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Cognitive Restructuring With Latinx Individuals

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Abstract
Cognitive behavioral therapy (CBT) is considered standard treatment for a number of psychiatric disorders, such as depression and anxiety. However, the great majority of psychotherapy process research examining the effectiveness of CBT interventions such as cognitive restructuring has been conducted with predominantly White samples while there is only limited research evaluating their validity with Latinx populations in the United States. As the largest and fastest growing minority group in the country, the mental health care of Latinx individuals warrants much attention. Thus, the ability to deliver CBT interventions in an effective and culturally sensitive manner is crucial. In this article, we discuss practice considerations and provide specific recommendations pertaining to the use of cognitive restructuring techniques with monolingual Spanish-speaking Latinx clients.

Keywords CBT · Cognitive restructuring · Latinx · Cultural adaptation · Evidence-based practice

Clinical Vignette

At the initial meeting, "Mrs. Lopez," a 56-year-old, monolingual Spanish-speaking White Latinx divorced woman with three adult children, was living by herself in an underserved community. Mrs. Lopez was born and raised in northern Mexico and moved to the United States as an adult. She was referred for cognitive behavioral therapy (CBT) by her psychiatrist of 1.5 years, who noted minimal improvement in functioning and increased levels of depressive symptomology despite pharmacotherapy. At the time of referral, Mrs. Lopez met DMS-5-TR (American Psychiatric Association, 2022) criteria for major depressive disorder.

Although Mrs. Lopez reported mild depressive symptoms that were present most of her life, she had been able to function well at work and home until 2 years ago when her youngest son moved out of her house. Mrs. Lopez's oldest son and daughter had both moved a few years earlier when each got married. When her youngest son moved out, Mrs. Lopez's functioning began to deteriorate, and she began displaying depressive symptoms and becoming socially withdrawn. Mrs. Lopez reported depressed mood, loss of pleasure, hopelessness, feeling easily hurt, irritability, difficulty to motivate herself to perform daily functions, and the tendency to avoid social contact and leaving her home. She also reported feeling extremely lonely and engaging in rumination over being alone. Mrs. Lopez also noted believing her life was never going to be the same now that all of her children were adults who no longer needed her and had limited time for her due to other life responsibilities.

Prior to starting services at the mental health community clinic, Mrs. Lopez's treatment was limited to pharmacotherapy only. While her psychiatrist was proficient in Spanish, their formal training and experience in providing psychotherapy to Latinx clients was limited. At the community clinic, her treating clinician had advanced training and extensive experience in the delivery of culturally congruent treatment to culturally diverse clients, including monolingual Latinx clients low in acculturation. Adopting a cultural humility stance, Mrs. Lopez's treating clinician continuously strived to critically understand her particular cultural identities and worldviews as those related to her treatment. The clinician also utilized the Cultural Formulation Interview (CFI; Lewis-Fernández et al., 2016), a brief semi-structured interview, to obtain information about the role of culture and cultural values on key aspects of the clinical presentation, symptom manifestation, and treatment recommendations for Mrs. Lopez.

Treatment began with Mrs. Lopez describing the "feelings of sadness" she was experiencing. Addressing the client's relationship with her adult children was a sensitive topic, but empathizing with her emotional pain and feelings of loneliness was important. Next, the clinician asked Mrs. Lopez to describe how being alone made her feel sad and

gloomy as a way to elicit her automatic thoughts. By inquiring about Mrs. Lopez's automatic thoughts, her clinician uncovered Mrs. Lopez's beliefs that her life was over now that she was no longer needed by her children and that she would go on forever alone. Mrs. Lopez identified a couple of unhelpful automatic thoughts such as "my children no longer need me" and "I have nothing else left to do." At this point in treatment, Mrs. Lopez's clinician introduced the idea of looking at her own thoughts, which is central to CBT. Cognitive restructuring with these thoughts proceeded through use of what Organista (1995) called the "*Si, pero*" ("Yes, but") technique, in which unhelpful thoughts are described to the client as "half-truths" that are partly but not completely true. This technique conveys empathy while encouraging the client to view their thinking as not fully accurate.

To teach Mrs. Lopez how to change such unhelpful thoughts, the clinician asked her to complete the following thought: "Yes, I am no longer occupied mothering my children, but...," to which Mrs. Lopez eventually responded, "but I can use my time to do other things." Mrs. Lopez was instructed to use the newly restructured thought to counter her original negative automatic thought whenever it emerged. Mrs. Lopez was then asked to evaluate how changing her thinking made her feel. While cognitive restructuring may not always provide immediate relief to clients, consistent practice can ultimately provide relief in a matter of hours or over the course of a few days. Restructuring Mrs. Lopez's thoughts also helped increase her daily activities thereby further reducing symptoms of depression. Even though she was initially wary of the cognitive behavioral model, as Mrs. Lopez continued to participate in services she displayed increased motivation to learn and apply different cognitive behavioral strategies for the management of her depression, resulting in clinically significant decreases in her levels of depression and hopelessness.

Background

Current evidence-based CBT integrates behavioral and cognitive techniques to help clients suffering from a variety of psychiatric disorders, including depression, anxiety, posttraumatic stress disorder, personality disorders, and even psychosis (e.g., Hofmann et al., 2012; Hofmann & Smits, 2008; Matusiewicz et al., 2010; Mendes et al., 2008; Stafford et al., 2013). On the behavioral side, CBT aims to get clients to increase their activity levels and to enjoy more activities. On the cognitive side, CBT guides clients to think in more adaptive and less negative ways. With these goals in mind, psychologists have developed different approaches to bring about these changes.

Notably, in the 1960s, Aaron T. Beck put forward a therapy approach that he called cognitive therapy (CT), which has made a significant contribution to CBT. Beck's (1987) CT is based on the cognitive model, which proposes that psychiatric disorders result from a pattern of negative thinking characterized by biased self-relevant thoughts, evaluations, and beliefs. The pattern of negative thinking may be triggered by current distressing circumstances contributing to both the development and persistence of psychopathological states. Beck claimed that CT could help clients overcome their negative thinking and therefore their psychopathology. Accordingly, the focus of CT is on guiding clients to identify and change negative cognitive processes (Beck et al., 1979). The term cognitive restructuring (CR) has been used to refer to the schematic change mechanism postulated in CT (Clark, 2013).

Since its inception, different definitions of CR have been offered. Clark (2013) defined CR as the structured, goal-directed, and collaborative intervention techniques employed to explore, appraise, and replace the maladaptive thoughts, interpretations, and beliefs that maintain psychological disturbance. A key goal of CR is to change this maladaptive schema-congruent processing bias by questioning the automatic acceptance of negative schema-congruent information and encouraging clients to try out new ways of thinking in their daily lives (Beck et al., 1979). Hence, the main focus of CR is on the content of maladaptive schemas. Such content comprises clients' negative idiosyncratic generalized attitudes, beliefs, and assumptions about themselves, their world, their future, their achievements, and interpersonal relations, which are used to guide information processing particularly in distressing situations (Dozois & Beck, 2008).

It is assumed that CR achieves schematic change through two fundamental processes. First, once the cognitive behavioral therapist together with the client have identified the key relevant schemas, the cognitive behavioral therapist employs a variety of cognitive interventions to reduce the activation threshold, accessibility, and availability of the maladaptive schemas. Gradually and with repeated effortful evaluation, the processing priority and interconnectedness of the maladaptive schemas are weakened and as a result the processing of maladaptive schema-congruent information becomes less automatic. Second, CR also involves learning to replace maladaptive schemas with more adaptive schemas about the self, world, and future. To sum up, lowering the activation threshold and strengthening the accessibility and acceptance of alternative adaptive schemas that counter disorder-related schemas are the ultimate goals of CR (Clark, 2013). It is presumed that in this way CR attains lasting symptom reductions and remission of psychiatric disorders.

The great majority of psychotherapy process research examining the efficacy and effectiveness of CBT interventions such as CR has been conducted with predominantly White samples composed of individuals from European-American and middle-class backgrounds (Clark, 2013; La Roche & Christopher, 2009). Nevertheless, some published studies explore the effectiveness of cultural adaptations of

CBT programs delivered to Latinx participants (for systematic reviews, see Escobar & Gorey, 2018; Hernandez et al., 2020; Pineros-Leano et al., 2017).

Ramos and Alegría (2014) described the process of a cultural adaptation that included accommodations for health literacy of a brief telephone cognitive-behavioral depression intervention for monolingual Latinos in low-resource settings. Cultural adaptations included condensation of the sessions, review, and modifications of materials presented to participants including the addition of visual aids, culturally relevant metaphors, values, and proverbs but no deep structure modification or adaptation of CR. Feedback from clinicians and participants suggested that further adaptation of certain areas was warranted (Ramos & Alegría, 2014). In particular, feedback strongly indicated that revisions to the presentation of CR to participants was much needed. Clinicians conveyed that participants had considerable difficulties grasping some of the concepts related to challenging negative thoughts. For instance, these participants struggled to understand the concept of negative thoughts and reported difficulty identifying and observing them (Ramos & Alegría, 2014). Similarly, participants struggled to challenge negative thoughts using questions such as "What is the evidence that supports your negative thought?" and "What are other explanations?" Clinicians surmised this approach was difficult to effectively explain to participants and required remembering too many questions to ask themselves to challenge a negative thought. Furthermore, clinicians underscored that the cognitive challenging techniques of exaggerating negative thoughts, imagining someone else telling you what you are thinking, and asking yourself "What if the worst were to happen?" were not helpful strategies for some patients. Clinicians drew attention to patients with trauma histories for whom these techniques might not have been helpful because their negative thoughts may be more related to traumatic memories. Overall, it remains unclear whether the difficulties arose from the way the concepts were presented or because these concepts were not consistent with the Latino culture.

Similarly, Landa-Ramírez et al. (2020) noted challenges in teaching CR to Mexican patients with low schooling levels. The goal of their study was to assess the effect of tailored CBT on depression and anxiety symptoms in a sample of Mexican terminal cancer patients. Nine patients participated in the study, each receiving four to six therapy sessions. Landa-Ramírez et al. (2020) determined that their tailored CBT intervention resulted in weak to moderate impact for anxiety and depression symptoms in this population. They also pointed out that many patients with low schooling levels had considerable difficulties grasping some components of the therapy, particularly those related to CR. Critically, low schooling levels have been reported as common among the Latin American population, making this a relevant challenge (UNESCO et al., 2022).

Clinical and Ethical Challenges

Latinx people comprise the largest ethnic minority group in the United States, accounting for 18.5% of the nation's total population (U.S. Census Bureau, 2020). Demographic projections indicate their proportion within the U.S. population will continue to expand, approaching that of Americans of European descent in the ensuing years (U.S. Census Bureau, 2020). Thus, mental health and healthcare access among Latinx individuals warrants much attention. Furthermore, Latinx individuals have been identified as being at an increased risk for developing mental health issues (Bridges et al., 2014). General distress levels may be reported as high for some Latinx individuals. For instance, Latinx groups in the United States are frequently over-affected by poverty, a well-documented risk factor for psychopathology (e.g., Kessler et al., 2012; Shrider et al., 2021). Similarly, Latinx groups are vulnerable to minority stress and discrimination. Those individuals experiencing discrimination are likely to have poorer mental health outcomes such as depression (e.g., Chin et al., 2020).

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA, 2021) National Survey on Drug Use and Health (NSDUH), overall mental health issues are on the rise among Latinx groups between the ages of 12 and 49. Between 2008 and 2021, serious mental illness increased from 4.0% to 9.8% among Latinx people ages 18–25, and from 2.2% to 4.8% in the 26–49 age group. The NSDUH also revealed that the percentage of adults aged 18 or older who attempted suicide was higher among Latinx adults (1.1%) compared to White (0.5%) and Asian adults (0.3%). Even more concerning, in 2019, suicide was the second leading cause of death for Latinx people ages 15 to 34 (Office of Minority Health, 2021).

Latinx groups in the U.S. face disparities in healthcare access, experiencing limited access to mental health care services and receiving poor quality of treatment (Turner et al., 2016). In 2018, non-Hispanic White individuals received mental health treatment twice as often as Latinx individuals (Office of Minority Health, 2021). In general, Latinx individuals underutilize mental health treatment more often than non-Hispanic White individuals, with only 36.1% of Latinx individuals experiencing symptoms of any psychological disorder receiving mental health services, compared to 52.4% of White individuals experiencing any mental illness (SAMHSA, 2021). Several barriers to accessing adequate mental health services have been identified, including difficulties with engagement in treatment, premature termination, a shortage of clinicians who speak Spanish, and difficulties accessing services due to inadequate transportation or childcare and long work hours (Turner et al., 2016; Benuto & Leany, 2017).

Moreover, most empirically supported treatments, as is the case with CBT treatment approaches, are centered on

Western European cultural values without taking into account the values of ethnic and racial minorities (Domenech Rodríguez & Bernal, 2012; Miranda et al.,, 2003; Wendt et al. 2015). A number of clinical theorists contend that providing these treatments to culturally diverse clients may be contraindicated at times because of the mismatch in cultural values, particularly pertaining to identity, interpersonal relations, family dynamics, emotion expression, and conceptualization of mental health and healing (Wendt et al., 2015). Similarly, Pan et al. (2011) argued that these treatments may fail to account for the cultural beliefs and practices that influence therapeutic processes and may compromise both the engagement and retention of multicultural populations.

Together with the aforementioned risk factors, these barriers to mental health services put Latinx individuals at a disproportionate risk of lower quality of life and reduced sense of overall well-being. Therefore, psychologists and other mental health professionals should address barriers to services and expand access for Latinx clients, especially those whose English proficiency and acculturation levels differ from the mainstream population in the United States.

Organista and Muñoz (1996) outlined cultural and economic reasons for advancing the application of CBT treatment approaches with traditionally oriented Latinx individuals of low socioeconomic status (i.e., traditional value orientation, low level of acculturation, etc.). Organista and Muñoz (1996) posited that the expectations of traditional Latinx clients include immediate symptom relief, guidance and advice, and a problem-centered approach, which are elements present in CBT. Equally, short-term, directive, problem-solving focused treatment approaches such as CBT are better aligned with the expectations of low-income people facing unrelenting life pressures that translate into the need for immediate attention and interfere with long-term treatment. CBT is also considered less abstract compared to some other therapy approaches, such as psychodynamic therapies, making CBT easier for some clients to grasp. Further, the didactic style of CBT, which involves the use of therapy manuals and regular homework assignments, reduces the stigma associated with therapy among clients of Latinx background. Organista and Muñoz (1996) noted that many Mexican and Central American immigrant clients report such stigma being quite strong in their countries of origin.

Practice Considerations

A number of studies suggest that conventional CBT may be an adequate mental health intervention for Latinx clients who can speak English and are more acculturated (e.g., Casas et al. 2020). However, conventional CBT may not be appropriate for Latinx clients who do not fall into the previous two categories. As a result, clinicians may need to employ a cultural adaptation of CBT to make treatment more culturally congruent for Latinx clients while making sure to preserve the authenticity of the treatment (Domenech Rodríguez & Bernal, 2012). There is evidence to suggest that culturally adapted versions of CBT can be effective for treating Latinx clients who do not speak English and are less acculturated, an example being select immigrant populations (Hinton et al., 2011). For instance, Mercado & Hinojosa (2017) suggested that providing culturally adaptive interventions is warranted for the enhanced treatment of the Latinx Spanish-speaking population in the United States.

The cultural adaptation process model (CAPM; Domenech-Rodríguez & Wieling, 2005) suggests that cultural adaption of interventions should include three phases: evaluating community needs and scientific integrity, selecting and adapting the intervention, and implementing the new intervention created. The CAPM also highlights using the eight elements of the ecological validity framework (Bernal et al., 1995)—language, persons, metaphors, content, concepts, goals, methods, and context—when formulating cultural adaptations. These elements are implemented in a variety of ways, ranging from the translation of content to be delivered by bilingual clinicians to the explicit reference to cultural values and contextual stressors of the target population and the integration of the target population's understanding of why the problem developed and how it can be fixed (Domenech-Rodríguez & Wieling, 2005; Falicov, 2009).

It has been argued that in order for cultural adaptations to be most effective they must involve deep structure modification addressing cultural values, beliefs, norms, and other relevant aspects pertaining to a culture's views and lifestyles (e.g., Resnicow et al., 2000). Therefore, a major challenge in adapting treatments to a particular cultural or ethnic group is making sure that the adaptations are relevant to the needs of the target population, efficacious, and consequently result in increased treatment engagement (Castro et al., 2010). Below, we offer several cultural adaptation recommendations for the treatment of monolingual Spanish-speaking Latinx clients who are low in acculturation, beginning with the case conceptualization all the way through termination utilizing the CAPM.

Case Conceptualization

Psychologists must take into account the influence of cultural factors on each aspect of treatment: diagnostic intake, case conceptualization, diagnosis, and treatment recommendations. However, Latinx people represent a dynamic group in the United States, encompassing diverse individuals who

may differ in terms of country of origin, generation level, language proficiency, socioeconomic status, adherence to cultural values, and several other factors. Therefore, the assessment of acculturation level and adherence to cultural values is a critical component of client conceptualization. While measuring acculturation is challenging, clinicians may consider, but not exclusively rely on, acculturation proxies such as length of time in the country, age of arrival, and language spoken at home (Alegria, 2009). However, some researchers have noted that measuring level of adherence to cultural values may be more relevant for providing culturally congruent mental health care (Edwards & Cardemil, 2015). To this end, clinicians can ask specific questions during the clinical interview (see Edwards & Cardemil, 2015 for examples of questions that clinicians can use for gathering information about clients' adherence to cultural values).

In the case of Mrs. Lopez, her presenting symptomology and treatment were conceptualized incorporating various aspects of the Latinx culture. For instance, her conceptualization included the core value of *familismo* (familism), which refers to a strong orientation and commitment toward the family. Mrs. Lopez's case conceptualization also incorporated the traditional gender role of *marianismo*, which refers to the expectation that Latinx women should place their family's needs above their own needs. For people of Latinx background, core values along with traditional gender roles are central to the standards of acceptable interpersonal behavior (Santiago-Rivera et al. 2002). Similarly, social researchers agree that *la familia* (the family) has a crucial role in the psychological well-being of Latinx individuals (Comas-Díaz, 1988; Sue et al., 2022). Most Latinx individuals highly value and seek to maintain close ties with their families throughout their life. Accordingly, the understanding of the importance of the family unity as a fundamental value in many Latinx families is key in the conceptualizing of Mrs. Lopez's presenting psychopathology and implementation of intervention content.

Engaging the Client

When engaging with the client, communication is most effective when taking into consideration persons, language, content, and context (Domenech-Rodríguez & Wieling, 2005). When working with less acculturated Latinx clients who are likely to endorse more traditional Latinx values, emphasis should be placed on following a traditional Latinx interaction protocol based on the values of *respeto* (respect), *personalismo* (personalism), and *simpatía* (congeniality). *Personalismo* refers to engaging in personalized interactions with clients (Añez et al., 2005). It may be common for a therapist to want to go straight into identifying what the presenting problems may be when starting therapy with a new client. However, with Latinx clients one should understand that there are cultural expectations that may make this way of providing therapy seem impersonal and may ultimately damage the therapeutic relationship before it ever begins (Organista, 2019). Another value that should be considered when evaluating how to engage in interaction with a client is *simpatia,* which requires the therapist to be warm and kind, avoiding a passive and neutral demeanor (Interian & Díaz-Martínez, 2007). A Latinx client may see the perceived coldness of a psychotherapist as a barrier to treatment and halt or avoid coming to sessions if *simpatia* cannot be successfully implemented (Pincay & Guarnaccia, 2007).

Incorporating cultural values and frequently using *dichos* (sayings) throughout the protocol helped Mrs. Lopez to feel comfortable and respected, thereby enhancing engagement. For the initial meeting, Mrs. Lopez's clinician met her in the waiting room and formally addressed her by her last name to acknowledge the respect that her older age prescribed. The clinician then thanked her for coming to the clinic to complete the intake assessment. Next, the clinician asked where Mrs. Lopez was from and, after she answered, provided her with warmth and informal communication. The next few minutes were spent talking about Mrs. Lopez's hometown and some of her favorite places to visit there. Before the conclusion of the initial meeting, the clinician informed Mrs. Lopez that they had previously worked with many clients with similar experiences to her and those clients were able to live a fulfilling life. The clinician then thanked Mrs. Lopez for the opportunity to work with her.

Even though some Latinx clients may be highly acculturated and thus such traditional engagement may not be as critical, it may be advisable to adhere to this cultural regularity at least initially until the client feels at ease in treatment. Additionally, Socratic questioning was central in the course of therapy to prompt Mrs. Lopez to evaluate her own thoughts without feeling attacked.

Cultural Adaptation of CR for Latinx Individuals

One CBT technique for which clients are receptive includes cognitive strategies tailored to language, cultural values, and metaphors (Domenech-Rodríguez & Wieling, 2005). Additionally, one way for a health service psychologist to create rapport with a client is to engage in small talk, which may help ease tension and nervousness. When engaging with a client, the psychologist can transition between using an informal and formal approach to effectively promote understanding of CR techniques (Domenech-Rodríguez & Wieling, 2005). Using Spanish *dichos* (sayings) throughout the intervention may help engage, redirect, and increase

client self-understanding and awareness (Santiago-Rivera et al., 2009). The *dichos* describe moral values, social behaviors, and attitudes to facilitate insight from the client, which may aid in believing and implementing CR strategies. Table 1 provides examples of common *dichos* and how they may aid in facilitating culturally adaptive CBT.

Organista and Muñoz (1996) described a prominent adaptation of CR for Latinx individuals, the "*Si, Pero*" ("Yes, But") technique. The authors explain that even though Latinx clients easily understand the basic notions of "positive" and "negative" thoughts, they frequently have difficulty employing a CR system such as Albert Ellis's A-B-C-D method in which clients are taught to identify the **A**ctivating event, **B**eliefs about the activating event, the emotional **C**onsequences of beliefs, and how to **D**ispute irrational beliefs about the event and related negative emotional consequences in order to change the feelings the event generates (Ellis & Grieger, 1977). Organista & Muñoz (1996) contended this A-B-C-D method is impractical when used with Latinx clients. Hence, they proposed simplifying Ellis' A-B-C-D method for CR into a two-pronged approach called "*Si, Pero*" ("Yes, But") originally developed by Organista (1995). This linguistic tool "*Si, Pero*" ("Yes, But") aids clients in understanding the concept of CR and replacing unhelpful thoughts with helpful ones (Organista & Muñoz, 1996).

A remarkable feature of the "*Si, Pero*" ("Yes, But") technique is that it conveys empathy while stimulating client curiosity about thoughts that may be unhelpful. Rather than labeling the client's thinking as irrational or dysfunctional, this technique empathically considers unhelpful thoughts and beliefs as half-truths that have to be turned into whole truths. Clients learn that thoughts that elicit depressive thinking patterns (i.e., "I don't speak English well") can be seen as half-truths that can be made into whole truths (i.e., "Yes [*si*], I am no longer occupied mothering my children, but [*pero*] I can use my time to do other things"). Organista & Muñoz (1996) asserted that this "*Si, Pero*" approach is effective in facilitating CR for low-income Spanish-speaking client with elementary education while using everyday speech.

The effectiveness of the "*Si, Pero*" ("Yes, But") approach has been empirically examined in at least three different studies by Interian et al. (2008), Piedra & Byoun (2012), and Aguilera et al. (2018). Although their findings are based on a small, nonrandomized studies, the results are promising, indicating acceptable treatment retention rates and clinically meaningful reductions in depressive and anxiety symptoms after treatment completion and at follow-up. Together these findings support the usefulness and effectiveness of this intervention for the treatment of depression among Spanish-speaking, low-income Latinx clients with limited educational attainment.

Culturally Appropriate Termination

In regard to termination, psychologists should routinely advise clients to reach out in case they believe they could benefit from a booster session or resuming services. While

Table 1 Examples of dichos/Spanish proverbs that can facilitate cognitive behavioral therapy

Dicho/Spanish proverb	Utilization
"Camaron que se duerme so lo lleva la corriente." The shrimp that falls asleep is taken by the tide	Used to promote behavioral activation practices
"Ojos que no ven, corazon que no siente." Eyes that do not see, a heart does not feel	Used to explain and explore avoidance behaviors
"Todo es según el color del cristal con que se mira." Everything is according to the color of the glass with which it is viewed	Used to promote cognitive restructuring and viewing event/self in a different way
"Buscando la quinta pata del gato." Searching for the fifth leg of the cat	Used to explain cognitive errors that might contribute to maladaptive behaviors
"Cavendo se aprende a andar." By failing, we learn to walk	Used to promote positive reinforcement to continue practicing therapeutic strategies
"No dejes para mañana lo que puedas hacer hoy." Don't leave for tomorrow what can be done today	Used to promote behavioral activation practices and practicing therapeutic strategies
"No hay mal que por bien no venga." Every cloud has a silver lining	Used to promote cognitive restructuring and viewing event/self in a different way
"Con esfuerzon y esperanza, todo se alcanza." With effort and hope, anything can be achieved	Used to promote positive reinforcement of work being done during sessions
"Ayúdate que yo [Dios] te ayudaré." Help yourself and I [God] will help you	Used to promote positive reinforcement to continue practicing therapeutic strategies
"Que sea lo que Dios quiera/Si Dios quiere." God's will be done/If God wants	Used to promote positive reinforcement to continue practicing therapeutic strategies

this may be important to do for all clients regardless of their background, "keeping a door open" may be especially important with Latinx clients because they may have grown to deem their clinician as an important and salient person in their lives. Four sessions prior to Mrs. Lopez's final session, her clinician started preparations for termination. The clinician reviewed Mrs. Lopez's progress toward her initial goals and the therapeutic strategies she acquired through treatment. She demonstrated a positive attitude toward and readiness for termination. Similarly, Mrs. Lopez displayed insight into the ongoing need to continue to apply cognitive behavioral strategies after termination.

Conclusions

CR is a complex therapeutic intervention that intends to reduce distressing symptoms by modifying the maladaptive schematic content involved in the development and maintenance of psychological disorders. Since its first conceptualization by Beck et al. (1979), there has been much interest in elaborating, refining, and applying CR to a range of psychopathological states and psychiatric disorders. Psychotherapy process research has demonstrated that CR is an effective intervention for anxiety and depression (Clark 2013). However, despite the robust empirical support for CR efficacy and effectiveness, it should be noted that the overwhelming majority of CR outcome studies have been conducted with non-Hispanic White samples with few studies including Latinx samples. Likewise, very limited attention has been devoted to the cultural adaptation of CR since its inception.

Latinx individuals face stressors and barriers to mental health services that put them at a disproportionate risk of lower quality of life and reduced sense of overall well-being. Thus, psychologists and other mental health professionals should endeavor to address the different barriers to services to expand access for Latinx clients, especially those whose English proficiency and acculturation levels differ from the mainstream population in the United States.

Culturally adapted CR to address depression symptoms among Latinx clients appears promising. Clinicians should consider the use of the "*Si, Pero*" ("Yes, But") technique (Organista & Muñoz, 1996) along with *dichos*/metaphors in the treatment of Latinx clients to facilitate insight (see Table 1*;* Santiago-Rivera et al., 2009). Nevertheless, additional research is warranted. To date, a small number of published studies have investigated the effectiveness of culturally adapted CR interventions for monolingual Latinx clients. As immigrant and diverse populations continue to grow in the United States, the ability to deliver CBT interventions, including CR, in a culturally sensitive manner becomes crucial.

Key Clinical Considerations

- Consider the influence of cultural factors on the clinical presentation of Latinx clients. Psychologists must consider the influence of cultural factors on each aspect of treatment: diagnostic intake, case conceptualization, diagnosis, and treatment recommendations.
- Incorporate cultural values to promote engagement of Latinx clients. When working with Latinx clients who are low in acculturation, cultural values such as *respeto, personalismo, and simpatia* may aid in creating trust, promoting engagement, and creating a comfortable atmosphere for treatment.
- Use cultural adaptations of cognitive restructuring (CR) with Latinx clients. Latinx clients may have difficulty applying CR techniques. Thus, clinicians may consider using the "*Si, Pero*" ("Yes, But") technique to aid clients in understanding the concept of CR and replacing "unhelpful" thoughts with "helpful" ones (Organista & Muñoz, 1996). Clinicians may also consider incorporating *dichos*/metaphors throughout treatment to aid in facilitating insight (see Table 1; Santiago-Rivera et al., 2009).
- Incorporate cultural values in the termination of Latinx clients. In regard to termination, "keeping a door open" may be especially important with Latinx clients because they may have grown to deem their clinician as an important and salient person in their lives.

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