Culturally Adapted Cognitive Interventions for Depression: Treatment Tools from Vida Alegre

10

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Cognitive interventions (CBT) remain widely used in the general population. They are also among the most prescribed treatments for depression for Hispanics/Latinos (Collado, Lim, & MacPherson, 2016) and Hispanic/Latino immigrants (Antoniades, Mazza, & Brijnath, 2014; Pineros-Leano, Liechty, & Piedra, 2017). In addition, extensive modifications have been done to cognitive interventions to accommodate the cultural and linguistic needs of Spanish-speaking populations. This chapter describes best practices underlying *adapted* cognitive interventions used with Hispanics/Latinos struggling with depression. We begin with an overview of the Hispanic/Latino population, the prevalence of depression, and a discussion of some cultural manifestations associated with depression. Next, we provide an overview of cognitive interventions for changing depressive thoughts and special modifications for providers in communities with new Hispanic/Latino immigrants. Finally, we present a synopsis of a treatment plan designed for Hispanics/Latinos to help change problematic thinking associated with depression. In the appendix, we include tools *in Spanish* adapted from a cognitive behavioral intervention, "Vida Alegre" (VA; "A Happy Life"; Piedra, Cintrón, Guardini, Marquez, & Sink, 2011), which was tested and found effective in alleviating depressive symptoms among Spanish-speaking mothers (Piedra & Byoun, 2012; Piedra, Byoun, Guardini, & Cintrón, 2012).

Hispanics/Latinos and Depression

Hispanic/Latino immigrants and their progeny constitute the largest and fastest-growing ethnically diverse group in the United States (U.S. Census Bureau, 2015). In 2014, there were 55.3 million people of Hispanic/Latino descent living in the United States, making up 17.3% of the population (Stepler & Brown, 2016). From this group Mexicans constitute 63% of the Hispanic/Latino immigrants in the United States, making them the largest ethnic Hispanic/Latino group (Ennis, Rios-Vargas, & Albert, 2011). However, as immigrants tend to be young, most of the population growth has come from natural increase rather than through migration. By 2050, Hispanics/Latinos are expected to reach 29% of the overall population (Passel & Cohn, 2008). As a result, this group is poised to play an important role in the future workforce, and, thus, their mental health needs warrant special attention. Among such considerations, service providers must keep in mind the role that the immigration experience

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has on families rearing native-born children, dual cultural and linguistic contexts, and the debilitating effects that depression has on families.

Among the mental disorders, depression ranks as the most common and is known to be highly treatable through medication, counseling, or a combination of both (U.S. Department of Health and Human Services, 2015). As a whole, Hispanics/Latinos, especially those of Mexican background, have lower levels of depression than the general population (Alegría et al., 2008). However, several national studies that examined a diverse sample of Hispanics/Latinos suggest a more complicated picture and underscore that many Hispanics/Latinos experience depression but fail to receive treatment. Alegría and her colleagues (2014) found high prevalence rates (28.1% and 28.6%, respectively) of elevated depressive symptomatology among Puerto Ricans in New York City and those on the island of Puerto Rico. When this study's sample was combined with subjects from the National Comorbidity Survey Replication, the investigation revealed that Hispanics/Latinos had lower rates of depressive disorders (15.4%) than non-Hispanic/Latino Whites (22.3%) but that those of Puerto Rican and Cuban backgrounds had higher rates than those of Mexican background (Alegría et al., 2008).

In the most comprehensive study of Hispanics/Latinos to date—Hispanic Community Health Study/Study of Hispanics/Latinos (HCHS/SOL)—investigators found an overall prevalence of depression of 27% (Wassertheil-Smoller et al., 2014). However, they also found that being US born or a second- or higher-generation immigrant was associated with higher levels of depression. Those of Puerto Rican background showed the highest levels of depressive symptoms; 38% reported high depressive symptoms, compared with 22% of those with Mexican background.

Although depression among Hispanics/Latinos can manifest in similar ways as in the general population, a few caveats are worth noting (Cabassa, 2007; Cabassa, Lester, & Zayas, 2007; Lackey, 2008; Martínez Pincay & Guarnaccia, 2007). Hispanic/Latino immigrants tend to define depression in ways that align with symptoms found in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), but they also attribute such symptoms to situational conditions such as the hardships of migration, the acculturation process, and the loss of social networks (Karasz & Watkins, 2006; Martínez Pincay & Guarnaccia, 2007). For example, many Hispanic/Latino immigrants identify isolation as a main contributor to feeling depressed (Lackey, 2008) but normalize the sadness as a natural consequence of leaving family and community behind (Lackey, 2008; Martínez Pincay & Guarnaccia, 2007).

However, somatic manifestations of depression such as stomachaches and headaches are commonplace (Lackey, 2008). In some cases, the symptoms may appear similar to those of anxiety, such as chest and muscle pain (Cabassa, Hansen, Palinkas, & Ell, 2008). Hispanic/Latino immigrants also use idioms such as *nervios* (nerves) to refer to depressive-like symptoms (Cabassa et al., 2008; Guarnaccia, 1993). The presence of physical symptoms and the stigma associated with mental illness frequently means that a primary care physician becomes the first point of entry into mental health care.

Service Barriers

Unfortunately, there is a worrisome underuse of mental health services by Hispanics/Latinos (Alegría et al., 2008; Cabassa, Zayas, & Hansen, 2006). One study found that only 36% of Hispanics/Latinos obtained mental health treatment, compared to 60% of their White counterparts (Alegría et al., 2008). For those Hispanics/Latinos who accessed depression treatment, half receive it in a primary care setting, and fewer than 13% obtain adequate guideline-based care, which is half the rate when compared to non-Hispanic/Latino Whites (Lagomasino et al., 2005). In addition, immigrants experience greater obstacles to services. When immigrants seek out discretionary mental health care (i.e., preventive services), they access such care at a substantially lower rate

than Puerto Ricans and US-born Hispanics/Latinos (Alegría et al., 2007).

Language also plays a role in service disparities. Non-English-speaking Hispanics/Latinos are less likely to receive mental health services than those who speak English (Alegría et al., 2007; Sentell, Shumway, & Snowden, 2007). One study that compared Spanish and English speakers with similar mental health service needs found that 43% of the English speakers had received mental health services. In contrast, 8% of those who spoke only Spanish received such services (Sentell et al., 2007).

Other factors such discrimination, acculturation issues, family separation, and economic hardship compound language barriers (Aguilar-Gaxiola, Kramer, Resendez, & Magaña, 2008; Martínez Pincay & Guarnaccia, 2007; Mendelson, Rehkopf, & Kubzansky, 2008). On average, Hispanic/Latino immigrants have less education than the general population and tend to work in low-wage jobs without health insurance (Andrade & Viruell-Fuentes, 2011; Ennis et al., 2011). Those who continue to be underinsured or who do not qualify for coverage under the Affordable Care Act (Doty, Blumenthal, & Collins, 2014) experience a cumulative effect of heightened vulnerability to mental health problems (Beeber, Lewis, Cooper, Maxwell, & Sandelowski, 2009). In addition, limited English proficiency accentuates the risk of discrimination and constrains employment options. Across one's lifetime, these obstacles lead to lower earnings, higher exposure to occupational and environmental hazards, and low levels of service access (Andrade & Viruell-Fuentes, 2011; for a detailed review, see Vega, Rodriguez, & Gruskin, 2009). Moreover, these negative factors magnify adverse life events and contribute to chronic stress, increasing the risk of depression (Beeber, Perreira, & Schwartz, 2008). Consequently, despite having better health (Horevitz & Organista, 2013) and mental health than the general population (Breslau, Kendler, Su, Gaxiola-Aguilar, & Kessler, 2005), long stays in the United States are associated with worsening health and mental health outcomes for Hispanic/Latino immigrants (Stone & Balderrama, 2008; Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007).

Hispanics/Latinos in New Growth Communities

Although Hispanics/Latinos remain concentrated in urban centers and their surrounding metro areas, over the past two decades the population has spread to nearly 3000 of the nation's 3141 counties (Fry, 2008; Lichter & Johnson, 2006, 2009). Their relocation into small towns and rural areas of the Northeast, the Midwest, and the South has led to the emergence of "new growth" communities—those with small but rapidly growing Hispanic populations—in many states (Cunningham, Banker, Artiga, & Tolbert, 2006). This demographic shift has revitalized the economies in many of these communities (Partridge, Rickman, & Ali, 2008) but has also created new challenges (Lichter & Johnson, 2009). These new communities tend to have limited organizational capacity and a scarce bilingual workforce to meet the needs of their growing Spanish-speaking populations (Arroyo, 2004; Buki & Piedra, 2011; Cunningham et al., 2006). Although mental health service disparities for Hispanics/Latinos are well documented, Hispanics/Latinos in "new growth" communities face unique challenges. The rapid increase of Hispanic/Latino immigrants in communities unaccustomed to such populations adds additional complexity to the problem of service access. For instance, adapting interventions have proven more challenging for providers in new growth communities, compared to those with established enclaves (Pineros-Leano et al., 2017). These environments tend to lack bilingual/bicultural professionals (Lichter & Johnson, 2009), and thus, the first step in their adaptations included finding ways to overcome bilingual personnel scarcity (Dwight-Johnson et al., 2011; Hovey, Hurtado, & Seligman, 2014; Piedra & Byoun, 2012; Shattell et al., 2010). However, these might not be easy to

achieve. In these communities, where few professionals speak Spanish, bilingual staff can aid in the delivery of therapy.

Cultural Adaptations

Cultural adaptations enhance the therapeutic receptivity of cognitive interventions for people from other cultures (Kalibatseva & Leong, 2014). These adaptations range from simple language translations to deeper modifications that address core values such as the importance of family, respect, humility, and friendliness. Castro, Barrera, and Martinez (2004) provide a useful way to categorize different types of cultural modifications as (a) cognitive-informational adaptations, (b) affective-motivational adaptations, and (c) environmental adaptations (Pineros-Leano et al., 2017). Cognitive-informational adaptations address language and literacy barriers. Affective-motivational adaptations deliver content and activities congruent to the traditions and values of the population to improve the relevance of the intervention and minimize potential cultural conflicts. Environmental adaptations focus on ecological barriers for the population and community, such as the need for childcare and/or transportation (Castro et al., 2004). A recent systematic review of cognitive behavioral interventions adapted for Hispanic/Latino immigrants categorized the adaptations using the model in the following way (Pineros-Leano et al., 2017).

Cognitive-informational adaptations Although language translations and the engagement of bilingual facilitators were usually the first step in adapting a cognitive intervention, practitioners also took into account the amount of formal education and literacy of the participants. Many made changes to CBT manuals accordingly; in some instances, visual aids were used, and the reading level of translated manuals adjusted (Alegría et al., 2014; Camacho et al., 2015; Le, Zmuda, Perry, & Munoz, 2010; Miranda, Azocar, Organista, Dwyer, & Areane, 2003; Muñoz et al., 2007; Piedra & Byoun, 2012; Shattell et al., 2010). For example, Camacho et al. (2015) drop the provider checklist and homework review. Instead, they use 15–20 minutes of receptive listening and support based on the first two steps of the intervention.

However, for practitioners in new growth communities, delivering a cognitive intervention in a cultural and linguistically congruent manner needs a strategy for overcoming bilingual personnel scarcity (Dwight-Johnson et al., 2011; Hovey et al., 2014; Piedra & Byoun, 2012; Shattell et al., 2010). Although still a challenging endeavor, a number of successful tactics were employed. Some used bilingual (and not bicultural) facilitators to deliver the intervention (Piedra & Byoun, 2012; Shattell et al., 2010). Others used a "team" approach that made use of existing community resources (Beeber et al., 2009; Hovey et al., 2014). Hovey et al. (2014) employed *promotoras* (health promoters)—trained community members—to help co-facilitate sessions with a bilingual and bicultural professional who had a very different background from that of the migrant workers in the group. Because the *promotoras* shared common life experiences with participants, their engagement facilitated the accessibility of the intervention. Beeber and her group (2009) paired project-trained interpreters with advance nurses to deliver a home-based depression treatment (Beeber et al., 2009). This approach required a rigorous protocol for how the interpreters were used in the intervention to protect the integrity of the therapeutic interaction. Lastly, project-trained bilingual and bicultural social work and psychology graduate students were used to deliver the intervention (Dwight-Johnson et al., 2011; Piedra & Byoun, 2012). While difficult to coordinate, the diversity of these strategies suggests practitioners can find ways to deliver cognitive interventions even in environments with scarce human resources.

Affective-motivational adaptations Beyond language accessibility, other cultural adaptations actually modify the treatment manual to better align with the culture and language of the participants (Interian, Allen, Gara, & Escobar, 2008; Organista & Muñoz, 1996; Piedra & Byoun,

2012). Organista (1995) recommends simplifying Albert Ellis' A-B-C-D method for cognitive restructuring into a two-pronged approach called *Si, Pero* ("Yes, But"; Interian et al., 2008; Organista & Muñoz, 1996; Piedra & Byoun, 2012). Participants use this linguistic tool to replace unhelpful thoughts with helpful ones (Organista & Muñoz, 1996). They learn that thoughts that invoke depressive thinking patterns (i.e., "I don't speak English well") can be understood as "half-truths" that can be converted into "whole truths" (i.e., "Yes [*si*], I don't speak English well, but [*pero*] I am learning more every day"). This method facilitates cognitive restructuring for Hispanics/Latinos using everyday speech.

A notable affective-motivational adaptation specific to Hispanic/Latino immigrants involves the inclusion of discussion topics related to migration and its associated hardships in the cognitive intervention (Cardemil, Kim, Pinedo, & Miller, 2005; Dwight-Johnson et al., 2011; Hovey et al., 2014; Interian et al., 2008; Le et al., 2010; Muñoz et al., 2007; Piedra & Byoun, 2012). Such a perspective recognizes the potentially traumatic nature of migration and the unanticipated losses associated with acculturation. This adaptation anticipates that prolonged depressive feelings may reflect the hardships of the lengthy transition to life in a new culture.

Environmental adaptations For many Hispanic/Latino immigrants, the stigma associated with mental health problems can pose serious obstacles to treatment. To address this problem, some scholars have posited that it is not enough to provide information to the person; rallying the support of family members can help. For example, one group of researchers provided two family sessions to each participant and an adult of her choosing (Cardemil et al., 2005). During these family sessions, information about depression and the effects of chronic stress was provided. Although not everyone took advantage of the family session (52% attended at least one session), those who did reported greater symptom reduction compared to those who did not attend any of these meetings. Thus, family inclusion can be a promising approach for those with significant others who are willing to lend support but may not understand how to do so (Pineros-Leano et al., 2017).

The use of technology to overcome environmental barriers such as the lack of transportation and childcare and the need for greater scheduling flexibility holds much promise. A recent study compared the usual care, which included a referral to a mental health provider and/or prescription antidepressants, to the effectiveness of two modes of CBT delivery with low-income Hispanics/Latinos who resided in either Boston or Puerto Rico (Alegría et al., 2014). The CBT intervention groups also received case management assistance for additional referrals and scheduling appointments. The study showed that both the telephone and face-to-face CBT interventions were more effective in reducing depressive symptoms than the usual care. In addition, the investigators found no differences between delivery modalities; both the telephone and face-to-face contact were effective in reducing depressive symptoms (Alegría et al., 2014). However, participants in the telephone intervention were more likely to schedule appointments compared those in the face-to-face intervention. It seems that for those who need greater flexibility or who struggle with transportation and childcare issues, delivering CBT by phone might facilitate the initiation and retention of treatment.

Technology can also be used to improve treatment adherence and enhance the experience (Aguilera & Muñoz, 2011). In one study, investigators sent daily text messages asking participants in a group intervention about a topic covered in treatment. For example, they might receive a message asking them how many people they interacted with or how many pleasant activities they did. The participants reported that these text messages strengthened their relationship with the group and with the therapists, making them feel closer. In addition to improving rapport between the therapist and the client, the text messages improved meeting attendance.

Table 10.1 List of sessions and activities

Title of the session	Session's goal
Treatment plan (Appendix 1)	In this session, we discuss the treatment plan and goals. As part of the therapeutic process, it is important to establish short- and long-term goals that can improve the client's mental health. Establishing goals will help the mental health professional and the client decide how they will work on the client's depression. In this treatment plan, we also emphasize the importance of homework as a useful method for the client to continue the therapeutic work outside of the sessions
What is depression? (Appendix 2)	In this session, the client learns about what depression is, some of its signals and causes, and how it addressed
Physical health and mental health go hand in hand (Appendix 3)	In this session, there is emphasis on the importance of taking care of the client's mental and physical health. We also include some guiding questions to help the client explore how she/he can maintain a general well-being
Working on the topic of immigration (Appendix 4)	In this session, we aim to address immigration as a source of strength. For many people, immigration is a difficult experience that can influence the development of depressive symptoms. In this activity, we use the "Strengths Perspectives" conceptual framework, favored by social workers. This perspective can help the client discuss his/her experience of immigration with an emphasis on his/her strengths and capabilities/skills
Introduction to cognitive therapy (Appendix 5)	In this session, we address what cognitive therapy is and how it works
Cognitive-behavioral therapy (Appendix 6)	In this session, we provide education about the connection between thoughts, feelings, and behaviors and their influence on the client's mood
Comparison between depressive and non-depressive thoughts (Appendix 7)	In this session, we focus on trying to distinguish between depressive and non-depressive thoughts
Thinking mistakes: Learn to recognize them (Appendix 8)	In this session, we introduce different categories of patterns of negative thoughts
Modifying negative thoughts: The "yes, but…" method (Appendix 9)	In this session, we introduce an innovative and culturally appropriate technique to modify negative thoughts
Working sheet for "yes, but…" method (Appendix 10)	In this appendix, we provide a worksheet to practice changing a negative thought to a positive or more realistic one
Mood and thought scale (Appendix 11)	This session provides a scale to monitor the client's mood and thoughts every day. First, this scale can help the client pay attention on how her/his thoughts and feelings influence his/her mood. Second, this scale can help the client and the mental health provider identify patterns of negative thoughts and the client's most frequent moods

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Treatment Plan and Related Activities from Vida Alegre

A cognitive treatment plan requires structure and activities to teach and reinforce positive thinking patterns (see Table 10.1). However, for new immigrants, such thinking patterns include adjusting to a new cultural environment. For many, this adjustment can be disorienting. Thus, any cognitive treatment plan for immigrants should include tools that will help with them make sense of their experience as newcomers. At the end of this chapter, we included a number of handouts *in Spanish* that focus on key strategies for implementing a cognitive intervention (see Appendices 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11). These worksheets have been adapted from a CBT intervention, "Vida Alegre" (VA; "A Happy Life"; Piedra et al., 2011), which was tested and found effective in alleviating depressive symptoms among Spanish-speaking mothers (Piedra & Byoun, 2012; Piedra et al., 2012). Because VA was developed for use in a new growth community, the worksheets assume low levels of Spanish

Table 10.2 Lista de Sesiones y Actividades

Título del Ejercicio	Explicación del Ejercicio
Plan de Tratamiento (Apéndice 1)	En esta sesión discutimos el plan de tratamiento y los objetivos. En el proceso terapéutico es importante establecer metas a corto y a largo plazo para mejorar la salud mental del cliente. El establecer metas ayuda tanto al profesional de la salud mental como al cliente a decidir cómo se va a contrarrestar la depresión. En este plan de tratamiento también recalcamos la importancia de las tareas como un método útil para que el cliente continúe el trabajo terapéutico fuera de las sesiones
¿Qué es la Depresión? (Apéndice 2)	En esta sesión el cliente aprende acerca de lo que es la depresión, cuáles son algunas de las señales y causas de la depresión, y cómo se puede superar
La salud física y la salud mental van de la mano (Apéndice 3)	En esta sesión se hace énfasis en la importancia de cuidar la salud mental y física del cliente. También, incluimos algunas preguntas para ayudarle a el/la cliente/a a explorar cómo se puede conservar un bienestar general
Trabajando el tema de la inmigración (Apéndice 4)	En esta sesión el principal objetivo es tratar el tema de la inmigración como una fuente de fortaleza. Para muchos, la inmigración es una experiencia muy difícil que puede influir en el desarrollo de los síntomas de la depresión. En este ejercicio, utilizamos el marco conceptual de la perspectiva de las fortalezas ("Strengths Perspective") preferido por los trabajadores sociales. Esta perspectiva puede ayudar al cliente a dialogar sobre su experiencia de inmigración con un énfasis en sus fortalezas y capacidades
Introducción a la terapia cognitiva (Apéndice 5)	En esta sesión se enfoca en qué es la terapia cognitiva y cómo funciona
Terapia cognitiva-conductual (Apéndice 6)	En esta sesión se provee educación sobre la conexión entre pensamientos, sentimientos y comportamientos y su influencia en el estado de ánimo del cliente
Comparación de pensamientos depresivos con pensamientos no-depresivos (Apéndice 7)	En esta sesión el cliente aprende a cómo distinguir los pensamientos depresivos de los no depresivos
Los errores en el pensamiento: Aprende a reconocerlos (Apéndice 8)	En esta sesión se hace una introducción a diferentes categorías de patrones modelos de pensamientos negativos
Modificar los pensamientos negativos: El método "sí, pero…" (Apéndice 9)	En esta sesión introducimos una técnica inventiva y culturalmente apropiada para modificar los pensamientos negativos
Hoja de trabajo para el método "sí, pero…" (Apéndice 10)	En este apéndice proveemos una hoja para practicar el cambio de pensamiento negativo a uno positivo o más realista
Escala del estado de ánimo y los pensamientos (Apéndice 11)	En esta sesión se provee la escala que se utiliza para monitorear los pensamientos y los estados de ánimo del cliente día a día. En primera instancia, la escala puede ayudar al cliente a prestar atención cómo sus pensamientos y sentimientos influyen su estado de ánimo. Y en segunda instancia, puede ayudar tanto al cliente como al profesional de la salud mental a identificar patrones modelos de pensamientos negativos y los estados de ánimos más comunes

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literacy and education in the participants. The simplified tools were also useful to novice clinicians, who consisted of project-trained graduate-level social work and psychology students.

In Table 10.1 (see Table 10.2 for a Spanish-language translation), we list the various tools and describe how to use them in the treatment process. The first three worksheets sequentially provide a way to create rapport between the clinician and the client (see Appendix 1), dispense psychoeducational information about depression (see Appendix 2), and help the client understand the link between physical well-being and mental health (see Appendix 3). This later point helps clients recognize some of the physical manifestations of depression (i.e., stomach or chest pains). These first three sessions help create a common language and a sense of familiarity

that will lay the groundwork for more difficult topics of conversation, such as immigration.

The next two worksheets open the discussion about immigration and its associated losses and gains (see Appendices 4 and 5). The immigration and acculturation experience will vary, and not all individuals will experience this process as traumatic and/or painful. It is important for the clinician to explore and discuss the experience with the client while being attuned to both verbal and nonverbal cues. The aim of this section is to determine whether some depressive feelings stem from this process and help reframe the meaning of difficult experiences. Appendix 5 is particularly useful in bringing a strength perspective to the immigrant experience.

At this point, the client is ready for solutions. The next worksheet introduces core tenets of cognitive therapy (see Appendix 6). This tool explains the concept of how experiences in a certain situation (A) will have a consequential feeling or reaction (C). This handout introduces clients on how to generate pleasant thoughts when negative ones arise. Appendix 7 describes the interconnection between thoughts, emotions, and behaviors and how they can reinforce depressive symptoms. In Appendix 8, we provide a comparison list between depressive and non-depressive thoughts to help clients identify what kind of thoughts occur more frequently. We provide examples for how depressive thoughts can be replaced with non-depressive ones. The worksheet in Appendix 9 helps clients identify errors in their thinking that generate their most prevalent depressive thoughts in order to challenge and change them.

The next two handouts provide an effective method of creating new schemas. First, the client is presented with an instructional guide on the *Si, Pero* ("Yes, But") method clients learn through the process of cognitive restructuring. The technique uses everyday Spanish language to convert half-truths into whole truths (see Appendix 10). Then the client is given an activity to practice the "Yes, But" method wherein she/he writes down a negative or depressive thought, such as "I am overweight," followed by describing how the thought makes her/him feel. Next, the client adds a positive truth that puts the negative thought into context: "But I am trying to eat healthier." Again, the person describes the associated feeling (see Appendix 11). Finally, we provide a mood scale for clients to monitor their feelings over time (see Appendix 12). This worksheet can be used from the beginning of therapy as a visual aid into the variability of one's feelings and the thoughts associated with particular moods.

Conclusion

Although many different cognitive interventions have been developed and adapted to work with the Hispanic/Latino population, many obstacles can hinder their effective implementation and/or reception by the intended population. First, the development and implementation of cognitive interventions can be more challenging in new destinations where there is a lack of human resources available. Second, the cultural adaptation of the intervention can range from the mere translation of materials to adaptations that adjust for low levels of literacy and education. This chapter provides examples of different forms of cognitive-informational, affective-motivational, and environmental adaptations (Pineros-Leano, Liechty, & Piedra, 2017). Although the inclusion of all these adaptations requires time, effort, and money, they can increase treatment attendance and even improve outcomes. Therefore, we include in the appendices of this chapter worksheets and activities that we have found useful when implementing Vida Alegre, an intervention tested in an emerging community in the Midwest with communities that are predominantly Mexican. Clinicians using these tools should modify them according to the needs of their client population, using the tenets mentioned here.

Apéndice 1. Plan de Tratamiento

Nombre: ________________________________
Fecha de comienzo: _______________________

Problema o situación que contribuye a los síntomas de la depresión:
____
____
____

Meta 1: ____

Objetivo a: ____

Objetivo b: ____

Objetivo c: ____

Meta 2: ____

Objetivo a: ____

Objetivo b: ____

Objetivo c: ____

Meta 3: ____

Objetivo a: ____

Objetivo b: ____

Objetivo c: ____

Intervención (es): ____

Fecha límite: _______ **Fecha de revisión**: __________ **Fecha de terminación**: __________

Me han explicado y entiendo mi plan de tratamiento. Me comprometo a dialogar y a trabajar dentro y fuera de las sesiones terapéuticas para aprender a cómo manejar y/o superar mi depresión.

____
Firma del Cliente

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Apéndice 2. ¿Qué es la depresión?

La depresión es más que sentirse triste por unos días. Las personas con depresión suelen sentirse tristes, preocupadas o vacías. Estos sentimientos no desaparecen, incluso durante períodos felices. También, la depresión puede interferir en el cumplimiento de las tareas diarias. Sin embargo, lo bueno es que la mayoría de las personas superan la depresión al recibir ayuda psicológica y/o medicamentos.

¿Cuáles son algunas señales de la depresión?

- Sentirse inquieto o irritable
- Sentirse triste o desesperado
- Llorar mucho o fácilmente
- Falta de energía o motivación
- Comer o dormir muy poco o demasiado
- Problemas de concentración y de memoria
- Tener baja estima de sí mismo
- Pérdida de interés o placer en actividades que antes disfrutaba
- Aislamiento de amigos y familiares
- Tener dolores de cabeza, de estómago o problemas de salud que no desaparecen

¿Qué causa la depresión?

No existe una sola causa para la depresión. Es probable que sea debido a una combinación de factores que incluyen:

- Tener familiares que sufren o han sufrido depresión
- Eventos estresantes
- Problemas hormonales

¿Cómo se supera la depresión? Usted puede:

- *Trabajar con un profesional de la salud mental* para aprender a superar la depresión.

- *Tomar un medicamento* antidepresivo recetado por su proveedor de salud legalmente autorizado.

Apéndice 3

La Salud Física y la Salud Mental van juntos de la mano

La salud es un estado de bienestar general en cuanto a nuestro estado físico, mental y social, y no la ausencia o déficits de enfermedades.

Por lo general, visitamos al doctor una vez al año para cerciorarnos que nuestro cuerpo esté saludable. O quizás, vamos al doctor cuando nos enfermamos para obtener los tratamientos necesarios para aliviar nuestras dolencias.

Al igual que cuidar nuestra salud física es importante cuidar la salud mental en todas las etapas de la vida, en la niñez, en la adolescencia, en la edad adulta y en la vejez.

¿Qué es la Salud Mental?

Nuestras emociones, pensamientos y comportamientos influyen en nuestro estado de ánimo y, a la vez, estos determinan cómo enfrentamos las situaciones diarias en nuestras vidas. Una buena salud mental incluye sentirse tranquilo, contento y satisfecho con nuestra vida personal. Además, el tener una buena salud mental nos ayuda a enfrentar los retos de la vida de una forma adaptable.

El déficit en la salud mental puede causar enfermedades mentales como la depresión o la ansiedad. Y en otras ocasiones puede causar padecimientos físicos como por ejemplo dolores de cabeza, espalda o malestares estomacales.

Entonces, ¿Qué es tener una buena Salud Mental?

Tener una buena salud mental se define como un estado de bienestar en el cual el individuo es consciente de sus propias habilidades, se siente capaz de afrontar las tensiones de la vida cotidiana, tiene buenas relaciones personales con todos y trabaja en forma productiva. Además, nosotros podemos desarrollar destrezas de cómo manejar la depresión, relacionarnos de muy buena manera con otras personas y tomar buenas decisiones.

¿De qué manera podemos mantener una buena salud mental?

Tener una fuente de apoyo social tal como fuertes lazos familiares o amistades.

Tomar tiempo personal para dedicarnos a nuestros pasatiempos o para relajarnos.

Aceptarse a uno mismo reconociendo los defectos y virtudes propias.

Tener una actitud de gratitud a la vida por lo que tenemos y no en lo que nos hace falta

¿De qué otras maneras podemos cultivar una buena salud mental?

____

____

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Apéndice 4

Trabajando el tema de la inmigración

Hoy vamos a dialogar sobre su experiencia de inmigración con un enfoque positivo. Sabemos que para muchos es un recuerdo agridulce. Sin embargo, todos tenemos fortalezas que nos ayudan a sobrellevar las experiencias tristes. A continuación, le presento una serie de preguntas que le van a ayudar a reflexionar sobre su experiencia de inmigración de una manera más balanceada:

1) ¿De dónde sacó el valor para venir a los Estados Unidos?
2) ¿Qué esperanzas tenía al tomar la decisión de inmigrar?
3) ¿Qué cualidades tiene que le han ayudado a adaptarse a este país?
4) ¿Cómo ha logrado sobrevivir hasta ahora a pesar de los desafíos que ha encontrado?
5) ¿Cuál ha sido su actitud al enfrentar estos desafíos?
6) ¿Qué ha aprendido acerca de usted mismo durante estas luchas?
7) ¿Cuáles de estas dificultades lo han fortalecido como persona? ¿Qué habilidades ha desarrollado?
8) ¿Qué personas en su vida le han dado comprensión, apoyo y guía?
9) ¿Qué agencias, organizaciones o grupos le han sido de gran utilidad después de haber venido a los Estados Unidos?

Reflexione acerca de lo que se necesita para venir aquí y para hacer una vida nueva. Marque las casillas que reflejan sus experiencias.

- ☐ Inteligencia
- ☐ Trabajo duro
- ☐ Tomar riesgos
- ☐ Persistencia
- ☐ Responsabilidad
- ☐ Habilidad para aprender un idioma y una cultura nueva
- ☐ Habilidad para superar la pobreza
- ☐ Ser ingeniosa y práctica
- ☐ Creatividad
- ☐ Sacrificio
- ☐ Otros (por favor describir): ______________________________

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Apéndice 5

Perspectiva de las fortalezas

Hoy vamos a dialogar sobre cómo disminuir los pensamientos negativos al aumentar el enfoque positivo hacia las variadas circunstancias de nuestras vidas. Todos tenemos fortalezas que nos ayudan a sobrellevar las experiencias tristes y estresantes. A continuación, le presento una serie de preguntas que le van a ayudar a reflexionar sobre su vida de una manera más balanceada:

1) ¿De dónde sacó el valor para venir a la consejería?
2) ¿Qué esperanzas tiene al tomar la decisión de mejorar su salud mental?
3) ¿Qué cualidades tiene que le han ayudado a adaptarse a sus problemas?
4) ¿Cómo ha logrado sobrevivir hasta ahora a pesar de los desafíos que ha encontrado?
5) ¿Cuál ha sido su actitud al enfrentar estos desafíos?
6) ¿Qué ha aprendido acerca de usted mismo durante estas luchas?
7) ¿Cuáles de estas dificultades lo han fortalecido como persona? ¿Qué habilidades ha desarrollado?
8) ¿Qué personas en su vida le han dado comprensión, apoyo y guía?
9) ¿Qué agencias, organizaciones o grupos le han sido de gran utilidad durante su vida?

Reflexione acerca de lo que se necesita para sobrellevar la depresión y para mejorar nuestra salud mental. Marque las casillas que reflejan sus experiencias.

- ☐ Inteligencia
- ☐ Trabajo duro
- ☐ Tomar riesgos
- ☐ Persistencia
- ☐ Responsabilidad
- ☐ Habilidad para aprender un idioma y una cultura nueva
- ☐ Habilidad para superar la pobreza
- ☐ Ser ingeniosa y práctica
- ☐ Creatividad
- ☐ Sacrificio
- ☐ Otros (por favor describir): ____

Apéndice 6

Introducción a la Terapia Cognitiva

La terapia cognitiva conductual es un tipo de terapia basada en evidencia científica en donde se aprende a identificar, evaluar y cambiar pensamientos y conductas no saludables por otros pensamientos y conductas que lo son. Cuando hablamos de pensamientos también nos referimos a creencias, ideas, actitudes, percepciones, etc. El objeto es examinar estos patrones modelos de pensamientos y cómo, a su vez, éstos influyen en nuestros sentimientos y acciones.

La fórmula vieja acerca del origen de nuestros sentimientos y/o acciones:

A--------→ C

(A) Situación
(C) Consecuencias de esta situación (pueden ser sentimientos o acciones)

Por ejemplo: Daniela y Lisa han tenido un leve accidente automovilístico. Sin embargo, sus reacciones han sido diferentes.

A (Accidente de auto)-----→ C (Daniela siente enojo)
A (Accidente de auto)-----→ C (Lisa siente alivio)

¿Qué está pasando? ¿De dónde viene el sentimiento de enojo o de alivio? Es aquí donde se presenta una nueva fórmula acerca del origen de nuestros sentimientos y/o acciones:

A----→ B----→ C

Donde B- representa nuestros pensamientos

A (Accidente de auto) -----→ B (Daniela pensó: ¡Voy a llegar tarde a mi cita médica! ¡Tanto trabajo que me dió conseguirla!) ----→ C (Sentimiento de alivio)
A (Accidente de auto) -----→ B (Lisa pensó: ¡No pasó nada grave! Mi familia está bien.) ----→ C (Sentimiento de enojo)

Otro ejemplo:
(María se vio en el espejo) ------→ B (Pensó: ¡Qué fea me veo!) ----→ C (Se sintió triste)

¡Vamos a practicar!

A (________________) -------→ B (__________________) ----→ C (__________________)

Traduccion y modificacion del libro: Mc Mullin, R. E. (2000). *The New Handbook of Cognitive Therapy Techniques*. New York, N.Y.: W. W. Norton & Company.

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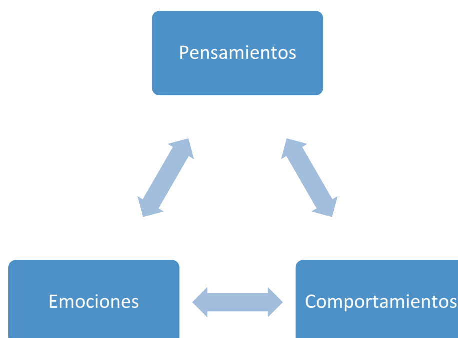
Apéndice 7

Terapia Cognitiva-Conductual

La palabra "Cognitiva" se refiere a nuestros pensamientos, creencias, ideas, imágenes, sueños, visiones, actitudes, recuerdos... En otras palabras, todo lo que sucede en nuestra mente. La palabra "Conductual" se refiere a nuestras acciones y comportamientos. Por tanto, en la terapia cognitiva-conductual nosotros vamos a trabajar en identificar esos pensamientos y conductas no saludables y reemplazarlas por pensamientos y conductas que lo sean.

Otro punto muy importante: a medida que crecemos, vamos desarrollando una perspectiva única sobre las situaciones que vivimos. Esta perspectiva es enriquecida por nuestras experiencias y nos lleva a interpretar situaciones de determinada manera. Por ejemplo, las personas optimistas, no importa lo que pase, siempre encuentran el lado positivo de las situaciones.

Los problemas e interpretaciones van a influenciar:



Como seres humanos, a veces tenemos pensamientos negativos y actuamos de manera negativa. Sin embargo, cuando estos pensamientos y comportamientos persisten por mucho tiempo y comenzamos a interpretar la mayoría de las situaciones de forma negativa, esto puede crear círculos viciosos de pensamientos y acciones que pueden llevar al desarrollo de la depresión.

Traducción y modificación del libro: Burns, D. D. (1999). *Feeling good: The new mood therapy*. New York, N.Y.: HarperCollins.

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Apéndice 8

Comparación De Pensamientos Depresivos Con Pensamientos No-Depresivos

Pensamientos Depresivos son:	Pensamientos No-Depresivos son:
Pensamientos INFLEXIBLES; es decir, son concretos y absolutos. Por ejemplo, una persona deprimida puede pensar: "Nunca me recuperaré de esta depresión" "Siempre fui y siempre seré un cobarde."	Pensamientos FLEXIBLES; nos llevan a reconocer que podemos cambiar nuestros pensamientos. Una persona flexible puede razonar: "Si salgo a caminar, por lo menos estoy tratando de sentirme mejor" "**A VECES** siento miedo de **ALGUNAS** situaciones."
Pensamientos CRÍTICOS que lo hacen sentir como una mala persona. Por ejemplo, una persona deprimida puede pensar: "Soy un fracaso porque quemé la comida y no pude servirla a tiempo." "En realidad no me importa si las cosas están bien hechas, soy un fracaso."	Pensamientos de ELOGIO se concentran en lo que hacemos (comportamiento), no en quiénes somos (la persona). El pensador no-deprimido diría, "No estuve prestando atención a la comida y me hace sentir mal que la haya quemado." Un pensamiento menos crítico sería: "Sí, he cometido errores, pero eso no significa que yo soy un fracaso. Puedo aprender de mis errores."
Pensamientos SIN ESPERANZA te hacen sentir como si tratar de ser mejor no tuviera ningún sentido. Por ejemplo, la persona que tiene pensamientos depresivos diría, "Nací para sentirme mal, toda mi vida ha sido una tragedia tras otra." "Nada me ha ayudado."	Pensamientos CON ESPERANZA; es decir, implica pensar que las cosas van a mejorar. El pensador con esperanzas dice, "He sufrido mucho, pero puedo hacer las cosas mejor." "A veces las cosas resultan. Esto es una nueva experiencia y estoy segura de que aprenderé algo útil."

Apéndice 9

Los Errores En El Pensamiento: Aprende A Reconocerlos

Manera De Pensar:	Se Define Como:	Por Ejemplo:
Pensamiento Todo-O-Nada	Las cosas se ven como completamente buenas o completamente malas. Si comete un error, piensa que todo salió mal.	"Se me olvidó echarle sal a la comida, jamás seré buena cocinera".
Filtro Mental	Concentrarse en un sólo detalle negativo exclusivamente, hace que todo lo demás se vea negativo también.	Susana sólo se enfoca en su diabetes y en los niveles de azúcar que tuvo esta mañana. Y aún después de controlarla, no disfruta del bonito día.
Llegar a Conclusiones Precipitadas	Asumes lo peor a. **Leyendo la Mente** b. **Adivinando la Fortuna**	a. Cuando ve a alguien que no se porta amistosamente, usted asume que no le cayó bien a esa persona o que está enojado/a con usted. b. Usted cree que las cosas resultarán mal. Cree que desastres o cosas malas están "destinados a suceder."
Debería:	Intenta motivarse con: "debería". Se siente culpable cuando aplica este tipo de pensamientos porque ponen presión emocional.	"Yo debería ser mejor persona" o "debería dejar de comer hasta que baje de peso."
Poniéndose Etiqueta	Definirse bajo una categoría simplemente por un error.	Por un error, empieza a pensar que es un "fracaso". Si su niño se porta mal, usted piensa que fracasó como padre/madre.
Auto-Culpa	Se culpa así mismo por cosas sobre las cuales no tuvo control.	"Si hubiera hecho algo, esto no hubiera ocurrido." Si no hubiera llevado al niño a jugar, no se hubiera lastimado.

Apéndice 10

Modificar Los Pensamientos Negativos: El Método "Sí, pero…"

Cuando se siente deprimida, verdades a medias reciben más atención que verdades completas. Debido a que los pensamientos depresivos deforman la realidad; mantener una percepción precisa de sí mismo y de la situación puede ayudar. Aunque no se sienta mejor inmediatamente, las percepciones precisas impiden que uno se sienta peor. Esto es lo que debe hacer: primero, pare y tome en consideración lo que se dice así mismo. Si el mensaje lo hace sentir mal o lo hace enojar, es probable que sea una verdad a medias. Para luchar con el pensamiento negativo puede incluir una declaración que comience con "PERO…".

Por ejemplo, tome en consideración los siguientes pensamientos:
Antes: "Jamás voy a bajar de peso."
"Jamás voy a poder aprender a hablar inglés".
¿Cómo la harían sentir estas declaraciones? Responda a estos pensamientos usando el método "sí, pero…".

Después: "Sí, estoy gordo, **PERO** trato de comer de la manera saludable."
Después: "Sí, no puedo hablar inglés, PERO estoy aprendiendo en mi nueva clase de inglés.

Ejercicio (use una tarjeta):
1) Por un lado de la tarjeta, escriba una frase que se diga frecuentemente y que le haga sentir mal.
2) Pregúntese a usted mismo, ¿esta frase es completamente cierta? ¿Qué parte de la situación estoy ignorando?
3) Por el otro lado de la tarjeta use el método SÍ, PERO para hacer otra frase que sea más precisa y realista.

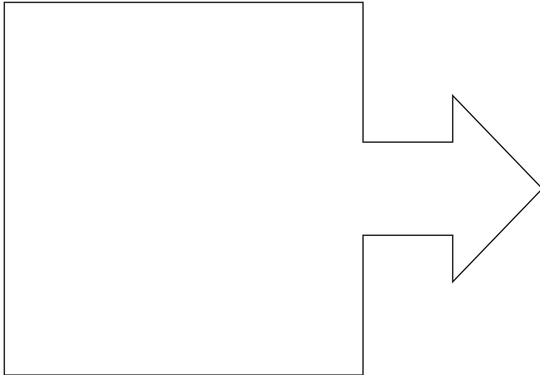
Traducción y modificación de Ellis' A-B-C-D method, esta adaptacion se encuentra en Organista, K. C. (1995). Cognitive-behavior treatment of depression and panic disorder in a Latina client: Culturally sensitive case formulation. *In Session: Psychotherapy in Practice, 1*(2), 53-64.

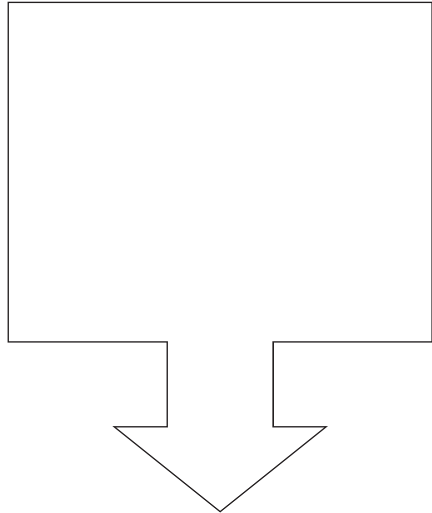
Apéndice 11

Hoja De Trabajo Para El Método "Sí, Pero…"

Escribe un pensamiento negativo

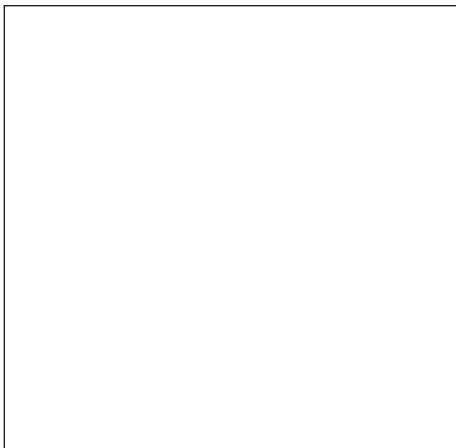
¿Cómo te hace sentir?

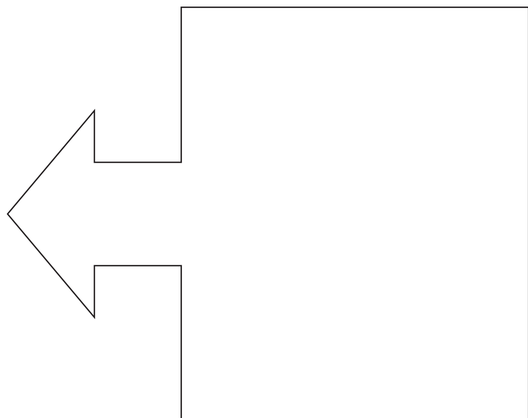




Ahora, ¿cómo te hace sentir?

Modifica el pensamiento negativo a uno positivo o más realista





Apéndice 12: Escala Del Estado De Ánimo Y Los Pensamientos

Instrucciones: Cada día, identifique el o los estados de ánimo que sintió. Ennegrezca la intensidad del estado de ánimo. En adición, escriba algunos pensamientos que contribuyeron a su o sus estados de ánimo.

Lunes

☐ Feliz	☐ Enojado/a	☐ Nervioso/a	☐ Cansado/a	☐ Esperanzado/a
☐ Solo/a	☐ Frustrado/a	☐ Asustado/a	☐ Aburrido/a	☐ Apreci ado/a
☐ Triste	☐ Preocupado/a	☐ Amado/a	☐ Orgulloso/a	☐ Decepcionado/a

Escribe tus pensamientos:

Martes

☐ Feliz	☐ Enojado/a	☐ Nervioso/a	☐ Cansado/a	☐ Esperanzado/a
☐ Solo/a	☐ Frustrado/a	☐ Asustado/a	☐ Aburrido/a	☐ Apreciado/a
☐ Triste	☐ Preocupado/a	☐ Amado/a	☐ Orgulloso/a	☐ Decepcionado/a

Escribe tus pensamientos:

Miércoles

☐ Feliz	☐ Enojado/a	☐ Nervioso/a	☐ Cansado/a	☐ Esperanzado/a
☐ Solo/a	☐ Frustrado/a	☐ Asustado/a	☐ Aburrido/a	☐ Apreciado/a
☐ Triste	☐ Preocupado/a	☐ Amado/a	☐ Orgulloso/a	☐ Decepcionado/a

Escribe tus pensamientos:

Jueves

☐ Feliz	☐ Enojado/a	☐ Nervioso/a	☐ Cansado/a	☐ Esperanzado/a
☐ Solo/a	☐ Frustrado/a	☐ Asustado/a	☐ Aburrido/a	☐ Apreciado/a
☐ Triste	☐ Preocupado/a	☐ Amado/a	☐ Orgulloso/a	☐ Decepcionado/a

Escribe tus pensamientos:

Viernes

☐ Feliz	☐ Enojado/a	☐ Nervioso/a	☐ Cansado/a	☐ Esperanzado/a
☐ Solo/a	☐ Frustrado/a	☐ Asustado/a	☐ Aburrido/a	☐ Apreciado/a
☐ Triste	☐ Preocupado/a	☐ Amado/a	☐ Orgulloso/a	☐ Decepcionado/a

Escribe tus pensamientos:

Sábado

☐ Feliz	☐ Enojado/a	☐ Nervioso/a	☐ Cansado/a	☐ Esperanzado/a
☐ Solo/a	☐ Frustrado/a	☐ Asustado/a	☐ Aburrido/a	☐ Apreciado/a
☐ Triste	☐ Preocupado/a	☐ Amado/a	☐ Orgulloso/a	☐ Decepcionado/a

Escribe tus pensamientos:				
Domingo				
☐ Feliz	☐ Enojado/a	☐ Nervioso/a	☐ Cansado/a	☐ Esperanzado/a
☐ Solo/a	☐ Frustrado/a	☐ Asustado/a	☐ Aburrido/a	☐ Apreciado/a
☐ Triste	☐ Preocupado/a	☐ Amado/a	☐ Orgulloso/a	☐ Decepcionado/a
Escribe tus pensamientos:				

Tomado de: Piedra, L. M., Cintrón, V., Guardini, L., Marquez, J., & Sink, L. (2011). *Vida Alegre: Cómo Lograr el Control sobre sus Emociones*. Manual de tratamiento -Versión en español (no publicado). [*Vida Alegre: How to Gain Control over Your Emotions*. Unpublished treatment manual-Spanish version]. University of Illinois at Urbana-Champaign. Urbana, IL.

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