of origin?
6. Are your friends South Asian or White or — ?
7. What food do you cook at home?
8. (If client has mentioned they are religious) Do you go to places of worship?

Ways to maintain engagement in therapy (p.42)**:**

1. Using examples from therapy as evidence: Clients like to know how successful their therapist has been with other clients. Therefore, we recommend discussing similar cases and how the individual's concerns benefited from therapy.
2. Describing current evidence from research can be helpful.
3. Creating a personal connection through similarities (for example: "Oh, I also have three kids.")
4. Rejecting food or gifts from a client may be interpreted as rude and harm the therapeutic relationship.
5. Present coping strategies compatible with the client's cultural/religious/spiritual background. Relaxation practices such as yoga, meditation, prayer, and extended head massage could be encouraged.

Tools to convey a message to a client (p.44)**:**

- Use stories, metaphors, and imagery (e.g., the blind men and the elephant story)

The two-stage rule: Focus and Connect (p.45)

- Stage one: Focus on the client's concern.
- Stage two: Connect the client's problem to the clinical concern (e.g., anxiety, depression, suicidal thoughts,) and share the plan.

Ways to adapt the cognitive model (p.63)**:**

- When addressing the cognitive model a few adjustments in terminology could be helpful:
  - Explain a concept rather than using the term (Example: 'cognitive error' vs black and white thinking, 'thoughts' vs images a person has in their minds) and then, ask the client how they would name this concept.
  - Document physical symptoms in thought diaries to help clients see the link between physical symptoms and thoughts.

Note: CA-CBT is flexible enough to allow techniques from other disciplines to be incorporated into it. We do not define CBT by its use of CBT techniques. It's a psychotherapy that is based on the cognitive model. The important part is changing client's ***thinking*** *and* ***behaviour*** *so that they can make lasting improvements to* ***mood*** *and* ***functioning****. To do this, we can use techniques from many different modalities, as the need arises.*

Therapist Tipsheet: Involving Family Members in CaCBT

Things to Do

Before bringing in family members:

- Find out who the decision-makers are in the family.
- Consider that different degrees of acculturation may exist within the family.
- Understand that family problems are connected to historical, intergenerational, cultural, and social power processes. Explore what values best serve the family. Are there any values that have been less helpful that family members would be willing to explore?
- When working with female clients, offering to engage with the accompanying family member if the client is willing and approves.
- Assess client safety before engaging with the family members.
- Check with the client about bringing up any family issues or secrets.
- Reiterate specifics of confidentiality to the client when involving a family member
  - In the case of possible high conflict or vulnerable situations, such as concerns around LGBTQ+ issues, agree beforehand with clients what would help them feel safe, what can and cannot be brought up within the family circle, and any other relevant cultural/generational factors that may impact the discussion.

When family members are involved:

- Explore the client's perceived place/role in the family.
- Get an understanding of how family members perceive what is happening for the client.
- Consider if faith leaders/healers may be included or referenced.
- Provide psychoeducation on causes of mental illness and the purpose(s) of therapy.
- Provide statements to the family to better support the client between sessions:
  - "I know this is difficult for you. I am here to support you."
  - "Let's review what your therapist has taught us."
  - "How about we write down this concern to discuss with your therapist next time?"
  - "What would your therapist recommend in this moment?"
  - "How has your anxiety been today?"
- Engage family in the client's homework assignments.
- Debrief with the client after a family session.

Things to Avoid

- Directly challenging/confronting specific family members.
- Assuming certain family members' perceptions of the client and mental health based on their age, gender, level of acculturation, etc.
- Involving family members without addressing any potential safety concerns.
- Telling involved family members what you and your client are working on in therapy without discussing limitations and confidentiality with the client.
- Using clinical language that is not culturally appropriate or without relevant psycho-education

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